Financial Services Commission of Ontario
5160 Yonge Street
Box 85
Toronto ON M2N 6L9

Dispute Resolution Services

Response by Insurer to an Application for Arbitration
Form E

Arbitration file number

An **Application for Arbitration** has been filed with the Dispute Resolution Services of the Financial Services Commission of Ontario (the "Commission"). A copy of the **Application for Arbitration** is attached. Your company **is named as** a party in this arbitration.

Use this form to respond to the issues raised in the Application. You can add new issues which have been mediated but not settled. You must complete **all** sections of the **Response**, serve a copy on the Applicant and provide proof of service to the Commission within **20** days of receiving this document.

Section 1

APPLICANT

Date of the motor vehicle accident?(yyyy/mm/dd)	

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

INSURANCE COMPANY

Company name			
Contact person ☐ Mr. ☐ Mrs. ☐ Ms.	Last name	First name	
Street address			Apt./Unit
City	Province/State	Postal Code/Zip	Country
Phone number ( )	Ext.	Fax number ( )	Email address (required)
Insurer's claim number		Policyholder name	Policy number

Section 1-continued

LEGAL 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
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 _____

TYPE OF HEARING

1.Does the insurer want an oral hearing?
☐ No ☐ Yes

2. Does the insurer require special service such as audio visual equipment?
☐ No ☐ Yes If Yes, describe? ►

3. Will the insurer be arranging for the services of a Court Reporter?
☐ No ☐ Yes If Yes, describe? ►

Section 2 ISSUES IN DISPUTE

Check the benefits that were not resolved in mediation and which the insurer now wants to respond to or now wants arbitrated. The insurer may add new issues which have been mediated at FSCO but not settled.
For each benefit disputed, briefly explain the insurer's position. (Attach OCF-9 and extra sheets if necessary.)

☐ **WEEKLY BENEFITS**

Which weekly benefit are you disputing?
☐ income replacement
☐ non-earner

What is being disputed?
☐ initial entitlement to benefits
☐ amount of weekly benefits
☐ other, specify ▼

If the insurer paid weekly benefits, state weekly amount and duration of payments.
$

From: To:

Date (yyyy/mm/dd)

Date of insurer's refusal to pay: _____

Reason for refusal:

PRINT RESET SAVE

Section 2 –continued

For each benefit checked, briefly explain the insurer's position on the issues in dispute. *(Attach OCF-9 and extra sheets if necessary.)*▼

☐ **CAREGIVER BENEFITS**

Amount in dispute?	Date (yyyy/mm/dd)
$	Date of insurer's refusal to pay:
What is being disputed? ☐ initial entitlement to benefits ☐ amount of weekly benefits ☐ other, specify ▼	Reason for refusal:

☐ **MEDICAL BENEFITS**

Amount in dispute?	Date (yyyy/mm/dd)
$	Date of insurer's refusal to pay:
	Reason for refusal:

☐ **MEDICAL BENEFITS**

Amount in dispute?	Date (yyyy/mm/dd)
$	Date of insurer's refusal to pay:
	Reason for refusal: Extra sheets attached ☐

☐ **REHABILITATION BENEFITS**

Amount in dispute?	Date (yyyy/mm/dd)
$	Date of insurer's refusal to pay:
	Reason for refusal:

☐ **REHABILITATION BENEFITS**

Amount in dispute?	Date (yyyy/mm/dd)
$	Date of insurer's refusal to pay:
	Reason for refusal: Extra sheets attached ☐

☐ **ATTENDANT CARE BENEFITS**

Amount in dispute?	Date (yyyy/mm/dd)
$	Date of insurer's refusal to pay:
	Reason for refusal:

☐ **CASE MANAGER SERVICES BENEFITS**

Amount in dispute?	Reason for refusal:
$	

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Section 2 –continued

For each benefit checked, briefly explain the insurer's position on the issues in dispute. *(Attach OCF-9 and extra sheets if necessary.)*▼

☐ **OTHER EXPENSES**

What is being disputed? ☐ lost educational expenses ☐ damage to clothing, glasses, etc ☐ expenses of visitors ☐ housekeeping and home maintenance Total amount in dispute? **$**	
☐ cost of examinations **$**	

☐ **DEATH BENEFITS**

Amount in dispute? **$**	

☐ **FUNERAL EXPENSES**

Amount in dispute? **$**	

☐ **OTHER DISPUTES**

Amount in dispute? **$**	

☐ **CLAIM FOR REPAYMENT**

Amount in dispute? **$**	Particulars:

☐ **INTEREST**

☐ **EXPENSES OF THE HEARING**

☐ **ABUSE OF PROCESS, FRIVOLOUS OR VEXATIOUS PROCEEDINGS**

☐ **RESPONSE TO SPECIAL AWARD CLAIM**

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SECTION 3 DOCUMENT LIST This section MUST be completed *(Attach OCF-9 and extra sheets)*

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 the insurer's possession, which you intend to get from other sources (such as employment records, Ontario Health Insurance records, Revenue Canada Agency records) for use in the arbitration. The insurer should also include any documents requested from the Applicant (such as financial or employment records) 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 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 Response and attachments is true and complete. I realize that copies of all information filed with this Response will be given to the other party in this dispute.

Name	Title	Signature	Date (yyyy/mm/dd)

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**

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