



# Fenchurch Claims Centre

## Supplemental Claimant Statement

We know an injury or illness can have an adverse impact on day-to-day activities that may involve physical or mental demands that are similar to those encountered at work. To assist us in the ongoing review of your disability as it relates to your ability to complete certain physical and mental tasks, we need to have a clear understanding of your functional capacities, activities of daily living, current medical treatment, and your compliance with prescribed treatment.

To allow a detailed review of your claim and determination of eligibility to continued benefits under your claim we ask that complete this questionnaire at the earliest opportunity and return the completed document by Fax or mail to the Fenchurch Claims Centre:

**Fax:** 1.888.473.5949

**Mail:** Fenchurch Claims Centre  
104 -2071 Kingsway Ave.  
Port Coquitlam, BC  
V3C 6N2

**INCOMPLETE/ILLEGIBLE ENTRIES WILL DELAY PROCESSING OF YOUR CLAIM**

Part 1 – Claimant Information		
Surname:	Given Name:	Initial(s):
Employer:	Occupation:	
Policy No:	Policy Class:	Claim No:
Part 2 – General Information		
Please describe your current medical status and provide comment on the progress you feel you have made since your disability commenced:		
<p>Other than the primary medical conditions accepted under your disability claim, do you feel there are any other medical conditions that contribute to your disability status? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please explain:</p>		

### Part 3 – Medical Information

Please list the name and contact information for all physicians/health care providers you are currently seeing for treatment:

Name: Phone: Specialty/Frequency of visits:

Address: Fax:

Name: Phone: Specialty/Frequency of visits:

Address: Fax:

Name: Phone: Specialty/Frequency of visits:

Address: Fax:

Please list all medications and dosages currently prescribed/taken:

Please list all pending/follow up appointments with your physicians/other health care providers:

### Part 3 – Functional Capacity

Please describe your typical daily activities at present:

Please describe any restrictions/limitations to your typical daily activities at present:

#### Part 4 – Rehabilitation and Retraining

Have you participated in any rehabilitation or retraining programs?  Yes  No

If yes, please provide details of the program, contact information, and dates attended:

Briefly describe the outcome/results of the rehabilitation/retraining program (if applicable):

#### Part 5 – Personal Care

What time do you typically wake up:

What time do you typically go to bed?

Do you have any trouble sleeping?  Yes  No

If yes, please describe your difficulty/sleeping pattern:

Has your sleeping pattern changed since your disability began?  Yes  No

If yes, please describe the change:

Do you require any assistance with your personal care and grooming needs?  Yes  No

If yes, please describe the assistance required:

## Part 6 – Household Care

Have your eating habits changed since your disability began?  Yes  No

Please describe any changes:

Are you able to do any housework?  Yes  No

If no, please describe your limitations (activity, frequency, duration, etc.):

Are you able complete the following household tasks?

Laundry  Yes  No    Dusting  Yes  No    Dishes  Yes  No    Mopping  Yes  No

Lawn care  Yes  No    Shoveling  Yes  No    Vacuum  Yes  No    Shopping  Yes  No

What distance do you travel to do your shopping:

How do you get there? Walk     Bike     Bus     Taxi     Drive self     Passenger     Other

If 'other', please describe:

Do you require assistance when shopping?  Yes  No

If yes, please explain:

Have there been any changes in your ability to care for your household since your disability began?  Yes  No

If yes, please describe these changes:

Do you participate or attend social activities/meetings/gatherings regularly?  Yes  No

If yes, please describe the nature and frequency of the activity:

Has there been any change to your regular social activities since your disability started?  Yes  No

If yes, please describe the changes:

#### ASSIGNMENT, CERTIFICATION AND AUTHORIZATION

**I CERTIFY** that the information in this form is true and complete to the best of my knowledge.

**I AUTHORIZE** any employer, physician, practitioner, health care professional, hospital, medical organization or clinic, insurance company, Workers' Compensation Board, group plan administrator, legal counsel, investigative body or agency, to release and exchange with FGIC any medical or benefit payment information, or any other information or records that may be required by FGIC in the management of my claim.

**I ACKNOWLEDGE** that any person who knowingly files a statement of claim containing materially false, incomplete, or misleading information, or conceals any material facts with intent to defraud or deceive the insurer, may be guilty of a fraudulent act subject to civil or criminal penalties, and may be denied benefits related to their claim.

**I ACKNOWLEDGE** that Fenchurch General Insurance Company (FGIC) and its authorized agents and representatives may investigate this statement.

**I AGREE** that a reproduction of this document (photocopy or electronic) shall be as valid as the original.

\_\_\_\_\_  
Claimant's Name (Printed) and Signature

\_\_\_\_\_  
Date

Contact number (day): \_\_\_\_\_

Contact number (evening): \_\_\_\_\_

Email: \_\_\_\_\_