Financial Services Commission Of Ontario

Dispute Resolution Services

Application for Arbitration
FORM C

Arbitration file number

Section 1 GENERAL INFORMATION

1. What was the date of the motor vehicle accident?
Year Month Day

2. Provide mediation number and attach Report of Mediator
M- Report of Mediator attached ☐ No ☐ Yes

3. Do you have issues in dispute currently in arbitration?
☐ No ☐ Yes If Yes, provide arbitration file numbers ► A-

4. Language preferred
☐ English ☐ French ☐ Other, specify ►

APPLICANT

☐ Mr. ☐ Mrs. ☐ Ms. Last name First name Middle name

Street address Apt./Unit

City Province/State Postal Code/Zip Country

Home phone number ( ) | Work phone number ( ) Ext. | Fax number ( ) | Birth date Year Month Day

1. What is the best way to reach you?
☐ phone ☐ mail ☐ Email ☐ fax ☐ through my representative

2. Where is the best place to reach you?
☐ home ☐ work ☐ other, specify ►

3. Email address (optional)

4. Is the Claimant under 18 years old? ☐ No ☐ Yes Or mentally incapable? ☐ No ☐ Yes If Yes, the person filing the application on behalf of the applicant must also complete ***Form P – Representing Minors and Mentally Incapable Persons*** – and sign this application form. Form P is available on the Commission website: www.fsco.gov.on.ca or by calling Arbitration Inquiries in Toronto at (416) 590-7202 or Toll-Free at 1-800-517-2332, ext. 7202.

APPLICANT'S REPRESENTATIVE

☐ Mr. ☐ Mrs. ☐ 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 ( ) Ext. | Fax number ( ) | Email address (required)

The representative is:

☐ Lawyer Law Society licence number _____

☐ Licensed paralegal Law Society licence number _____

☐ Not required to be licensed

Specify the type of exemption from the list of exemptions recognized in the Law Society 's by-laws _____

Section 1 continued

INSURANCE COMPANY

Company name

Claim representative name	Claim number
Policyholder name	Policy number

NEUTRAL EVALUATION

Do you want Neutral Evaluation through the Commission?

☐ No ☐ Yes If Yes, 1. do you have the consent of the insurance company? ☐ No ☐ Yes

2. do you certify that all documents or reports listed in the Report of Mediator have been exchanged and that no other documents are required for the purpose of evaluating the issues in dispute?▼

☐ Yes **Signature ►**

ARBITRATION HEARING

1. Do you want to have an oral arbitration hearing? ☐ No ☐ Yes

2. Do you want the arbitration hearing to be conducted in French?	3. Will you require the services of an interpreter at the arbitration hearing?
☐ No ☐ Yes	☐ No ☐ Yes If Yes, what language? ►

4. Do you have any accessibility requirements for the arbitration? (e.g., wheel chair access, sign language interpreter, visual aids, or any other accommodation)
☐ No ☐ Yes If Yes, describe ►

5. Do you want the hearing to be outside the Greater Metropolitan Toronto Area?
☐ No ☐ Yes If Yes, where? ►

Section 2 ISSUES IN DISPUTE

Does this claim involve optional benefits? ☐ No ☐ Yes

Does this claim involve catastrophic impairment? ☐ No ☐ Yes

Check the benefits that were not resolved in mediation and which you now want arbitrated.
You cannot add new issues at this stage until they have been mediated.
For each benefit claimed, briefly explain the details, adding extra sheets or a Schedule if necessary.

☐ **WEEKLY BENEFITS**

Which weekly benefit are you disputing?

☐ income replacement
☐ non-earner

Weekly amount in dispute?

$ _____

From: Year Month Day To: Year Month Day

☐ **CAREGIVER BENEFITS**

Weekly amount in dispute?

$ _____

From: Year Month Day To: Year Month Day

☐ **ATTENDANT CARE BENEFITS**

Monthly amount in dispute?

$ _____

From: Year Month Day To: Year Month Day

PRINT RESET SAVE

Section 2 continued

☐ **MEDICAL BENEFITS** **1**

Year Month Day

Amount in dispute?

$

Date of Treatment and Assessment Plan:

Name of service provider(s):

Type of service(s) provided:

☐ **MEDICAL BENEFITS** **2**

Year Month Day

Amount in dispute?

$

Date of Treatment and Assessment Plan:

Name of service provider(s):

Type of service(s) provided:

☐ **MEDICAL BENEFITS** **3**

Year Month Day

Amount in dispute?

$

Date of Treatment and Assessment Plan:

Name of service provider(s):

Type of service(s) provided:

☐ **MEDICAL BENEFITS** **4**

Year Month Day

Amount in dispute?

$

Date of Treatment and Assessment Plan:

Name of service provider(s):

Type of service(s) provided:

☐ **REHABILITATION BENEFITS** **1**

Year Month Day

Amount in dispute?

$

Date of Treatment and Assessment Plan:

Name of service provider(s):

Type of service(s) provided:

☐ **REHABILITATION BENEFITS** **2**

Year Month Day

Amount in dispute?

$

Date of Treatment and Assessment Plan:

Name of service provider(s):

Type of service(s) provided:

☐ **REHABILITATION BENEFITS** **3**

Year Month Day

Amount in dispute?

$

Date of Treatment and Assessment Plan:

Name of service provider(s):

Type of service(s) provided:

☐ **CASE MANAGER SERVICES BENEFITS**

Amount in dispute?

$

Name of service provider(s):

from : to:

Year Month Day Year Month Day

Service(s) provided from: to:

PRINT RESET SAVE

Section 2 continued

For each benefit claimed, briefly explain the details. *(Attach extra sheets if necessary.)*▼

☐ **OTHER EXPENSES**

What is being disputed?
- ☐ **lost educational expenses**
- ☐ **expenses of visitors**
- ☐ **damage to clothing, glasses, etc**.

Amount in dispute?
$

- ☐ **housekeeping and home maintenance**

Total Amount in dispute?
$

Weekly amount in dispute:

Service(s) provided from: Year Month Day to: Year Month Day

Name of service provider(s):

- ☐ **cost of examinations**

Amount in dispute?
$

Date of examination or report: Year Month Day

Type of examination(s):

Examination(s) provided by:

Amount in dispute?
$

Date of examination or report: Year Month Day

Type of examination(s):

Examination(s) provided by:

Amount in dispute?
$

Date of examination or report: Year Month Day

Type of examination(s):

Examination(s) provided by:

☐ **DEATH BENEFITS**

Amount in dispute?
$

☐ **FUNERAL EXPENSES**

Amount in dispute?
$

☐ **OTHER DISPUTES**

Amount in dispute?
$

☐ **INTEREST**

☐ **EXPENSES OF THE HEARING**

☐ **SPECIAL AWARD -PROVIDE PARTICULARS**

PRINT RESET SAVE

Section 3 Document List **This section MUST be completed** (Attach extra sheets if necessary)

It is expected that the Applicant and the Insurer have exchanged key documents prior to the filing of an Application for Arbitration.

Documents -1. List key documents in your possession to which you will refer in the arbitration.
Identify the type of document (letter, medical report, tax return), the name of the writer or issuing institution and the date of the document.

Extra sheets attached ☐

Documents -2. List key documents not currently in your possession, which you intend to get from other sources (such as employers, doctors, Revenue Canada) for use in the arbitration. You should also include any documents requested from the other party (such as surveillance evidence, a summary of benefits paid) which have not yet been provided. *Wherever possible, identify the type of document (letter, medical report, tax return), the name of the writer or issuing institution and the date of the document.*

Extra sheets attached ☐

Personal information requested on this form is collected under the authority of the Insurance Act, R.S.O. 1990, c.1.8 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 Arbitration 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.

Applicant name (please print)	Applicant 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 Arbitration Services at the address noted below. Keep an additional copy of the completed application for yourself.

Arbitration Services
Dispute Resolution Services
Financial Services Commission of Ontario
5160 Yonge Street, 14th Floor, Box 85
Toronto, ON M2N 6L9

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

Arbitration Inquiries In Toronto at: 416-590-7202 or Toll Free: 1-800-517-2332, ext. 7202 Fax: 416-590-8462

FSCO website: www.fsco.gov.on.ca