Property and Casualty - Auto Bulletins

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Bulletin

No. A-05/04

Property & Casualty

- Auto

Revised Transportation Expense Guideline, Revised Guideline on Insurers' Delivery of Documents to Insured Persons, Revised Professional Services Guideline and Revised Accident Benefits Application Package

To the attention of all insurance companies licensed

to transact automobile insurance in Ontario and to the attention of

Designated Assessment Centres (DACs)

With this Bulletin, the Financial Services Commission of Ontario (FSCO) is highlighting, for your reference, a revised *Transportation Expense Guideline*, a revised *Guideline on Insurers' Delivery of Documents to Insured Persons,* a revised *Accident Benefits Application Package*, a revised *Professional Services Guideline*, and clarification regarding administration fees.

Revised Transportation Expense Guideline

The amendments to the *Statutory Accident Benefits Schedule - Accidents On or After November 1, 1996* (SABS) set out in O. Reg. 458/03 require certain changes to the *Transportation Expense Guideline*.

Under the amended provisions of the SABS, as reflected in the revised *Transportation Expense Guideline*, an insurer is no longer liable to pay, in the case of accidents occurring on or after April 15, 2004, for the first 50 kilometres of any transportation to and from treatment sessions, counselling sessions, training sessions, assessments or examinations unless the person has sustained a catastrophic impairment. These provisions also extend to the transportation expenses of the insured person's aide or attendant.

The revised *Transportation Expense Guideline* is effective as of April 15, 2004 and replaces Superintendent's Guideline No. 03/01 released on March 31, 2001.

Revised Guideline on Insurers' Delivery of Documents to Insured Persons

Additional amendments to the SABS made by O. Reg. 458/03, effective as of January 10, 2004, the date of publication of O. Reg. 458/03 in *The Ontario Gazette*, revoke the prohibition against the use of certified or registered mail when delivering documents, including a notice, that must be given within five or fewer days. In light of these amendments, the revised Guideline clarifies the circumstances in which a health care provider may act as an insured person's authorized representative for the limited purpose of receiving certain documents from an insurer if specific conditions have been met.

The revised *Guideline on Insurers' Delivery of Documents to Insured Persons* replaces Superintendent's Guideline No. 09/03 released in October 2003.

Revised OCF-1 Accident Benefits Application Package

The OCF-23/198 *Pre-approved Framework Treatment Confirmation Form* will now replace the OCF-18 *Treatment Plan* in the OCF-1 *Accident Benefits Application Package* to encourage use of the *Pre-approved Framework (PAF) Guidelines*. The OCF-23/198 is a claim form used by a provider to notify the insurance company that they have initiated treatment under a PAF Guideline.

The new forms are effective March 1, 2004.

Revised Professional Services Guideline

The *Professional Services Guideline* released on January 9, 2004 with Bulletin No. A- 02/04 outlines new hourly rates for certain professional services applicable to catastrophic impairments. The revised *Professional Services Guideline* released with this Bulletin clarifies the application of the maximum hourly rates for catastrophic impairments.

When the insured person has been determined to have sustained a catastrophic impairment, the higher hourly rates for catastrophic impairments will be applied back to the later of February 1, 2004 (the effective date of the revised *Professional Services Guideline*) or the date of the accident. For example, if the insured person has an automobile accident on December 2, 2003 and is determined on March 1, 2004 to have a catastrophic impairment, the higher hourly rates are effective for all applicable services rendered on or after on February 1, 2004. Insurers will be expected to readjust accounts already paid where required as the result of a catastrophic impairment determination.

Administration Fees

"Expenses related to professional services" under the SABS, the *Professional Services Guideline* and the *Designated Assessment Centre Fee Guideline* include all administration costs, overhead, and related fees. Health care providers and Designated Assessment Centres (DACs) are not permitted to bill for administration or any other charges or add surcharges that have the result of increasing the effective hourly rate beyond what is permitted under the *Professional Services Guideline or Designated Assessment Centre Fee Guideline.*

Copies of Guidelines and Forms

Copies of the revised *Transportation Expense Guideline, Guideline on Insurers' Delivery of Documents to Insured Persons* and revised *Professional Services Guideline*, referred to in this Bulletin are attached for your information and will be published in the March 13, 2004 edition of The Ontario Gazette. Also attached is the revised OCF-1. The Guidelines and forms can also be downloaded from the FSCO Web site at: www.fsco.gov.on.ca

Bryan P. Davies

Chief Executive Officer and Superintendent of Financial Services

March 3, 2004

Attachments (PDF):

- Revised Transportation Expense Guideline
- Revised Guideline on Insurers' Delivery of Documents to Insured Persons
- Revised Professional Services Guideline
- Revised OCF-1 Accident Benefits Application Package


To view PDF files, you will require Adobe Acrobat® Reader version 7.0. You can download this free software from Adobe's Web site.

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Financial Services Commission of Ontario
Commission des services financiers de l'Ontario

March 2004

Transportation Expense Guideline

Superintendent's Guideline No. 04/04

Transportation Expense Guideline

This Guideline is issued pursuant to section 268.3 of the *Insurance Act* for the purpose of subsections 14 (5), 15 (11) and 24 (3) of the *Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996* (SABS). This Guideline replaces Guideline No. 3/01 effective April 15, 2004.

Purpose

The purpose of the *Transportation Expense Guideline* is to provide a framework for insurers and insured persons to determine the circumstances under which expenses related to transportation of an insured person to and from treatment sessions, counselling sessions, training sessions, assessments and examinations must be paid by an insurer. The Guideline sets out authorized expenses and applicable rates for the purpose of subsections 14 (5), 15 (11) and 24 (3) of the SABS.

In light of amendments made to subsections 14 (6), 15 (12) and 24 (4) of the SABS by O. Reg. 458/03 as filed on December 24, 2003, the amounts payable under the SABS for transportation expenses depend in part on whether the accident occurred before or after April 15, 2004. For this reason, the Guideline is divided into two sections:

(a) *Accidents occurring before April 15, 2004*; and
(b) *Accidents occurring on or after April 15, 2004.*

Please ensure that you refer to the appropriate section of this Guideline, based on the date of the accident in question.

(a) *Accidents occurring before April 15, 2004*

Authorized Expenses

The insurer is liable to pay for all reasonable and necessary transportation expenses for each trip that the insured person makes to and from treatment sessions, counselling sessions, training sessions, assessments and examinations. The insurer is also liable to pay for all reasonable and necessary transportation expenses of the insured person's aide or attendant. Transportation expenses are calculated based on the most direct route. Transportation expenses include parking fees incurred.

The mode of transportation selected should be the most economical, practical for the distance to be travelled, and appropriate under the specific circumstances.

Use of Automobiles

The insurer is liable to pay a mileage expense for transportation of the insured person and their aide or attendant, to and from treatment sessions, counselling sessions, training sessions, assessments and examinations using the insured person's automobile, excluding the first 50 kilometres of each

round-trip. The 50 kilometre “deductible” is only applicable once in any round-trip. This applies also to minors who are driven to treatment sessions, counselling sessions, training sessions, examinations or assessments.

For the purpose of this Guideline, the “insured person’s automobile” includes any automobile owned or leased by the insured person or any other automobile to which the insured person has access.

The rate that is to be used to calculate transportation expenses for the use of the insured person’s automobile is 27.5¢ per kilometre travelled.

Use of Taxis

The insurer is liable to pay for reasonable and necessary taxi fare incurred by an insured person and their aide or attendant provided that,

- the insured person does not own or have access to an automobile; or
- the insured person is unable to operate an automobile; or
- it is reasonable and practical in the circumstances to take a taxi.

Other Modes of Transportation

Insurers are liable to pay for reasonable and necessary expenses for other modes of transportation where circumstances warrant. An insured person should discuss the matter with his/her insurer before incurring expenses for air, rail and bus transportation services.

(b) *Accidents occurring on or after April 15, 2004*

Authorized Expenses

Subject to the 50 kilometre “deductible” referred to below, the insurer is liable to pay for all reasonable and necessary transportation expenses for each trip that the insured person makes to and from treatment sessions, counselling sessions, training sessions, assessments or examinations. The insurer is also liable to pay for all reasonable and necessary transportation expenses of the insured person’s aide or attendant. Transportation expenses are calculated based on the most direct route. Transportation expenses include parking fees incurred.

The mode of transportation selected should be the most economical, practical for the distance to be travelled, and appropriate under the specific circumstances.

Use of Automobiles

For the purpose of this Guideline, the “insured person’s automobile” includes any automobile owned or leased by the insured person or any other automobile to which the insured person has access.

Subject to the 50 kilometre “deductible” referred to below, the rate that is to be used to calculate transportation expenses for the use of the insured person’s automobile is 27.5¢ per kilometre travelled.

Use of Taxis

Subject to the 50 kilometre "deductible" referred to below, the insurer is liable to pay for reasonable and necessary taxi fare incurred by an insured person and their aide or attendant provided that,

- the insured person does not own or have access to an automobile; or
- the insured person is unable to operate an automobile; or
- it is reasonable and practical in the circumstances to take a taxi.

This provision also applies to all transportation expenses of the insured person's aide or attendant.

Other Modes of Transportation

Subject to the 50 kilometre "deductible" referred to below, the insurer is liable to pay for reasonable and necessary expenses for other modes of transportation where circumstances warrant. An insured person should discuss the matter with his/her insurer before incurring expenses for air, rail and bus transportation services.

50 Kilometre "Deductible"

As set out in clauses 14 (6) (b), 15 (12) (b) and 24 (4) (b) of the SABS as amended by O. Reg. 458/03, the insurer is not liable to pay for the first 50 kilometres of transportation (whether or not in the insured person's automobile) to and from treatment sessions, counselling sessions, training sessions, assessments and examinations, unless the insured person sustained a catastrophic impairment as a result of the accident. The 50 kilometre "deductible" is only applicable once in any round-trip. These provisions also apply to minors who are driven to treatment sessions, counselling sessions, training sessions, assessments and examinations, and to transportation expenses of the insured person's aide or attendant.

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

March 2004

Guideline on Insurers' Delivery of Documents to Insured Persons

Superintendent's Guideline No. 05/04

Guideline on Insurers' Delivery of Documents to Insured Persons

Introduction

This Guideline is issued pursuant to section 268.3(1) of the *Insurance Act* for the purposes of O. Reg. 403/96, the *Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996* (SABS) as amended. This revised Guideline replaces Superintendent's Guideline No. 09/03 released in October, 2003 titled *Insurers' Delivery of Documents to Insured Persons*. This revised Guideline clarifies the options for insurers when delivering documents and notices to insured persons in light of recent amendments to the SABS made by O. Reg. 458/03.

Section 68 of the SABS sets out options for delivery of documents and notices. The amendments to this section made by O. Reg. 458/03 revoke the prohibition against the use of certified or registered mail when delivering documents, including a notice, that must be given within five or fewer days. These changes became effective on January 10, 2004, the date of publication of O. Reg. 458/03 in *The Ontario Gazette*. Regular mail continues to be prohibited for delivery of any notice that must be given within five or fewer days.

As a result of these amendments to the SABS, where a document must be delivered within five or fewer business days to an insured person who is not represented by a solicitor or other authorized representative and does not have a fax machine, the SABS permits the insurer to deliver the document personally or by certified or registered mail. Subsection 68(4) of the SABS contains provisions for leaving the document with an adult at the insured person's residence if delivery directly to the insured person is not possible.

A health care provider[1] may, for the purpose of receiving certain documents from the insurer on behalf of the insured person, agree to act as the insured person's authorized representative for that limited purpose in the particular situations enumerated below.

Process for health care provider to act as an insured person's authorized representative for purpose of receiving documents from an insurer

The insurer may deliver a document to an insured person via a health care provider in the following circumstances:

1. The insured person is not already represented by a lawyer or other authorized representative[2];

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[1] For the purposes of this Guideline, "health care provider" means:

(a) in the case of an OCF-18, a member of a health profession as defined in the SABS
(b) in the case of an OCF-22, a member of a health profession as defined in the SABS
(c) in the case of an OCF-23/198, a health practitioner as defined in the SABS.

A health care provider should, before agreeing to act in accordance with such an authorization, confirm with the insured person that he or she is not already represented by a lawyer or other authorized representative.

[2] For the purposes of this Guideline, "other authorized representative" is a person named in Part 2 of the insured person's OCF-1, Application for Accident Benefits, to whom the insurer can deliver documents by fax under subsection 68(2)(a) of the SABS.

2. The insured person's authorization is expressly limited to authorizing the health care provider to receive:

    i. the insurer's written notice in response to:

        (a) a Treatment Plan (OCF-18),
        (b) an Application for Approval of an Assessment or Examination (OCF-22), or
        (c) a Pre-approved Framework Treatment Confirmation Form (OCF-23/198), or,

    ii. an insurer examination report under subsection 42(7) of the SABS;

3. The health care provider agrees to act in accordance with the authorization;

4. The signed authorization is provided to the insurance company prior to the insurer's delivery of the document referred to in the authorization; and

5. The insurer relies on the authorization to deliver only such documents as are expressly referred to in the authorization.

Health care provider's obligation upon receiving the document from the insurer:

Upon receipt of the document from the insurer, the health care provider is obliged to immediately notify the insured person of the substance of the document by telephone and mail a copy of the document to the insured person by ordinary mail.

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

March 2004

Professional Services Guideline

Superintendent's Guideline No. 06/04

Professional Services Guideline

Introduction

This Guideline is issued pursuant to subsection 268.3 (1) of the *Insurance Act* for the purposes of subsections 14 (4), 15 (6), 17 (2) and 24 (2) of the *Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996* (SABS), and applies to expenses related to services rendered on or after February 1, 2004.

The Superintendent's *Professional Services Guideline No. 05/03* continues to apply to expenses related to services rendered between November 1, 2003 and January 31, 2004 with the following exception: expenses related to services provided pursuant to treatment plans approved before September 18, 2003 are payable at the rates set out in the treatment plans as approved, whether such services are rendered before or after November 1, 2003.

Purpose

This Guideline establishes the maximum expenses payable by automobile insurers under the SABS related to the services of any of the health care professions or health care providers listed in the Guideline. These maximums are applicable to:

- a medical benefit under clauses 14 (2) (a), (b), or (h) of the SABS;
- a rehabilitation benefit under clauses 15 (5) (a) to (g) or (l) of the SABS;
- case management services under subsection 17 (1) of the SABS; or
- conducting an examination or assessment or provision of a certificate, report or treatment plan under subsection 24 (1) of the SABS.

Insurers are not prohibited from paying above any maximum amount or hourly rate established in the Guideline.

Services provided by health care professionals/providers, unregulated providers and other occupations not listed in the Guideline are not covered by the Guideline. The amounts payable by an insurer related to services not covered by the Guideline are to be determined by the parties involved.

The Guideline does not apply to fees charged by Designated Assessment Centres.

Maximum Fees

Automobile insurers are not liable to pay for expenses related to professional services rendered to an insured person that exceed the following maximum hourly rates.

Health Care Profession or Provider	Maximum Hourly Rate *except catastrophic impairments*	Maximum Hourly Rate *catastrophic impairments*[*]
Chiropractors	$95.00	$114.00
Massage Therapists	$49.00	$75.00
Occupational Therapists	$84.00	$101.00
Physiotherapists	$84.00	$101.00
Podiatrists	$84.00	$101.00
Psychologists and Psychological Associates	$126.00	$151.00
Speech Language Pathologists	$94.50	$113.00
Registered Nurses, Registered Practical Nurses and Nurse Practitioners	$77.00	$92.00
Unregulated Providers:		
Case Managers	$49.00	$75.00
Kinesiologist	$49.00	$75.00
Family Counsellors	$49.00	$75.00
Psychometrists	$49.00	$75.00
Rehabilitation Counsellors	$49.00	$75.00
Vocational Counsellors	$49.00	$75.00

Expenses for Completion of Forms

Automobile insurers are not liable to pay for expenses related to the completion of certain accident benefit forms by the health professionals and providers listed in this Guideline that exceed the maximums set out below. These maximums do not apply to the assessments related to the completion of these forms.

[*] This rate applies to all services rendered on or after February 1, 2004 to an insured person whose impairment is determined to be a catastrophic impairment as defined in SABS ss. 2 (1.1) (a) to (g) and 2 (1.2) (a) to (g), whether such services are rendered before or after such determination is made.

The expense for completion of an Application for Approval of an Assessment or Examination (OCF-22) is payable only following the approval by the insurer of any assessment or examination proposed in the OCF-22, or a determination by a Designated Assessment Centre that any assessment or examination proposed in the OCF-22 is reasonably required.

Form	Maximum Payable for Completion of Form
Disability Certificate (OCF-3)	$62
Treatment Plan Form (OCF-18)	$62
Form 1 - Assessment of Attendant Care Needs	$62
Automobile Insurance Standard Invoice (OCF-21)	$0
Application for Approval of an Assessment or Examination (OCF-22)	$62

Collateral Benefits

In respect of any expense referenced in this Guideline or in Superintendent's *Professional Services Guideline* No. 05/03, the amount which an insurer would otherwise be liable to pay is subject to reduction by that portion of the expense for which payment is reasonably available under any insurance plan or law or under any other plan or law.

Accident Benefits Application Package

Use this package to apply for benefits if you were injured in an automobile accident on or after November 1, 1996.

About this Application for Accident Benefits

Please note that all automobile accidents involving bodily injury must be reported to the police. Claims for certain accident benefits must be made within 7 days. Please contact your adjuster for further information.

There are five forms in this package:

- **Application for Accident Benefits (OCF-1)**

  Fill out this form when you are applying for benefits **for the first time** as a result of an accident, including if you are injured and are applying for income replacement benefits. You may be eligible for weekly benefits even if you were unemployed or retired at the time of the accident.

  This Application for Accident Benefits form must be returned within 30 days after receiving the package. If you are unable to return it within 30 days, submit it to your insurance company anyway and explain why you were not able to complete it within 30 days. Return the original form to the insurance company and make a copy for your records.

- **Employer's Confirmation of Income (OCF-2)**

  If the insurance company asks you to, please give this form to your employer. This form is completed by you or your representative and by your employer. If you had more than one employer during the past 52 weeks, it may be necessary for each employer to complete a separate form. Your insurance company may ask for other proof of income.

- **Disability Certificate (OCF-3)**

  If the insurance company asks you to, please fill out the first section and give this form to your health practitioner (chiropractor, dentist, occupational therapist, nurse practitioner, optometrist, physician, physiotherapist, occupational therapist, speech language pathologist or psychologist). This form is completed by you or your representative and by your health practitioner.

- **Permission to Disclose Health Information (OCF-5)**

  If the insurance company asks you to, please complete this form. The insurance company requires your medical information in order to correctly determine your eligibility for benefits. Health professionals require your written permission to disclose this information to the insurance company.

- **Pre-approved Framework Treatment Confirmation Form (OCF-23/198)**

  This form must be completed to confirm treatment received under a Pre-approved Framework Guideline. There are exceptions. Please contact your insurance company to find out if this form is required.

After the insurance company reviews your complete application package, you will be contacted about the benefits you are entitled to receive. If your insurance company needs any additional information in order to process your application, they will contact you.

Warning - Offences

It is an offence under the *Insurance Act* to knowingly make a false or misleading statement or representation to an insurer in connection with the person's entitlement to a benefit under contract of insurance. The offence is punishable on conviction by a maximum fine of $100,000 for the first offence and a maximum fine of $200,000 for any subsequent conviction.

It is an offence under the federal *Criminal Code* for anyone to knowingly make or use a false document with the intent it be acted on as genuine and the offence is punishable, on conviction, by a maximum of 10 years imprisonment.

It is an offence under the federal *Criminal Code* for anyone, by deceit, falsehood or other dishonest act, to defraud or to attempt to defraud an insurance company. The offence is punishable, on conviction, by a maximum of 10 years imprisonment for fraud involving an amount over $5,000 or otherwise a maximum of 2 years imprisonment.

Incomplete or incorrect information may result in your application being denied.

Where do I send the Application Forms?

Please follow the instructions below.

1. If You Own, Lease, or Have Regular Use of a Company Automobile

As of the date of the accident did you, your spouse or someone you are dependent on (please check all the options that apply to you):

- ☐ Own an automobile?
- ☐ Lease or have a contract to rent an automobile for more than 30 days?
- ☐ Drive a company automobile which was made available for your regular use?

☐ Yes - If you checked only one, send the forms to the insurance company that insures this automobile.

☐ Yes - If you checked more than one, send the forms to the insurance company of the vehicle in which you were an occupant at the time of the accident.

☐ Yes - If you checked more than one and were not an occupant in either of the automobiles, send the forms to the insurer of either vehicle (you choose).

☐ No - If none apply, continue to 2.

2. If You are a Listed Driver

Are you listed as a driver on somebody's insurance policy?

☐ Yes - If yes, send your forms to the insurance company that issued the policy you are listed on.

☐ No - If no, continue to 3.

The following categories only apply if:

- You, your spouse or someone that you are dependent upon **does not own, lease, or regularly use a company** automobile.
- You are **not listed** as a driver on a policy.

3. Occupant of Somebody Else's Automobile

Were you an occupant of somebody else's automobile that was insured at the time of the accident?

☐ Yes - If yes, send your forms to the insurance company that insures this automobile.

☐ No - If no, continue to 4.

4. Pedestrian or Bicyclist

Were you a pedestrian or a bicyclist struck by an automobile that was insured at the time of the accident?

☐ Yes - If yes, send your forms to the insurance company of the automobile that struck you.

☐ No - If no, continue to 5.

5. Uninsured Automobile

Were you an occupant of an automobile that was not insured at the time of the accident?

☐ Yes - If yes, send your forms to the insurance company of any other automobile that was involved in the accident.

☐ No - If no, continue to 6.

6. None of the Above Apply

If you do not have automobile insurance and no other automobile involved in the accident either has automobile insurance or can be identified, you may be entitled to obtain accident benefits from the Motor Vehicle Accident Claims Fund. Please complete the entire application package and see Part 11.

Return this form to:

Application for Accident Benefits (OCF-1)

Use this form for accidents that occur on or after November 1,1996.

Claim Number:	
Policy Number:	
Date of Accident: (YYYYMMDD)	

A separate form must be completed for each person who is applying for accident benefits. Completion of ALL sections is mandatory. **Your application may be denied if information is incomplete or incorrect. Please print clearly.**

Part 1 Applicant Information

Last Name

☐ Male ☐ Female

Marital or Same Sex Partner Status
☐ Single ☐ Separated ☐ Same-Sex Partner
☐ Married ☐ Divorced
☐ Common-law ☐ Widow(er)

First Name and Initial

Address

City

Province

Is anyone dependent on you for financial support or care?
☐ Yes, how many persons? _____
☐ No

Postal Code

Fax Number

Area Code

Birth Date (year month day)

Home Telephone

Work Telephone

You can be reached:
☐ by telephone
☐ by personal visit
☐ other _____
☐ at home
☐ at work

Language Spoken:

What is the best time to reach you:
Day(s) of the week
Time of day ☐ a.m. ☐ p.m.

Part 2 Applicant's Representative (if applicable)

Complete this section only if the applicant injured in the accident is deceased, is a minor, is unable to fill out the form on their own, or has retained you as their representative.

Last Name

First Name and Initial

Relationship with applicant
☐ Parent ☐ Guardian
☐ Lawyer ☐ Other _____
☐ Other Paid Representative

Address

City

Province

Postal Code

Home Telephone

Work Telephone

FAX Number

Part 3 Accident Details

Date of Accident (year month day)

Time of Accident : ☐ a.m. ☐ p.m

You were a: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other _____

Accident Location: Hwy. No./Street Name

City

Province

Did the accident occur while you were at work?	☐ Yes	☐ No
Did you file a claim with the Workplace Safety and Insurance Board?	☐ Yes	☐ No
Was the accident reported to the police?	☐ Yes (Give details below)	☐ No

Officer Name	Badge No.	Date accident reported to the police	year month day

Police Department/Collision Reporting Centre

Were you charged? ☐ Yes (Give details) ☐ No

Give a brief description of the accident. If you suffered any injuries as a result of the accident, describe the cause and extent of the injuries.

☐ additional sheets attached

Part 3 Accident Details (cont'd)

Were you able to return to your normal activities following the accident?	☐ Yes	☐ No
Did you go to the hospital?	☐ Yes (Give details below)	☐ No
Did you go see a health professional? (eg. physician, chiropractor, physiotherapist)	☐ Yes (Give details below)	☐ No

Name of Facility	Name of Health Professional	
Address		
City	Province	Postal Code

Has this provider begun any treatment?

☐ additional sheets attached

Part 4 Details of Automobile Insurance

In order to determine which automobile insurer is responsible for paying benefits, it is necessary to know whether you have your own policy or whether you are covered by somebody else's insurance policy. To help make that determination, please complete the following:

A Are you covered under any of the following automobile insurance policies?

Your own policy	☐ Yes	☐ No
Your spouse's policy	☐ Yes	☐ No
The policy of any person on whom you are dependent (e.g. - a parent)	☐ Yes	☐ No
A policy that lists you as a driver (e.g.- a friend)	☐ Yes	☐ No
Your employer's policy (e.g.- company car) or spouse's employer's policy	☐ Yes	☐ No
A policy insuring long-term rental cars (for rentals exceeding 30 days)	☐ Yes	☐ No

If you answered **'No"** to **all** of the above, go to **B** If you answered **"Yes"** to **any** of the above, complete the following:

Name of Policyholder		
Insurance Company	Policy Number	
Automobile - Make, Model, Year	Licence Plate Number	
Were you an occupant of this automobile at the time of the accident?	☐ Yes	☐ No

If you answered **"Yes"** to more than one box in this part, provide additional insurance details below.

Name of Policyholder		
Insurance Company	Policy Number	
Automobile - Make, Model, Year	Licence Plate Number	
Were you an occupant of this automobile at the time of the accident?	☐ Yes	☐ No

B If you checked "**No**" to all of the boxes in **A** **you must send** your application to the insurer of the automobile that you occupied at the time of the accident, or the vehicle that struck you if you were a pedestrian or bicyclist. If this automobile was not insured or unidentified, describe any other vehicle involved in the accident. **Provide details below.**

The policy you are claiming under insures:	**Vehicle type covered by this policy:**	
☐ The vehicle I was riding in at the time of the accident	☐ Passenger	☐ Truck
☐ The vehicle that struck me as a pedestrian/bicyclist	☐ Motorcycle	☐ Bus
☐ Another vehicle that was involved in the accident	☐ Taxi/Limousine	☐ Snowmobile
	☐ Other _____	

Part 4 Details of Automobile Insurance (cont'd)

Owner of the Vehicle	Home Telephone	
Address	Work Telephone	
City	Province	Postal Code
Automobile - Make, Model, Year		
Insurance Company	Policy Number	
Name of Policyholder	Licence Plate Number	

Did you report the accident to any other insurance company? ☐ Yes (Give details below) ☐ No

Insurance Company	Type of Insurance

Part 5 Applicant Status

Which of the following describes your status at the time of the accident?

Employed
- ☐ Employed and working
- ☐ Self-Employed

Not Employed
- ☐ Unemployed
- ☐ Unemployed **and**,
  - ☐ have worked 26 weeks in the last 52 weeks
  - ☐ receiving Employment Insurance Benefits
  - ☐ have a written agreement to start work within 1 year
- ☐ Retired

- ☐ **Student or recent graduate**
- ☐ **Caregiver**

Part 6 Student Attending School

Were you attending school on a full-time basis at the time of accident or had you completed your education less than one year before the accident?

☐ Yes (Give details below) ☐ No (Continue to Part 7)

Name of School			Date Last Attended	year month day
Address			Program and Level	
City	Province	Postal ~~C~~ode	Projected Date for Completion of Studies	year month day

Are you now attending school? ☐ Yes (Enter date) year month day ☐ No

Were you able to return to school after the accident? ☐ Yes (Enter date) year month day ☐ No

Part 7 Caregiver

You can apply for caregiver benefits if, at the time of the accident, you were primarily responsible for the care of persons who are living with you and are under 16 years of age or over 16 years of age and are physically or mentally disabled. If you qualify for this benefit you are required to submit bills and receipts for expenses incurred for the care of your dependants.

Were you the main caregiver to people living with you, at the time of the accident?

☐ Yes (Complete information below) ☐ No (Continue to Part 8)

Were you paid to provide care to these people? ☐ Yes (Continue to Part 8) ☐ No

List the people who you were caring for at the time of the accident.

Name	Date of Birth year month day	Disabled Yes	Disabled No
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

☐ additional sheets attached

Part 7 Caregiver (cont'd)

As a result of your injuries do you suffer a substantial inability to engage in the caregiving activities in which you engaged at the time of the accident?

☐ Yes (Explain below) From what date? year month day ☐ No

Explanation:

☐ additional sheets attached

Were you able to return to the caregiving activities after the accident?

☐ Yes (Enter date) year month day ☐ No

Part 8 Income Replacement Determination

Give details of your employment for the past 52 weeks. Start with your current or most recent employer. If you had accepted a written job offer to start within the next year, list the employer below and include the start date. If you held more than one position with the same employer, use a separate line for each position. Gross income is before taxes and deductions. **If you were self-employed during the 4 weeks prior to the accident, please consider yourself the employer for the purpose of completing this section.**

Date Year/Month/Day	Name and address of Most Recent Employer	Position/Essential Tasks	No. of Hours Per Week	Gross Income for the Period	DO NOT WRITE HERE Occupational Code
From: To:				$	
From: To:				$	
From: To:				$	
From: To:				$	

☐ additional sheets attached

Do your injuries prevent you from working?

☐ Yes From what date? year month day ☐ No (Continue to Part 10)

Were you able to return to work after the accident?

☐ Yes (Enter date) year month day ☐ No

The amount of your benefit is based on your past income. During which of the following periods did you have the highest average weekly income?

☐ last 4 weeks(not applicable for self-employed persons)
☐ last 52 weeks
☐ last fiscal year (self-employed only)

Part 9 Income Tax Status

The amount of the benefit you are eligible for, depends on your income tax status. We require the following information to calculate the amount of your benefit. You may be required to provide additional information to help your insurance company calculate your benefit (eg. pay stubs, tax receipts).

On the date of the accident, were you paying support payments to a spouse or former spouse?

☐ Yes (Enter dates) ☐ No

From: year month day To: year month day Total Amount Paid $

☐ additional sheets attached

Marital status for tax purposes?	If you are married or equivalent to married, what is the expected annual income of your spouse or dependant for the calendar year in which the accident occurred?	Did you claim the Disability Amount Non-Refundable Tax Credit on your most recent income tax return?
☐ Single ☐ Same-Sex Partner ☐ Married ☐ Equivalent to Married	$	☐ Yes ☐ No

Part 10 Other Insurance or Collateral Payments

Do you, your spouse or anyone you are dependent on (eg. parents) have any other benefit plan that covers you (eg. group or private, union, disability, medical or dental, etc.)?

☐ Yes (Give details below) ☐ No

Name of Benefit Payor	Type of Coverage	Policy or Certificate Number

During the past 52 weeks, did you receive any income from a disability benefit plan? ☐ Yes (Enter dates) ☐ No

From: year month day To: year month day Total Amount Received $

Are you receiving Employment Insurance Benefits? ☐ Yes (Enter dates) ☐ No

From: year month day To: year month day Total Amount Received $

Are you receiving Social Assistance Benefits (welfare)? ☐ Yes ☐ No ☐ additional sheets attached

Part 11 Motor Vehicle Accident Claims Fund

DO NOT FILL OUT UNLESS ITEMS (1) TO (5) ON PAGE 2 DO NOT APPLY AND YOU ARE APPLYING TO THE MOTOR VEHICLE ACCIDENT CLAIMS FUND

You and your representative acknowledge that you have the responsibility to investigate and apply to all potential insurers to which the applicant may have recourse BEFORE submitting an application to the Motor Vehicle Accident Claims Fund (MVACF).

You and your representative acknowledge that the application MUST INCLUDE a completed:

☐ NOTICE OF COLLECTION OF PERSONAL INFORMATION FORM, signed and attached*
☐ Form 3 - Section 6 MVACF Application for Statutory Accident Benefits, signed and attached*
☐ Motor Vehicle Accident (Police) Report, attached

before the applicant can make an application for the payment of accident benefits from the MVACF.
(***** These forms are available at www.fsco.gov.on.ca)

I certify that I have read this part and understand that this application for accident benefits is not complete until the required forms are completed, signed and provided to the MVAC Fund.

Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)

Motor Vehicle Accident Claims Fund
PO Box 85
5160 Yonge Street
Toronto, ON M2N 6L9

Toronto calling area: (416) 250-1422
Toll Free: 1- (800) 268-7188

Part 12 Signature

I certify that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.

Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)