



Financial  
Services  
Commission  
Of Ontario

Dispute  
Resolution  
Services

# Application for Mediation FORM A

Mediation file number

## Section 1 GENERAL INFORMATION

This section **MUST** be completed.

|                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                   |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. What was the date of the motor vehicle accident?<br>Year      Month      Day                                                                                                                                                                |  | 2. Who is making this application?<br><input type="checkbox"/> Claimant <input type="checkbox"/> Claimant's representative <input type="checkbox"/> Insurance company <input type="checkbox"/> Insurance company's representative |  |
| 3. Have you applied for mediation before?<br><input type="checkbox"/> No <input type="checkbox"/> Yes                                                                                                                                          |  |                                                                                                                                                                                                                                   |  |
| 4. Language preferred<br><input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other, specify ►                                                                                                            |  | 5. Do you want the mediation to be conducted in French?<br><input type="checkbox"/> No <input type="checkbox"/> Yes                                                                                                               |  |
| Do you want an in-person meeting with the other party?<br><input type="checkbox"/> No <input type="checkbox"/> Yes                                                                                                                             |  | Please note that it is within the mediator's discretion to conduct the mediation in person or by telephone conference.                                                                                                            |  |
| Do you have any accessibility requirements for the mediation? (e.g., wheel chair access, sign language interpreter, visual aids, or any other accommodation)<br><input type="checkbox"/> No <input type="checkbox"/> Yes    If Yes, describe ► |  |                                                                                                                                                                                                                                   |  |

## CLAIMANT

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                             |                                                                                                                                                   |                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Last name                   | First name                                                                                                                                        | Middle name          |
| Street address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                             | Apt./Unit                                                                                                                                         |                      |
| City                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Province/State              | Postal Code/Zip                                                                                                                                   | Country              |
| Home phone number<br>(    )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Work phone number<br>(    ) | Ext.                                                                                                                                              | Fax number<br>(    ) |
| Birth date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                             | Year                                                                                                                                              | Month    Day         |
| 1. What is the best way to reach you?<br><input type="checkbox"/> phone <input type="checkbox"/> mail <input type="checkbox"/> Email <input type="checkbox"/> fax <input type="checkbox"/> through my representative                                                                                                                                                                                                                                                                                                                                                                                     |                             | 2. Where is the best place to reach you?<br><input type="checkbox"/> home <input type="checkbox"/> work <input type="checkbox"/> other, specify ► |                      |
| 3. Email address (optional)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             |                                                                                                                                                   |                      |
| 4. Is the Claimant under 18 years old? <input type="checkbox"/> No    Or mentally incapable? <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> Yes    If Yes, the person filing the application on behalf of the claimant must also complete <b>Form P – Representing Minors and Mentally Incapable Persons</b> – and sign this application form. Form P is available on the Commission website: <a href="http://www.fSCO.gov.on.ca">www.fSCO.gov.on.ca</a> or by calling Mediation Inquiries in Toronto at (416) 590-7210 or Toll-Free at 1-800-517-2332, ext. 7210. |                             |                                                                                                                                                   |                      |

## CLAIMANT'S REPRESENTATIVE

|                                                                                                                                                                                                                                                                                                                                                     |                |                      |                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------|--------------------------|
| <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.                                                                                                                                                                                                                                                             | Last name      | First name           | File reference number    |
| Title                                                                                                                                                                                                                                                                                                                                               |                | Firm Name            |                          |
| Street address                                                                                                                                                                                                                                                                                                                                      |                | Apt./Unit            |                          |
| City                                                                                                                                                                                                                                                                                                                                                | Province/State | Postal Code/Zip      | Country                  |
| Work phone number<br>(    )                                                                                                                                                                                                                                                                                                                         | Ext.           | Fax number<br>(    ) | Email address (required) |
| The representative is:<br><input type="checkbox"/> Lawyer    Law Society licence number _____<br><input type="checkbox"/> Licensed paralegal    Law Society licence number _____<br><input type="checkbox"/> Not required to be licensed<br>Specify the type of exemption from the list of exemptions recognized in the Law Society's by-laws _____ |                |                      |                          |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|
| <b>Section 1 continued</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |
| <b>INSURANCE COMPANY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |
| Company name                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |
| Claim representative name                                                                                                                                                                                                                                                                                                                                                                                                                                             |                               | Claim number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                       |
| Policyholder name                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               | Policy number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                       |
| <b>INSURANCE COMPANY'S REPRESENTATIVE</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |
| <input type="checkbox"/> Mr.                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Mrs. | <input type="checkbox"/> Last name                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | First name            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | File reference number |
| Title                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                               | Firm name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                       |
| Street address                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Apt./Unit             |
| City                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Province/State                | Postal Code/Zip                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Country               |
| Work phone number<br>(   )                                                                                                                                                                                                                                                                                                                                                                                                                                            | Ext.                          | Fax number<br>(   )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Email address         |
| <b>MEDIATION PROCEEDINGS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |
| Did the Claimant notify the Insurance Company of the circumstances giving rise to a claim for a benefit and submit an application for the benefit within the times prescribed by the Statutory Accidents Benefits Schedule (SABS)?                                                                                                                                                                                                                                    |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |
| <input type="checkbox"/> Yes<br><input type="checkbox"/> No    If No, give reason ►                                                                                                                                                                                                                                                                                                                                                                                   |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |
| Was the Claimant provided with notice by the Insurance Company in accordance with the SABS that it requires an examination                                                                                                                                                                                                                                                                                                                                            |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |
| <input type="checkbox"/> Yes<br><input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                           |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |
| If Yes, did the claimant attend?                                                                                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |
| <input type="checkbox"/> Yes<br><input type="checkbox"/> No    If No, give reason ►                                                                                                                                                                                                                                                                                                                                                                                   |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |
| Does an issue in dispute relate to the denial by the Insurance Company of an invoiced amount on the grounds that a provider has not complied in whole or part with a request for information made by the Insurance Company on or after July 1, 2011?                                                                                                                                                                                                                  |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |
| <input type="checkbox"/> Yes    If Yes, give reason ►<br><input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                  |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |
| <b>Section 2 ISSUES IN DISPUTE</b> Provide a <b>full</b> description of the accident benefits that are in dispute.<br>(Attach extra sheets if necessary)                                                                                                                                                                                                                                                                                                              |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |
| <b>Does this claim involve optional benefits?</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |                               | <input type="checkbox"/> No <input type="checkbox"/> Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                       |
| <b>Does this claim involve catastrophic impairment?</b>                                                                                                                                                                                                                                                                                                                                                                                                               |                               | <input type="checkbox"/> No <input type="checkbox"/> Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                       |
| <input type="checkbox"/> <b>WEEKLY BENEFITS</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |
| Which weekly benefit are you disputing?<br><input type="checkbox"/> income replacement<br><input type="checkbox"/> non-earner<br><br>What are you disputing?<br><input type="checkbox"/> initial entitlement to benefits<br><input type="checkbox"/> length of time benefits were paid<br><input type="checkbox"/> amount of weekly benefits<br><input type="checkbox"/> entitlement to benefits past 104 weeks<br><input type="checkbox"/> other, specify ▼<br>_____ |                               | <div style="display: flex; justify-content: space-between;"> <div>           Year    Month    Day<br/>           Date submitted to insurer:         </div> <div>           Year    Month    Day<br/>           Date denied:         </div> </div>                                                                                                                                                                                                                                                              |                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                               | <div style="display: flex;"> <div style="flex: 1;">           If the Claimant received income benefits, state weekly amount and duration of payments.<br/>           \$ _____<br/>           From: _____ To: _____<br/>           Is the insurance company claiming a repayment of benefits?<br/> <input type="checkbox"/> No    <input type="checkbox"/> Yes    If yes, amount ▼<br/>           \$ _____         </div> <div style="flex: 1; border-left: 1px solid black; padding-left: 10px;"></div> </div> |                       |

| Section 2 continued                                                                                                                                                                                                                                                                   |                                    |  |              |  |     |  |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--|--------------|--|-----|--|--|--|--|
| <input type="checkbox"/> <b>CAREGIVER BENEFITS</b>                                                                                                                                                                                                                                    |                                    |  |              |  |     |  |  |  |  |
| Weekly amount in dispute?<br>\$ _____                                                                                                                                                                                                                                                 | Date submitted to insurer:         |  | Date denied: |  |     |  |  |  |  |
| From: _____ To: _____                                                                                                                                                                                                                                                                 | Name of service provider(s): _____ |  |              |  |     |  |  |  |  |
| What are you disputing?                                                                                                                                                                                                                                                               |                                    |  |              |  |     |  |  |  |  |
| <input type="checkbox"/> initial entitlement to benefits<br><input type="checkbox"/> length of time benefits were paid<br><input type="checkbox"/> amount of benefits<br><input type="checkbox"/> entitlement to benefits past 104 weeks<br><input type="checkbox"/> other, specify ► |                                    |  |              |  |     |  |  |  |  |
| <input type="checkbox"/> <b>ATTENDANT CARE BENEFITS</b>                                                                                                                                                                                                                               |                                    |  |              |  |     |  |  |  |  |
| Monthly amount in dispute?<br>\$ _____                                                                                                                                                                                                                                                | Date submitted to insurer:         |  | Date denied: |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Name of service provider(s): _____ |  |              |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Time period in dispute from:       |  |              |  | to: |  |  |  |  |
| <input type="checkbox"/> <b>MEDICAL BENEFITS 1</b>                                                                                                                                                                                                                                    |                                    |  |              |  |     |  |  |  |  |
| Amount in dispute?<br>\$ _____                                                                                                                                                                                                                                                        | Date submitted to insurer:         |  | Date denied: |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Name of service provider(s): _____ |  |              |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Type of service(s): _____          |  |              |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Time period in dispute from:       |  |              |  | to: |  |  |  |  |
| <input type="checkbox"/> <b>MEDICAL BENEFITS 2</b>                                                                                                                                                                                                                                    |                                    |  |              |  |     |  |  |  |  |
| Amount in dispute?<br>\$ _____                                                                                                                                                                                                                                                        | Date submitted to insurer:         |  | Date denied: |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Name of service provider(s): _____ |  |              |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Type of service(s): _____          |  |              |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Time period in dispute from:       |  |              |  | to: |  |  |  |  |
| <input type="checkbox"/> <b>MEDICAL BENEFITS 3</b>                                                                                                                                                                                                                                    |                                    |  |              |  |     |  |  |  |  |
| Amount in dispute?<br>\$ _____                                                                                                                                                                                                                                                        | Date submitted to insurer:         |  | Date denied: |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Name of service provider(s): _____ |  |              |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Type of service(s): _____          |  |              |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Time period in dispute from:       |  |              |  | to: |  |  |  |  |
| <input type="checkbox"/> <b>MEDICAL BENEFITS 4</b>                                                                                                                                                                                                                                    |                                    |  |              |  |     |  |  |  |  |
| Amount in dispute?<br>\$ _____                                                                                                                                                                                                                                                        | Date submitted to insurer:         |  | Date denied: |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Name of service provider(s): _____ |  |              |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Type of service(s): _____          |  |              |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Time period in dispute from:       |  |              |  | to: |  |  |  |  |
| <input type="checkbox"/> <b>REHABILITATION BENEFITS 1</b>                                                                                                                                                                                                                             |                                    |  |              |  |     |  |  |  |  |
| Amount in dispute?<br>\$ _____                                                                                                                                                                                                                                                        | Date submitted to insurer:         |  | Date denied: |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Name of service provider(s): _____ |  |              |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Type of service(s): _____          |  |              |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Time period in dispute from:       |  |              |  | to: |  |  |  |  |
| <input type="checkbox"/> <b>REHABILITATION BENEFITS 2</b>                                                                                                                                                                                                                             |                                    |  |              |  |     |  |  |  |  |
| Amount in dispute?<br>\$ _____                                                                                                                                                                                                                                                        | Date submitted to insurer:         |  | Date denied: |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Name of service provider(s): _____ |  |              |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Type of service(s): _____          |  |              |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Time period in dispute from:       |  |              |  | to: |  |  |  |  |
| <input type="checkbox"/> <b>REHABILITATION BENEFITS 3</b>                                                                                                                                                                                                                             |                                    |  |              |  |     |  |  |  |  |
| Amount in dispute?<br>\$ _____                                                                                                                                                                                                                                                        | Date submitted to insurer:         |  | Date denied: |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Name of service provider(s): _____ |  |              |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Type of service(s): _____          |  |              |  |     |  |  |  |  |
|                                                                                                                                                                                                                                                                                       | Time period in dispute from:       |  |              |  | to: |  |  |  |  |

| Section 2 continued                                                 |  |  |                                       |       |     |  |              |  |      |       |     |
|---------------------------------------------------------------------|--|--|---------------------------------------|-------|-----|--|--------------|--|------|-------|-----|
| <input type="checkbox"/> <b>CASE MANAGER SERVICES BENEFITS</b>      |  |  |                                       |       |     |  |              |  |      |       |     |
|                                                                     |  |  | Year                                  | Month | Day |  |              |  | Year | Month | Day |
| Amount in dispute?                                                  |  |  | Date submitted to insurer:            |       |     |  | Date denied: |  |      |       |     |
| \$                                                                  |  |  | Name of service provider(s):          |       |     |  |              |  |      |       |     |
|                                                                     |  |  | Time period in dispute from:          |       |     |  | to:          |  |      |       |     |
| <input type="checkbox"/> <b>OTHER EXPENSES</b>                      |  |  |                                       |       |     |  |              |  |      |       |     |
| <b>A <input type="checkbox"/> lost educational expenses</b>         |  |  | Year                                  | Month | Day |  |              |  | Year | Month | Day |
| Amount in dispute?                                                  |  |  | <b>A</b> Date submitted to insurer:   |       |     |  | Date denied: |  |      |       |     |
| \$                                                                  |  |  | Detail of expenses:                   |       |     |  |              |  |      |       |     |
|                                                                     |  |  | Time period in dispute from:          |       |     |  | to:          |  |      |       |     |
| <b>B <input type="checkbox"/> expenses of visitors</b>              |  |  | Year                                  | Month | Day |  |              |  | Year | Month | Day |
| Amount in dispute?                                                  |  |  | <b>B</b> Date submitted to insurer:   |       |     |  | Date denied: |  |      |       |     |
| \$                                                                  |  |  | Detail of expenses:                   |       |     |  |              |  |      |       |     |
|                                                                     |  |  | Time period in dispute from:          |       |     |  | to:          |  |      |       |     |
| <b>C <input type="checkbox"/> damage to clothing, glasses, etc</b>  |  |  | Year                                  | Month | Day |  |              |  | Year | Month | Day |
| Amount in dispute?                                                  |  |  | <b>C</b> Date submitted to insurer:   |       |     |  | Date denied: |  |      |       |     |
| \$                                                                  |  |  | Detail of expenses:                   |       |     |  |              |  |      |       |     |
|                                                                     |  |  | Date of replacement expenses:         |       |     |  |              |  |      |       |     |
| <b>D <input type="checkbox"/> housekeeping and home maintenance</b> |  |  | Year                                  | Month | Day |  |              |  | Year | Month | Day |
| Amount in dispute?                                                  |  |  | <b>D</b> Date submitted to insurer:   |       |     |  | Date denied: |  |      |       |     |
| \$                                                                  |  |  | Name of service provider(s):          |       |     |  |              |  |      |       |     |
|                                                                     |  |  | Time period in dispute from:          |       |     |  | to:          |  |      |       |     |
| <b>E <input type="checkbox"/> cost of examinations</b>              |  |  | Year                                  | Month | Day |  |              |  | Year | Month | Day |
| Amount in dispute?                                                  |  |  | <b>E</b> Date submitted to insurer:   |       |     |  | Date denied: |  |      |       |     |
| \$                                                                  |  |  | Date of examination or report:        |       |     |  |              |  |      |       |     |
|                                                                     |  |  | Type of examination(s):               |       |     |  |              |  |      |       |     |
|                                                                     |  |  | Examination(s) provided by:           |       |     |  |              |  |      |       |     |
| <b>E <input type="checkbox"/> cost of examinations</b>              |  |  | Year                                  | Month | Day |  |              |  | Year | Month | Day |
| Amount in dispute?                                                  |  |  | <b>E</b> Date submitted to insurer:   |       |     |  | Date denied: |  |      |       |     |
| \$                                                                  |  |  | Date of examination or report:        |       |     |  |              |  |      |       |     |
|                                                                     |  |  | Type of examination(s):               |       |     |  |              |  |      |       |     |
|                                                                     |  |  | Examination(s) provided by:           |       |     |  |              |  |      |       |     |
| <b>E <input type="checkbox"/> cost of examinations</b>              |  |  | Year                                  | Month | Day |  |              |  | Year | Month | Day |
| Amount in dispute?                                                  |  |  | <b>E</b> Date submitted to insurer:   |       |     |  | Date denied: |  |      |       |     |
| \$                                                                  |  |  | Date of examination or report:        |       |     |  |              |  |      |       |     |
|                                                                     |  |  | Type of examination(s):               |       |     |  |              |  |      |       |     |
|                                                                     |  |  | Examination(s) provided by:           |       |     |  |              |  |      |       |     |
| <input type="checkbox"/> <b>DEATH BENEFITS</b>                      |  |  |                                       |       |     |  |              |  |      |       |     |
|                                                                     |  |  | Year                                  | Month | Day |  |              |  | Year | Month | Day |
| Amount in dispute?                                                  |  |  | Date submitted to insurer:            |       |     |  | Date denied: |  |      |       |     |
| \$                                                                  |  |  | Name of deceased:                     |       |     |  |              |  |      |       |     |
|                                                                     |  |  | Relationship of deceased to claimant: |       |     |  |              |  |      |       |     |
| <input type="checkbox"/> <b>FUNERAL EXPENSES</b>                    |  |  |                                       |       |     |  |              |  |      |       |     |
|                                                                     |  |  | Year                                  | Month | Day |  |              |  | Year | Month | Day |
| Amount in dispute?                                                  |  |  | Date submitted to insurer:            |       |     |  | Date denied: |  |      |       |     |
| \$                                                                  |  |  | Name of deceased:                     |       |     |  |              |  |      |       |     |
|                                                                     |  |  | Relationship of deceased to claimant: |       |     |  |              |  |      |       |     |
| <input type="checkbox"/> <b>OTHER DISPUTES</b>                      |  |  |                                       |       |     |  |              |  |      |       |     |
|                                                                     |  |  | Year                                  | Month | Day |  |              |  | Year | Month | Day |
| Amount in dispute?                                                  |  |  | Date submitted to insurer:            |       |     |  | Date denied: |  |      |       |     |
| \$                                                                  |  |  | Detail of expenses:                   |       |     |  |              |  |      |       |     |
|                                                                     |  |  | Time period in dispute from:          |       |     |  | to:          |  |      |       |     |
| <input type="checkbox"/> <b>INTEREST</b>                            |  |  |                                       |       |     |  |              |  |      |       |     |
| Amount in dispute? Set out calculations.                            |  |  |                                       |       |     |  |              |  |      |       |     |
| \$                                                                  |  |  |                                       |       |     |  |              |  |      |       |     |

**It is expected that both parties have exchanged key documents prior to filing this Application for Mediation.**

**Documents -1.** List key documents in your possession which you will refer to in the mediation.

Extra sheets attached ☐

**Documents -2.** List key documents not currently in your possession which you intend to get from other sources.

Extra sheets attached ☐

Personal information requested on this form is collected under the authority of the Insurance Act, R.S.O. 1990, c. I.8 as amended. This information, including documents submitted with this application, will be used in the dispute resolution process for accident benefits.

### **Signature and Certification**

I certify that all information in this Application and attachments is true and complete. I authorize the insurance company to release all medical reports and information relating to the issues in dispute to Mediation Services, Dispute Resolution Services, Financial Services Commission of Ontario. I realize that information filed with this Application may be given to the other party in this dispute.

|                                    |                          |      |      |       |     |
|------------------------------------|--------------------------|------|------|-------|-----|
| Claimant name (please print)       | Claimant Signature       | Date | Year | Month | Day |
| Representative name (please print) | Representative Signature | Date | Year | Month | Day |

Send the **original and one copy** of the **completed** application to Mediation Services at the address noted below. Keep an additional copy of the completed application for yourself.

**Mediation Services  
Dispute Resolution Services  
Financial Services Commission of Ontario  
5160 Yonge Street, 14<sup>th</sup> Floor, Box 85  
Toronto, ON M2N 6L9**

**If you have any questions about this application, or want more information, contact:**

**Mediation Inquiries** In Toronto at: 416-590-7210 or Toll Free: 1-800-517-2332, ext. 7210 Fax: 416-590-7077

**FSCO website:** [www.fSCO.gov.on.ca](http://www.fSCO.gov.on.ca)