

Providing Services Across
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Bulletin

No. A- 03/06

Property & Casualty

– Auto

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The bulletins posted may contain forms that are no longer current. For the current version of any FSCO form, please visit the [forms area](#) of this website.

New and Revised Accident Benefit Claims Forms

To the attention of all insurance companies licensed to transact automobile insurance in Ontario

With this Bulletin, the Financial Services Commission of Ontario (FSCO) is issuing 14 new or revised forms for Statutory Accident Benefit Claims. The forms reflect changes to the Statutory Accident Benefits Schedule (SABS) to eliminate the Designated Assessment Centre (DAC) system which becomes effective on March 1, 2006. The forms also include revisions to consent language, elimination of same-sex partner references and other housekeeping changes.

Two existing accident benefit claims forms are being dropped and consolidated into other claims forms. In addition, two claims forms that relate specifically to DAC assessments will also be phased out following the run-off of ongoing DAC assessments.

Form 1, Assessment of Attendant Care Needs, is no longer printed as part of the SABS. A revised version of this form with updated hourly rates will be used for accidents on or after March 1, 2006. The revised form is attached and has been posted on FSCO's website.

Changes to these forms have been made in consultation with the insurance industry, health care professionals, and legal representatives.

For your convenience, an attached chart sets out a list of revised, new and eliminated claims forms.

How to Obtain the New / Revised Forms

Copies of the new and revised forms are attached for your information. The forms are also available on FSCO's website at: www.fSCO.gov.on.ca.

Bob Christie

Chief Executive Officer and

Superintendent of Financial Services

January 31, 2006

Attachments:

- [Summary Chart](#)
- [OCF-1](#) Application for Accident Benefits
- [OCF-3](#) Disability Certificate
- [OCF-4](#) Death and Funeral Benefits
- [OCF-5](#) Permission to Disclose Health Information
- [OCF-9](#) Explanation of Benefits
- [OCF-12](#) Activities of Normal Life
- [OCF-18](#) Treatment Plan
- [OCF-19](#) Application for Determination of Catastrophic Impairment
- [OCF-21](#) Auto Insurance Standard Invoice
- [OCF-22](#) Application for Approval of an Assessment or Examination
- [OCF-23/198](#) Pre-Approved Framework Treatment Confirmation Form

- [OCF-25](#) Notice of Examination
- [OCF-26](#) Voluntary Consent for Pre-Claim Examination
- [Form 1](#) Assessment of Attendant Care Needs

Summary Description of Accident Benefit Forms

ACCIDENT BENEFIT CLAIMS FORM	DESCRIPTION AND APPLICABILITY
OCF-1 Application for Accident Benefits	Revised. Use for accidents on or after November 1, 1996.
OCF-3 Disability Certificate	Revised. Use for accidents on or after November 1, 1996.
OCF-4 Death and Funeral Benefits	Revised. Use for accidents on or after January 1, 1994.
OCF-5 Permission to Disclose Health Information	Revised. Use for accidents on or after January 1, 1994.
OCF-9 Explanation of Benefits	Revised. Use for accidents on or after November 1, 1996.
OCF-11 Designated Assessment Centre Referral, Plan and Summary Form	To be phased out in 2006.
OCF-12 Activities of Normal Life	Revised. Use for accidents on or after November 1, 1996.
OCF-14 Permission to Disclose Health Information to the Designated Assessment Centre	To be phased out in 2006.
OCF-17 Notice of Stoppage of Weekly Benefits and Request for Assessment	Eliminated. Form consolidated into New OCF-25 and revised OCF-9.
OCF-18 Treatment Plan	Revised. Use for accidents on or after November 1, 1996.

OCF-19 Application for Determination of Catastrophic Impairment	Revised. Use for accident on or after November 1, 1996.
OCF-20 Catastrophic Impairment Determination and Request for Assessment	Eliminated. Form consolidated into New OCF-25 and revised OCF-9.
OCF-21 Auto Insurance Standard Invoice	Revised. Use for accidents on or after November 1, 1996.
OCF-22 Application for Approval of an Assessment or Examination	Revised. Use for accidents on or after November 1, 1996.
OCF-23/198 Pre-Approved Framework Treatment Confirmation Form	Revised. Use for accidents on or after October 1, 2003.
OCF-25 Notice of Examination	New. Use for accidents on or after November 1, 1996.
OCF-26 Voluntary Consent for Pre-Claim Examination	New. Use for accidents on or after November 1, 1996.
Form 1, Assessment of Attendant Care Needs	Revised. Use for accidents on or after March 1, 2006.



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



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			Gender ☐ Male ☐ Female		Marital Status ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Common-law ☐ Widow(er)	
First Name and Initial			Address			
City			Province			
Postal Code			Fax Number		Area Code	
Birth Date year month day			Home Telephone		Work Telephone	
			Area Code		Area Code	

You can be reached:

- ☐ by telephone ☐ at home
☐ by personal visit ☐ at work
☐ other _____

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			Relationship with applicant ☐ Parent ☐ Guardian ☐ Lawyer ☐ Other _____ ☐ Other Paid Representative		
First Name and Initial					
Address					
City			Province		Postal Code
Home Telephone	Area Code		Work Telephone	Area Code	
FAX Number		Area Code			

Part 3 Accident Details and Health Information

Date of Accident year month day	Time of Accident ☐ a.m. ☐ p.m.	You were a: ☐ Driver ☐ Pedestrian ☐ Passenger ☐ 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. _____ _____		
Were you able to return to your normal activities following the accident? ☐ Yes ☐ No		

☐ additional sheets attached

OCF-1 (03/06)

Page 3 of 8

Part 3 Accident Details and Health Information (cont'd)

Did you go to the hospital? ☐ Yes (Give details below) ☐ No		
Did you go see a health professional? (for example: physician, chiropractor, physiotherapist) ☐ Yes (Give details below) ☐ No		
Name of Health Professional		Name of Facility
Address		
City	Province	Postal Code
Has this Health Professional begun any treatment? ☐ Yes (Give details below) ☐ No		

☐ 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: ☐ The vehicle I was riding in at the time of the accident ☐ The vehicle that struck me as a pedestrian/bicyclist ☐ Another vehicle that was involved in the accident	Vehicle type covered by this policy: ☐ Passenger ☐ Motorcycle ☐ Taxi/Limousine ☐ Other _____ ☐ Truck ☐ Bus ☐ Snowmobile
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Part 4 Details of Automobile Insurance (cont'd)

Owner of the Vehicle		Home Telephone	Area Code	
Address		Work Telephone	Area Code	
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 ☐ Retired	☐ Student or recent graduate ☐ Caregiver
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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 Code	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			Disabled	
	year	month	day	Yes	No
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

☐ additional sheets attached

Part 7 Caregiver (cont'd)

As a result of your injuries were you able 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

Did you return to 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 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?

☐ Single ☐ Equivalent to Married
☐ Married ☐ Other

If you are married or equivalent to married, what is the expected annual income of your spouse or dependent 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?

☐ 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.fscs.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
P.O. Box 85
5160 Yonge Street
Toronto, ON M2N 6L9

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

Part 12

Signature

TO THE INSURER TO WHOM THIS APPLICATION IS BEING SUBMITTED:

I UNDERSTAND that you, and persons acting for you, will collect and use personal information and personal health information about me that is related to my claims for accident benefits arising out of the accident described in this application, and that all such information will be collected directly from me, or from any other person with my consent.

I ALSO UNDERSTAND that this information will be collected and used only as reasonably necessary for the purposes of:

- Investigating my claims and processing my claims as required by law, including the Ontario Automobile Policy;
- Obtaining or verifying information relating to my claims in order to determine entitlement and the proper amount of payment;
- Recovering payment from insurers and others liable in law for amounts that you pay in connection with my claims;
- Identifying and analyzing the nature and costs of goods and services that are provided to automobile accident victims by health care providers;
- Preventing fraud, and detecting fraud where there are reasonable grounds to suspect fraud;
- Compiling anonymized statistics for government agencies; and
- Assessing underwriting risks and claims experience.

I ALSO UNDERSTAND that you, and persons acting for you, may disclose this information to the following persons, who may collect and use this information only as reasonably necessary to enable you to carry out the purposes described above:

- Insurers; insurance adjusters, agents and brokers; employers; health care professionals; hospitals; accountants; financial advisors; solicitors; organizations that consolidate claims and underwriting information for the insurance industry; and my agents or representatives as designated by me from time to time.

I CONSENT to you collecting, using and disclosing this information in the manner described above, but no more of such information than is reasonably necessary to meet the legitimate purpose of such collection, use or disclosure.

I UNDERSTAND that if I have any questions about this consent I am free to consult with my insurance company representative or legal advisor before signing this document.

I AM ALSO AWARE that you, and persons acting for you, may be required or permitted by law to disclose this information to others without my knowledge or consent.

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)

Return this form to:

Disability Certificate (OCF-3)

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

Claim Number:

Policy Number:

Date of Accident:
(YYYYMMDD)

For this applicant, this is Disability Certificate number _____ from this health professional/facility

Use this form for accidents that occur on or after November 1, 1996. If your insurance company asks you to complete this form, fill out Parts 1 to 3 and give the form to your **health practitioner (chiropractor, dentist, nurse practitioner, occupational therapist, optometrist, physician, physiotherapist, psychologist, speech language pathologist)**. After your health practitioner has explained your accident-related injury to you, sign Part 4. Your health practitioner will complete the rest of the form, based on his/her most recent assessment, and return it to the insurance company.

If this disability certificate is being completed to support your application for accident benefits, it must be completed by your health practitioner no earlier than 10 business days of the date of your application. If your insurer has requested a new disability certificate, it must be provided within 15 business days of this request. Only an authorized health practitioner can complete this form. The health practitioner's opinion will be relied upon by people who review the certificate to make important decisions. Accordingly, it is necessary to be accurate and complete. Please print clearly and provide all information requested. This form may not be materially altered.

Confidentiality: Collection, use and disclosure of this information is subject to all applicable privacy legislation.

Part 1 Applicant Information

To be completed
by the applicant

Date Of Birth (YYYYMMDD)	Gender ☐ Male ☐ Female	Telephone Number	Extension
Last Name			
First Name		Middle Name	
Address			
City	Province	Postal Code	

Part 2 Insurance Company Information

To be completed
by the applicant

Name of Insurance Company		City or Town of Branch Office (if applicable)
Name of Insurance Company Representative		
Telephone		Fax
Name of policy holder same as: ☐ Applicant OR	Policy Holder Last Name	Policy Holder First Name

Part 3 Accident Description

To be completed
by the applicant

Give a brief description of the accident and what happened to you. Please describe any injuries you sustained as a direct result of the accident.

☐ additional sheets attached

Part 4 Applicant Signature

I authorize my treating health professional to collect, use and disclose to my insurer or to a health professional, social worker, or rehabilitation expert properly identified by my insurer to conduct an examination, only such information relating to my health condition and treatment received as a result of the automobile accident and any pre-existing or subsequently occurring health conditions that may be barriers to my recovery as a result of the automobile accident, as is reasonably required for the purpose of providing treatment and determining my eligibility for benefits. I authorize the health practitioner who completes this form to contact my employer, if this is necessary, to confirm the essential tasks of my employment and the nature and extent of any available work with modified hours or duties.

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)
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To the Health Practitioner:

Please complete the following information based on your most recent examination of the applicant named in Part 1 and return the form to the insurance company listed in Part 2. **Please print clearly.**

Part 5 Injury and Sequelae Information

This part and the rest of this form must be completed by your Health Practitioner

Provide a description (list most significant first) and associated ICD-10-CA ⁺ code for any injuries and sequelae that are the direct result of the automobile accident.	
Description	Code
Note ⁺ : Refer to the User manual at www.hcaiinfo.ca for ICD-10-CA coding information.	

Part 6 Relevant Dates

Date symptoms first appeared: (YYYYMMDD)	Date of most recent examination: (YYYYMMDD)
Date of first post-accident examination: (YYYYMMDD)	(a) Applicant was seen by me prior to the accident. Yes ☐ No ☐ (b) If answer to (a) is yes, enter date on which applicant was first seen: _____

Part 7 Disability Tests and Information

a) Based on your current knowledge and information provided by the applicant, please provide a response to each Benefit/Applicant Category

Benefit/Applicant Category	Disability Test	Onset of Disability (YYYYMMDD)	Task/Activity Limitations	Anticipated Duration
Income Replacement Benefits	Is the applicant substantially unable to perform the essential tasks of his/her employment at the time of the accident as a result of and within 104 weeks of the accident? ☐ Yes ☐ No ☐ N/A		Please explain:	☐ 1-4 weeks ☐ 5-8 weeks ☐ 9-12 weeks ☐ more than 12 weeks
Employed: working at the time of the accident	Can the applicant return to work on modified hours and/or duties? ☐ Yes ☐ No ☐ N/A		Please explain:	☐ 1-4 weeks ☐ 5-8 weeks ☐ 9-12 weeks ☐ more than 12 weeks
Unemployed: but worked 26 weeks during the 52 weeks before the accident	Is the applicant substantially unable to perform the essential tasks of the employment held for most of the time during the 52 weeks before the accident? ☐ Yes ☐ No ☐ N/A		Please explain:	☐ 1-4 weeks ☐ 5-8 weeks ☐ 9-12 weeks ☐ more than 12 weeks
Non-Earner Benefits	Does the applicant suffer a complete inability to carry on a normal life? (i.e., Has the applicant sustained an impairment that continuously prevents the person from engaging in substantially all of the activities in which the person ordinarily engaged before the accident?) ☐ Yes ☐ No ☐ N/A		Please explain:	☐ 1-4 weeks ☐ 5-8 weeks ☐ 9-12 weeks ☐ more than 12 weeks

Benefit/Applicant Category	Disability Test	Onset of Disability (YYYYMMDD)	Task/Activity Limitations	Anticipated Duration
Caregiver Benefits	As the Primary Caregiver, does the applicant suffer a substantial inability to engage in the caregiving activities in which he/she engaged at the time of the accident? (Primary Caregiver means that, at the time of the accident, the applicant was residing with a person in need of care and the applicant was the primary caregiver for the person in need of care and did not receive any remuneration for engaging in caregiver activities.) ☐ Yes ☐ No ☐ N/A		Please explain:	☐ 1-4 weeks ☐ 5-8 weeks ☐ 9-12 weeks ☐ more than 12 weeks
Lost Educational Expenses	Is the applicant, as a result of the accident, unable to continue in an elementary, secondary, post-secondary or continuing education program that the applicant was enrolled in at the time of the accident? ☐ Yes ☐ No ☐ N/A		Please explain:	☐ 1-4 weeks ☐ 5-8 weeks ☐ 9-12 weeks ☐ more than 12 weeks
Housekeeping and Home Maintenance Expenses	Does the applicant suffer a substantial inability to perform the housekeeping and home maintenance services that he/she normally performed before the accident? ☐ Yes ☐ No ☐ N/A		Please explain:	☐ 1-4 weeks ☐ 5-8 weeks ☐ 9-12 weeks ☐ more than 12 weeks
b) If you responded Anticipated Duration 'more than 12 weeks' to any disability test above, please explain why the task/activity limitations are likely to persist beyond 12 weeks.				

Part 8 Further Investigations or Consultations

a) Have there been any examinations, investigations, or consultations not previously reported by you? ☐ No ☐ Yes (please specify findings and results)
b) Are further examinations, investigations or consultations contemplated or required? ☐ No ☐ Yes (please specify)

Part 9 Prior and Concurrent Conditions

- a) Prior to the accident, did the applicant have any disease, condition or injury that affected his/her ability to perform the activities listed in Part 7?

☐ No ☐ Unknown ☐ Yes (please explain)

If yes, is the applicant currently receiving any disability benefits for the pre-existing disease, condition or injury?

☐ No ☐ Unknown ☐ Yes (please explain)

If you treated the applicant for similar conditions prior to the accident, please describe (include date of onset, any subsequent interventions, and status at the time of the accident).

- b) Since the automobile accident, has the applicant developed any disease, condition or injury, not related to the accident, that could affect his/her disability?

☐ No ☐ Unknown ☐ Yes (please explain)

Part 10 Medications

- a) Please list any medications (including dosage and frequency) that the applicant is currently taking for injuries related to the automobile accident.

Were these medications prescribed by you? ☐ No ☐ Yes

- b) Please list any medications (including dosage and frequency) that the applicant is currently taking as a result of prior or concurrent conditions identified in Part 9.

Were these medications prescribed by you? ☐ No ☐ Yes

Part 11 Health Practitioner Signature

Name of Health Practitioner		College Registration Number		You are a: ☐ Chiropractor ☐ Dentist ☐ Nurse Practitioner ☐ Occupational Therapist ☐ Optometrist ☐ Physician ☐ Physiotherapist ☐ Psychologist ☐ Speech-Language Pathologist
Facility Name (if applicable)		AISI Facility Number (if applicable)		
Address				
City		Province	Postal Code	
Telephone Number	Extension	Fax Number		
Email Address				
I confirm 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 Health Practitioner (please print)		Signature of Health Practitioner		Date (YYYYMMDD)

Note: The fee for completing this certificate is not a health care benefit of the Ontario Ministry of Health and Long-Term Care. This fee should be billed to the insurer directly.

Return this form to:

Death and Funeral Benefits Application (OCF-4)

Use this form for accidents that occur on or after January 1, 1994

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

This form must be completed by or on behalf of the spouse and dependant(s) of the deceased and any other person entitled to claim for benefits. If more than one person is applying for benefits, they can apply together or separately. If you have not done so, please complete the **Application for Accident Benefits form**. Attach a copy of the death certificate.

Please print clearly.

Part 1 Deceased's Information

Deceased's Last Name				Marital Status ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Common-law ☐ Widow(er)	
Deceased's First Name and Initial					
Address					
City		Province		Postal Code	
Birth Date		(YYYYMMDD)		Date of Accident (YYYYMMDD)	
Date of Death		(YYYYMMDD)		Date of Death (YYYYMMDD)	

Part 2 Survivor Information

☐ (attach additional sheets if necessary)

If you are applying for death benefits, please indicate your relationship to the deceased.

Applicant 1

Last Name				Relationship to deceased ☐ Spouse ☐ Parent ☐ Guardian ☐ Dependant ☐ Former spouse entitled to support ☐ Other person on whom the deceased was dependent (Specify)	
First Name and Initial					
Address					
City		Province			
Home Telephone	Area Code	Work Telephone	Area Code	Fax Number	Area Code

Applicant 2

Last Name				Relationship to deceased ☐ Spouse ☐ Parent ☐ Guardian ☐ Dependant ☐ Former spouse entitled to support ☐ Other person on whom the deceased was dependent (Specify)	
First Name and Initial					
Address					
City		Province			
Home Telephone	Area Code	Work Telephone	Area Code	Fax Number	Area Code

Applicant 3

Last Name				Relationship to deceased ☐ Spouse ☐ Parent ☐ Guardian ☐ Dependant ☐ Former spouse entitled to support ☐ Other person on whom the deceased was dependent (Specify)	
First Name and Initial					
Address					
City		Province			
Home Telephone	Area Code	Work Telephone	Area Code	Fax Number	Area Code

☐ (attach additional sheets if necessary)

Date (YYYYMMDD)	Description of Service and Name of Supplier or Provider	Amount Claimed
		\$
		\$
		\$
		\$
		\$
		\$
		\$
	TOTAL PAYMENT REQUESTED	\$

Details of Missing Data of Receipts

☐ (attach additional sheets if necessary)

I certify that the information provided is true and correct. I understand that it is an offence under the Insurance Act to 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. I further understand that the information contained on this form may be used and disclosed in the manner described in my Application for Accident Benefits.		
Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)

I certify that the information provided is true and correct. I understand that it is an offence under the Insurance Act to 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. I further understand that the information contained on this form may be used and disclosed in the manner described in my Application for Accident Benefits.		
Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)

I certify that the information provided is true and correct. I understand that it is an offence under the Insurance Act to 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. I further understand that the information contained on this form may be used and disclosed in the manner described in my Application for Accident Benefits.		
Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)

Return this form to:

Permission to Disclose Health Information (OCF-5)

Use this form for accidents that occur on or after January 1, 1994.
Collection, use and disclosure of this information is subject to all
applicable privacy legislation.

Claim Number:

Policy Number:

Date of Accident:
(YYYYMMDD)

Part 1 Applicant Information

Last Name		First Name and Initial		Date of Accident	year	month	day
Address							
City		Province		Postal Code			
Birth Date	year	month	day	Home Telephone		Work Telephone Extension	

Part 2 Insurance Company Information

Name of Insurance Company			
Name of Insurance Company Representative			
Address		City	
Province	Postal Code	Telephone Number	FAX Number

Part 3 Treating Health Professional

Name of Health Professional		Health Profession	
Address			
City		Province	Postal Code
Telephone Number		FAX Number	

Part 4 Signature

I authorize my treating health professional to collect, use and disclose to my insurer or to a health professional, social worker, or vocational rehabilitation expert properly appointed by my insurer to conduct an examination, only such information relating to my health condition and treatment received as a result of the automobile accident and any pre-existing or subsequently occurring health conditions that may be a barrier to my recovery as a result of the automobile accident, as is reasonably required for the purpose of providing treatment and determining my eligibility for benefits. This authorization is valid until my claim for Statutory Accident Benefits has been concluded or until I withdraw this consent. (Please note withdrawal of this consent may impact your benefit entitlement).

Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)
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Return this form to:

Explanation of Benefits (OCF-9)

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

Claim Number:

Policy Number:

Date of Accident:
(YYYYMMDD)

Revised:
(YYYYMMDD)

We have reviewed your application for accident benefits or your ongoing entitlement to benefits. This review has included any information that you or your health care provider has submitted as well as the findings of an examination by a health care provider or providers if one was required by the insurer. This form tells which benefits are approved, the amount payable and any benefits that have not been approved or are ending. If an examination was performed, a copy of the report of examination has been enclosed or has been sent to you separately. **If you disagree with this determination, you have the right to dispute it according to the procedure described in Part 6 on page 3 of this form.**

Part 1 Applicant Information

Last Name		First Name and Initial	
Address			
City		Province	Postal Code
Birth Date	(YYYYMMDD)	Home Telephone	Work Telephone Extension

Part 2 Income Replacement Non Earner or Caregiver Benefits Payable

Report of
Examination:
☐ Attached
☐ Sent
Separately

We have reviewed your application for income replacement benefits and have determined you are:

☐ A. Eligible

Calculation

Gross Weekly Income	
Net Income	
80% of Net Weekly Income	
Minus Post-Accident Net Weekly Income/Payments from Other Sources	
Income Replacement Benefit Payable	
Non Earner or Caregiver Benefit Payable	

Details of how we calculated your income replacement benefit, including adjustments for income or payments from other sources.

☐ additional sheets attached

☐ B. Not Eligible/Stoppage of Benefit

☐ additional sheets attached

Part 3 Catastrophic Impairment Determination

Report of
Examination:
☐ Attached
☐ Sent
Separately

We have reviewed your application for determination of catastrophic impairment and have determined:

- ☐ You have sustained a catastrophic impairment as a result of the accident
☐ You have not sustained a catastrophic impairment as a result of the accident for the following reasons:

Part 4 Medical and Rehabilitation and Other Benefits

Report of
Examination:

- ☐ Attached
☐ Sent
Separately

Benefit Identification	Benefit Description
MR	Medical and Rehabilitation
AC	Attendant Care Expenses
CM	Case Manager Expenses
LE	Lost Educational Expenses
HH	Housekeeping and Home Maintenance Expenses
RR	Expenses to Repair or Replace Lost or Damaged Clothing, Hearing Aids, etc.
FE	Funeral Expenses
DB	Death Benefits
AE	Assessment or Examination

Item	Details	Amount Claimed	Amount Payable	Interest Payable	Item Not Payable
		\$	\$	\$	☐
		\$	\$	\$	☐
		\$	\$	\$	☐
		\$	\$	\$	☐
		\$	\$	\$	☐
		\$	\$	\$	☐
		\$	\$	\$	☐
		\$	\$	\$	☐
		\$	\$	\$	☐
		\$	\$	\$	☐
		\$	\$	\$	☐
		\$	\$	\$	☐
		\$	\$	\$	☐
		\$	\$	\$	☐

Reasons why expenses are not payable or being stopped:

☐ additional sheets attached

Part 5 Insurance Company Information

Name of Insurance Company Representative	
Name of Insurance Company	
Telephone Number	FAX Number
Signature of Insurance Company Representative	
Date (YYYYMMDD)	

YOUR RIGHT TO DISPUTE THE INSURER'S DETERMINATION OF YOUR CLAIM FOR STATUTORY ACCIDENT BENEFITS

Under the Insurance Act, if your claim for statutory accident benefits has been reduced or denied by your insurer, you have a right to dispute your insurer's determination. There are a numbers of steps you can take to try and resolve the dispute.

STEP 1: NOTIFY YOUR INSURER/FURTHER EXAMINATION

Notify your insurer that you dispute the insurer's decision. You may have the right to a further examination or assessment in respect of the insurer's decision by your health professional or, in certain circumstances, another health professional, paid for by your insurer. Please contact your insurance adjuster, health professional or legal representative for further information about this additional examination.

STEP 2: MEDIATION

If you are unable to resolve your dispute by speaking to your adjuster, you may apply to mediate your dispute through the Financial Services Commission of Ontario (FSCO) within two years of your insurer's refusal to pay, or reduction of a benefit.*

To begin the mediation process, you must complete an application for mediation. The application for mediation can be provided to you by your insurance company, or can be obtained from FSCO's web site at www.fSCO.gov.on.ca or by contacting FSCO at:

Dispute Resolution Services
Mediation – Financial Services Commission of Ontario
Box 85, 14th Floor
Toronto, Ontario
M2N 6L9

Toll Free: 1-800-517-2332 ext. 7210
Fax: (416) 590-7077
Mediation Hotline: (416) 590-7210

Once you submit a completed application for mediation, FSCO will appoint a mediator to conduct the mediation. At the end of the mediation, the mediator will issue a written report of mediation indicating whether or not the mediation resolved the issues between you and your insurer.

STEP 3: ARBITRATION, LAWSUIT OR EVALUATION

If mediation does not resolve the dispute, you have the right to:

(i) apply for the appointment of an arbitrator at FSCO, or

(ii) commence a lawsuit in court, or

(iii) if you and your insurer both agree, you may request a neutral evaluation at FSCO before proceeding to arbitrate or commence a lawsuit in court. If you and your insurer proceed to a neutral evaluation, the neutral evaluator will provide an oral opinion on the likely outcome of a proceeding in court or an arbitration and a written report identifying issues evaluated and still in dispute.

However, you CANNOT arbitrate, commence a lawsuit or request a neutral evaluation UNLESS:

(i) you proceeded with mediation, AND

(ii) the mediation failed.

***WARNING: TWO YEAR TIME LIMIT**

You have TWO YEARS from the date of your insurer's refusal to pay, or reduction of a benefit, to arbitrate or commence a lawsuit in court. You may have longer than two years if the arbitration or lawsuit is commenced 90 days from the date the mediator provides his or her mediation report, or within 30 days from the date the neutral evaluator provides his or her report.

Return this form to:

Activities of Normal Life (OCF-12)

Claim Number:

Policy Number:

Date of Accident:
(YYYYMMDD)

Use this form for accidents that occur on or after January 1, 1994. This form must be completed by the applicant. If the applicant is unable to do so, a guardian or family member may assist. The information collected in this form will help your insurance company determine the services you may need as a result of the accident, and any other accident benefits that you are entitled to receive. **Please print clearly.**

Part 1 Applicant's Information

Last Name		First Name and Initial	
Address			
City		Province	Postal Code
Home Telephone - -	Date of Accident	Date (YYYYMMDD)	☒ Check one ☐ Initial ☐ Follow-up

Part 2 Description Of Home

Type of Home			
☐ House	☐ Condominium	☐ Other (Specify)	Number of residents
			Number of floors
☐ Apartment	☐ Townhouse	Size of lot	Number of stairs

Part 3 Physical Activities

Please go through the list of activities and use a ☒ to indicate your usual activities before and after the accident. Describe any limitations.

	Task	Before Accident				After Accident				Limitations (Briefly explain)	
		Can Do			Can Not Do	Can Do			Can Not Do		
		All	Partially	With Help		All	Partially	With Help			
Personal Care	Bathing	☐	☐	☐	☐	☐	☐	☐	☐		
	Grooming	☐	☐	☐	☐	☐	☐	☐	☐		
	Dressing/Undressing	☐	☐	☐	☐	☐	☐	☐	☐		
	Toileting	☐	☐	☐	☐	☐	☐	☐	☐		
	Other	☐	☐	☐	☐	☐	☐	☐	☐		
Functional Ability	Walking	☐	☐	☐	☐	☐	☐	☐	☐		
	Climbing Stairs	☐	☐	☐	☐	☐	☐	☐	☐		
	Driving	☐	☐	☐	☐	☐	☐	☐	☐		
	Riding in Car	☐	☐	☐	☐	☐	☐	☐	☐		
	Public Transportation	☐	☐	☐	☐	☐	☐	☐	☐		
	Standing	☐	☐	☐	☐	☐	☐	☐	☐		
	Sitting	☐	☐	☐	☐	☐	☐	☐	☐		
	Other	☐	☐	☐	☐	☐	☐	☐	☐		

**Part 3
Physical
Activities
(cont'd)**

	Task	Before Accident				After Accident				Limitations (Briefly explain)	
		Can Do			Can Not Do	Can Do			Can Not Do		
		All	Partially	With Help		All	Partially	With Help			
Shopping	Groceries	☐	☐	☐	☐	☐	☐	☐	☐		
	Other	☐	☐	☐	☐	☐	☐	☐	☐		
Meals	Meal Preparation	☐	☐	☐	☐	☐	☐	☐	☐		
	Cooking	☐	☐	☐	☐	☐	☐	☐	☐		
	Washing Dishes	☐	☐	☐	☐	☐	☐	☐	☐		
Cleaning	Sweeping	☐	☐	☐	☐	☐	☐	☐	☐		
	Dusting	☐	☐	☐	☐	☐	☐	☐	☐		
	Vacuuming	☐	☐	☐	☐	☐	☐	☐	☐		
	Bedmaking	☐	☐	☐	☐	☐	☐	☐	☐		
	Bathrooms	☐	☐	☐	☐	☐	☐	☐	☐		
	Washing Floors	☐	☐	☐	☐	☐	☐	☐	☐		
	Oven	☐	☐	☐	☐	☐	☐	☐	☐		
	Refrigerator	☐	☐	☐	☐	☐	☐	☐	☐		
	Garbage Removal	☐	☐	☐	☐	☐	☐	☐	☐		
	Other	☐	☐	☐	☐	☐	☐	☐	☐		
Laundry	Washing/Drying	☐	☐	☐	☐	☐	☐	☐	☐		
	Ironing	☐	☐	☐	☐	☐	☐	☐	☐		
	Sewing	☐	☐	☐	☐	☐	☐	☐	☐		
Home Maintenance Activities	Grass Cutting	☐	☐	☐	☐	☐	☐	☐	☐		
	Gardening	☐	☐	☐	☐	☐	☐	☐	☐		
	Snow Shovelling	☐	☐	☐	☐	☐	☐	☐	☐		
	Other	☐	☐	☐	☐	☐	☐	☐	☐		

**Part 4
Other
Abilities**

	Task	Before Accident				After Accident				Limitations (Briefly explain)	
		Can Do			Can Not Do	Can Do			Can Not Do		
		All	Partially	With Help		All	Partially	With Help			
Cognitive Activities	Balancing a Bank Book	☐	☐	☐	☐	☐	☐	☐	☐		
	Keeping Appointments	☐	☐	☐	☐	☐	☐	☐	☐		
	Remembering to do Errands	☐	☐	☐	☐	☐	☐	☐	☐		
	Reading and Remembering What You Have Read	☐	☐	☐	☐	☐	☐	☐	☐		
	Following a Movie or TV Show	☐	☐	☐	☐	☐	☐	☐	☐		
	Planning and Organizing Meals or Shopping	☐	☐	☐	☐	☐	☐	☐	☐		
	Remembering and Following Directions	☐	☐	☐	☐	☐	☐	☐	☐		
	Prioritizing Activities	☐	☐	☐	☐	☐	☐	☐	☐		
	Other	☐	☐	☐	☐	☐	☐	☐	☐		

**Part 4
Other
Abilities
(cont'd)**

	Task	Before Accident				After Accident				Limitations (Briefly explain)
		Can Do			Can Not Do	Can Do			Can Not Do	
		All	Partially	With Help		All	Partially	With Help		
Controlling Emotion/ Behavior	Driving/Riding	☐	☐	☐	☐	☐	☐	☐	☐	
	Relating to Others Without Irritability or Temper	☐	☐	☐	☐	☐	☐	☐	☐	
	Participating in Social Activities	☐	☐	☐	☐	☐	☐	☐	☐	
	Other	☐	☐	☐	☐	☐	☐	☐	☐	
	Keeping Track of Conversation	☐	☐	☐	☐	☐	☐	☐	☐	
Communi- cation	Finding Words to Express Your Thoughts	☐	☐	☐	☐	☐	☐	☐	☐	
	Writing So Others Understand	☐	☐	☐	☐	☐	☐	☐	☐	
	Other	☐	☐	☐	☐	☐	☐	☐	☐	

**Part 5
Other
Information**

Please describe any other activities you normally did before the accident that you are no longer able to do.

☐ additional sheets attached

**Part 6
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.

Signature of Applicant, or Substitute Decision Maker	Date (YYYYMMDD)
--	-----------------

Treatment Plan (OCF-18)	
Use this form for accidents that occur on or after November 1, 1996.	
Claim Number:	
Policy Number:	
Date of Accident: (YYYYMMDD)	

For this applicant, this is Treatment Plan number _____ from this health professional/facility or social worker

To the Applicant:
Please complete Parts 1 and 2. After your health professional or practitioner or social worker has reviewed your Treatment Plan with you, sign Part 14.

Your health professional/practitioner or social worker will complete all other parts of the form. **A health practitioner (chiropractor, dentist, nurse practitioner, occupational therapist, optometrist, physician, physiotherapist, psychologist, speech language pathologist) must sign Part 5.**

Please provide all information requested.

Collection, use and disclosure of this information is subject to all applicable privacy legislation.

To the Health Professional/Facility or Social Worker:
To the extent possible, this Treatment Plan should include all goods and services contemplated by this health professional/facility or social worker for the period of this Treatment Plan.

Consent: It is the responsibility of the health professional/facility or social worker to ensure that their collection, use and disclosure of information submitted are authorized by a consent form. Health professionals/facilities or social workers can use the Ontario Claims Form 5 (OCF – 5) *Permission to Disclose Health Information* as a consent form.

Note: If this is an impairment that comes within a PAF Guideline, you are required to complete an OCF – 23/198 Pre-approved Framework Treatment Confirmation form instead of this Treatment Plan form unless application is being made for additional goods or services not provided under a PAF Guideline.

**Part 1
Applicant
Information**

To be completed by the applicant

Date Of Birth (YYYYMMDD)	Gender ☐ Male ☐ Female	Telephone Number
Last Name		
First Name	Middle Name	
Address		
City	Province	Postal Code

**Part 2
Insurance
Company
Information**

To be completed by the applicant

Insurance Company Name	City or Town of Branch Office (if applicable)	
Adjuster Last Name	Adjuster First Name	
Adjuster Telephone Extension	Adjuster Fax	
Name of policy holder same as: ☐ Applicant OR	Policy Holder Last Name	Policy Holder First Name

**Part 3
Other
Insurance
Information**

To be completed by the health professional or social worker responsible for plan preparation and supervision with information from the applicant

OTHER INSURANCE: Is there other insurance coverage for any goods and services listed in this Treatment Plan? I have made reasonable enquiries of the applicant and have determined that: ☐ NO <i>There is no other insurance coverage identified for these goods and services</i> ☐ YES <i>There is other insurance coverage that is potentially available to cover/partially cover these goods and services.</i>		
MOH	Is there Ministry of Health and Long-Term Care (MOH) coverage for any goods and services included in this Treatment Plan? ☐ Yes ☐ No ☐ Not applicable	
Other Insurer 1	Other Insurer Name	Other Insurance Plan Or Policy Number
	Name of Plan Member	Other Insurer's Identifier
Other Insurer 2	Other Insurer Name	Other Insurance Plan Or Policy Number
	Name of Plan Member	Other Insurer's Identifier

Part 4 Conflict of Interest Definition

A person has a conflict of interest relating to a Treatment Plan if,

- i) the person or a related person may receive a financial benefit, directly or indirectly, as a result of the provision, by the related person or another person, of goods or services contemplated by the Treatment Plan, and
- ii) the person who may receive the financial benefit is not the employee of the person who will provide the goods or services and does not have a contract with the person who will provide the goods or services or under which goods or services of that kind are provided.

Note: After approving this Treatment Plan, if the insurer determines that there is a conflict of interest that was not disclosed, the insurer may give the applicant notice to amend the Treatment Plan to remove the conflict of interest and if no amendment is made, the insurer is not required to pay for any further expense for which there is the conflict.

Part 5 Signature of Health Practitioner Plan Certification

Name of Health Practitioner		College Registration Number		You are a: ☐ Chiropractor ☐ Dentist ☐ Nurse Practitioner ☐ Occupational Therapist ☐ Optometrist ☐ Physician ☐ Physiotherapist ☐ Psychologist ☐ Speech-Language Pathologist
Facility Name (if applicable)		AISI Facility Number (if applicable)		
Address				
City	Province	Postal Code		
Telephone Number	Extension	Fax Number		
Email Address				
☐ I wish to declare that I have no conflicts of interest relating to this Treatment Plan, and I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this Treatment Plan on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this Treatment Plan. or ☐ I am declaring the following conflicts of interest relating to this Treatment Plan:				
I confirm that, to the best of my knowledge, the information in this Treatment Plan is accurate, the Treatment Plan has been reviewed with the applicant by the regulated health professional or social worker in Part 6, and the goods and services contemplated are reasonable and necessary for the treatment and rehabilitation of the applicant for the injuries identified in Part 7. 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. This information will be used for processing payments of claims; identifying and analysing the nature, effects and costs of goods and services that are provided to automobile accident victims, by health care providers; and detecting and preventing fraud.				
Name of Health Practitioner (please print)		Signature of Health Practitioner		Date (YYYYMMDD)

Part 6 Signature of Regulated Health Professional or Social Worker

Plan Preparation and Supervision If same person as Part 5 check here ☐ and **DO NOT COMPLETE Part 6**

Name of Regulated Health Professional or Social Worker		Registration Number		You are a: ☐ Chiropractor ☐ Dentist ☐ Massage Therapist ☐ Nurse ☐ Occupational Therapist ☐ Optometrist ☐ Physician ☐ Physiotherapist ☐ Psychologist ☐ Social Worker ☐ Speech-Language Pathologist ☐ Other _____
Facility Name (if applicable)		AISI Number (if applicable)		
Address				
City	Province	Postal Code		
Telephone Number	Extension	Fax Number		
Email Address				
☐ I wish to declare that I have no conflicts of interest relating to this Treatment Plan, and I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this Treatment Plan on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this Treatment Plan. or ☐ I am declaring the following conflicts of interest relating to this Treatment Plan:				
I confirm 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 Regulated Health Professional/Social Worker (please print)		Signature of Regulated Health Professional/Social Worker		Date (YYYYMMDD)

Part 10 Treatment Plan Goals, Outcome Evaluation Methods and Barriers to Recovery

[illegible]

Applicant Name:		INSURER FAX BACK	Claim Number:	
Policy Number:			Date of Accident:	

Part 11

Health Providers/ Social Workers

Provider Reference	Provider Type	Provider		Regulated (College Registration Number)	Unregulated (AISI Number if applicable, or blank)	Hourly Rate (if applicable)
		Last Name	First Name			
A						
B						
C						
D						
E						
F						

Part 12

Proposed Goods and Services

To the extent possible, this Treatment Plan should include **all goods and services (G/S)** contemplated by the Health Professional/Facility or Social Worker for the period of this Treatment Plan

G/S Ref	Description	'Code	'Attribute	Provider Ref	Estimate / Day			Projected	
					Quantity	'Measure	Cost	Total Count	Total Cost
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
Estimated duration of this Treatment Plan:				weeks	Sub-Total:				
How many treatment visits have you already provided:				visits	Minus MOH:				
Note 1: Refer to the User Manual at www.hcaiinfo.ca for coding. Attributes codes are used to further qualify the service codes and are described in the manual. Payment by auto insurer is secondary to available collateral benefits.					- Minus Other Insurer 1 + 2:				
					GST (if applicable):				
					PST (if applicable):				
					Auto Insurer Total:				
Please indicate any additional comments regarding proposed goods and services:									
☐ additional sheets attached									

Part 13

Signature of Insurer

☐ I waive the requirement of the Applicant's signature.

I have reviewed this Treatment Plan and based upon the information provided, I:

☐ Approve this Treatment Plan
 ☐ Partially approve
 ☐ Do not approve

The Statutory Accident Benefits Schedule states that subject to the conflict of interest provisions, the insurer shall, within 10 business days of receiving the completed application (within 5 business days if the insurer rejects the Treatment Plan on the basis that a PAF Guideline applies) give the applicant a notice:

1. Stating the goods and services contemplated by the treatment plan the insurer will pay for; or
2. Advising the applicant that an examination is required for any goods or services that the insurer has not agreed to pay for; or
3. Stating that an examination is required to determine if a Pre-approved Framework Guideline applies.

Name of Adjuster (please print)

Signature of Adjuster

Date (YYYYMMDD)

To the insurer: Please provide a copy of this page to the applicant, the Health Practitioner indicated in Part 5 and the Regulated Health Professional or Social Worker, if applicable, indicated in Part 6.

Note:

The fee for completing this form is not a health care benefit of the Ontario Ministry of Health and Long-Term Care. This fee should be billed to the insurer directly. The Health Practitioner will contact each of the health professionals listed in Part 11 and provide details of the services and other charges that have been approved and are payable under this Treatment Plan.

Part 14
Signature of
Applicant

Must be
completed
unless waived
by insurer

I have reviewed and agree with this Treatment Plan. I understand that payment for this Treatment Plan is subject to the approval of the insurer.

In the event that my insurer does not agree to pay for all the goods and services contemplated in this treatment plan, I understand that an examination may be required to determine my eligibility to the goods and services outlined or this Treatment Plan.

In the event that an examination is requested, I authorize my insurer and my treating health professional or social worker, to give the health professional, social worker, or vocational rehabilitation expert properly identified by the insurer to review this application, only such information relating to my health condition, treatment and rehabilitation received as a result of the accident, as is reasonably required for the purposes of determining my eligibility to benefits.

As required by law, a copy of the examination report by the health professional, social worker, or vocational rehabilitation expert identified by the insurer to conduct the examination as well as the insurance company's determination will be sent to me.

Subject to the Statutory Accident Benefits Schedule, in those circumstances, where prior approval is required, I understand that, if I undertake any of the proposed services prior to approval by the insurer, I may be responsible for payment to my provider for any of the services rendered on my behalf.

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)

Return this form to:

Application for Determination of Catastrophic Impairment (OCF-19)

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

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

Note to the Applicant:

This form must be completed in full and submitted to your auto insurer if you wish to establish that you have suffered a catastrophic impairment as a result of your motor vehicle accident. Persons determined to have a catastrophic impairment are entitled to request extended medical, rehabilitation and/or attendant care benefits and other expenses. On the basis of this Application, your insurer may designate you as catastrophically impaired.

To the Health Professional/Facility:

Consent: It is the responsibility of the health professional/facility to ensure that their collection, use and disclosure of information submitted are authorized by a consent form. Health professionals/facilities can use the Ontario Claims Form 5 (OCF-5) *Permission to Disclose Health Information* as a consent form, although additional disclosure and consent may be required depending on the manner in which the information is used and disclosed.

Part 1 Applicant Information (completed by the applicant or substitute decision maker)

Last Name		First Name and Initial	
Address		Date of Accident	(YYYYMMDD)
City		Province	Postal Code
Home Telephone	Area Code	Work Telephone	Area Code Extension

Applicant Status:

- ☐ Applicant is currently in a general hospital, rehabilitation centre, nursing home or chronic care facility.
- ☐ This is the first application for catastrophic determination.
- ☐ This is a reapplication for catastrophic determination.

Reason for Reapplication: _____

I authorize my treating health professional to collect, use, and disclose to my insurer or to a health professional, social worker, or vocational rehabilitation expert properly identified by my insurer to conduct an examination, only such information relating to my health condition or injuries arising as a result of the automobile accident as is reasonably required for the purpose of determining whether I have a catastrophic impairment.

I confirm 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.

Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)
---	-----------------

**Part 2
Health
Practitioner
Information**

Name			
Facility			
Address			
City		Province	Postal Code
Telephone Number	Area Code	ext	FAX Number Area Code

Type of Practitioner:

- ☐ chiropractor
 ☐ dentist
 ☐ nurse practitioner
 ☐ occupational therapist
 ☐ optometrist
 ☐ physician
 ☐ physiotherapist
 ☐ psychologist
 ☐ speech language pathologist

**Part 3
Health
Practitioner's
Report of
Catastrophic
Impairment**

Knowledge of Applicant

- ☐ Applicant is currently in my care and most recently seen on Number of years in my care.....
 (YYYYMMDD)
- ☐ Applicant was seen for the purpose of preparing this application, on.....
 (YYYYMMDD)
- ☐ Applicant was in my care but no longer actively followed. Date last seen by me:
 (YYYYMMDD)
- ☐ I have reviewed the file but have not seen the applicant. The most relevant material reviewed is dated
 (YYYYMMDD)
- ☐ I have seen this person time(s) for the purpose of evaluating impairment.

Provide a description of the impairment(s) sustained in the automobile accident. Use the applicable definition of catastrophic impairment as a guide. **Please attach a report explaining the impairment and your findings.** If you are able, and it's relevant, refer to the whole person impairment rating based on the AMA Guides.

Please refer to the following definition of catastrophic impairment when completing this form.

For Accidents Between November 1, 1996 and September 30, 2003

Criterion 1.

Based on my assessment, I believe the following criteria are applicable to this applicant. Please check all that apply.

"Catastrophic impairment" means

- ☐ (a) paraplegia or quadriplegia,
- ☐ (b) amputation or other impairment causing the total and permanent loss of use of both arms,
- ☐ (c) amputation or other impairment causing the total and permanent loss of use of both an arm and a leg,
- ☐ (d) total loss of vision in both eyes,
- ☐ (e) brain impairment that, in respect of an accident, results in,
 - (i) a score of 9 or less on the Glasgow Coma Scale as published in Jennett, B. and Teasdale, G., Management of Head Injuries, Contemporary Neurology Series, Volume 20, F.A. Davis Company, Philadelphia, 1981, according to a test administered within a reasonable period of time after the accident by a person trained for that purpose, or
 - (ii) a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale as published in Jennett, B. and Bond, M., Assessment of Outcome After Severe Brain Damage, Lancet i: 480, 1975, according to a test administered more than six months after the accident by a person trained for that purpose,
- ☐ (f) an impairment or combination of impairments that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in 55 per cent or more impairment of the whole person, or
- ☐ (g) an impairment that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder.

Note:

For the purpose of clauses (f) and (g) of the definition of "catastrophic impairment" in subsection (1), an impairment that is sustained by an insured person but is not listed in the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, shall be deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person.

Criterion 2.

Clauses (f) and (g) of the definition of "catastrophic impairment" do not apply unless,

- ☐ (a) the insured person's condition has stabilized and is not likely to improve with treatment, or
 ☐ (b) three years have elapsed since the accident.

**Part 4
Criteria For
Accidents
Between
November 1,
1996 and
September
30, 2003**

**Part 5
Criteria For
Accidents
on or after
October 1, 2003**

For Accidents on or after October 1, 2003

Criterion 1.

Based on my assessment, I believe the following criteria are applicable to this applicant. Please check all that apply.

"Catastrophic impairment"

- ☐ (a) paraplegia or quadriplegia;
- ☐ (b) the amputation or other impairment causing the total and permanent loss of use of both arms or both legs;
- ☐ (c) the amputation or other impairment causing the total and permanent loss of use of one or both arms and one or both legs;
- ☐ (d) the total loss of vision in both eyes;
- ☐ (e) brain impairment that, in respect of an accident, results in
 - (i) a score of 9 or less on the Glasgow Coma Scale as published in Jennett, B. and Teasdale, G., Management of Head Injuries, Contemporary Neurology Series, Volume 20, F.A. Davis Company, Philadelphia, 1981, according to a test administered within a reasonable period of time after the accident by a person trained for that purpose, or
 - (ii) a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale as published in Jennett, B. and Bond, M., Assessment of Outcome After Severe Brain Damage, Lancet i: 480, 1975, according to a test administered more than six months after the accident by a person trained for that purpose,
- ☐ (f) an impairment or combination of impairments that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in 55 per cent or more impairment of the whole person; or
- ☐ (g) an impairment that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder.

Note:

If an insured person is under the age of 16 years at the time of the accident and none of the Glasgow Coma Scale, the Glasgow Outcome Scale or the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, referred to in clause (e), (f), or (g) can be applied by reason of the age of the insured person, then an impairment sustained in an accident by the insured person that can reasonably be believed to be a catastrophic impairment shall be deemed to be the impairment that is most analogous to the impairment referred to in clause (e), (f), or (g), after taking into consideration the developmental implications of the impairment.

For the purpose of clauses (f) and (g), an impairment that is sustained by an insured person but is not listed in the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993 shall be deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person.

Criterion 2.

Clauses (f) and (g) of Criterion 1 do not apply to the applicant unless,

- ☐ (a) the insured person's health practitioner states in writing that the insured person's condition is unlikely to cease to be a catastrophic impairment; or
- ☐ (b) two years have elapsed since the accident.

Health Practitioner Explanation or Comments for Criteria Selected Above:

--

**Part 6
Signature
of Health
Practitioner**

I confirm that the applicant suffered a catastrophic impairment as described in the relevant definition attached to this application. 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 a contract of insurance. 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.

Name of Health Practitioner (please print)	Signature of Health Practitioner	Date (YYYYMMDD)
--	----------------------------------	-----------------

Note: The fee for completing this form is not a health care benefit of the Ontario Ministry of Health. The fee and the cost of any examination(s) necessary to complete this form, should be billed to the insurance company.

Auto Insurance Standard Invoice (OCF-21)

Claim Number:

Policy Number:

Date of Accident:
(YYYYMMDD)

Use this form for accidents that occur on or after November 1, 1996 for medical and rehabilitation goods and services that are payable by an automobile insurer. The User Manual for completion of the form and its versions may be found at www.hcaiinfo.ca.

Attach Version C - pages 2 and 3 for Pre-approved Frameworks (PAFs). Attach Version A - page 2 where there is a previously approved treatment or assessment plan. Version B - pages 2 and 3 must be used for all other goods and services and may be used for previously approved treatment plans and assessments, at the discretion of the provider.

Please provide all information requested.

Confidentiality: Collection, use and disclosure of this information is subject to all applicable privacy legislation.

Part 1 Applicant Information

Date Of Birth (YYYYMMDD)	Gender ☐ Male ☐ Female	Telephone Number	Extension
Last Name			
First Name		Middle Name	
Address			
City	Province	Postal Code	

Part 2 Insurance Company Information

Company Name		City or Town of Branch Office (if applicable)	
Adjuster Last Name		Adjuster First Name	
Adjuster Telephone	Extension	Adjuster Fax	
Name of policy holder same as: ☐ Applicant OR	Policy Holder Last Name	Policy Holder First Name	

Part 3 Invoice Information

Invoice Number	
First Invoice	☐ Yes ☐ No
Last Invoice	☐ Yes ☐ No

For previously approved goods and services, please complete the following:

Type of Plan or Pre-approved Framework	Plan Date (YYYYMMDD)	Plan Number	Approved Amount	Previously Billed
☐ Treatment Plan (OCF-18) ♦				
☐ Assessment Plan (OCF-22) ♦				
☐ PAF Type: ♣				
♦ Attach Version A or B ♣ Attach Version C				
For all other invoices, attach Version B				

Part 4 Payee Information

Facility Name (if applicable)		AISI Facility Number (if applicable)	
Payee Last Name		Payee First Name	Payee Number (if applicable)
Address			
City	Province	Postal Code	
Telephone Number		Extension	Fax Number
Email Address			
☐ I wish to declare that I have no conflicts of interest relating to this invoice, and I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this invoice on the part of any person who referred the applicant to a person who provided goods or services referred to in this invoice. Or ☐ I am declaring the following conflicts of interest relating to this invoice:			
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. This information will be used for processing payments of claims; identifying and analysing the nature and costs of goods and services that are provided to automobile accident victims, by health care providers; preventing fraud and detecting fraud where there are reasonable grounds to suspect fraud.			
Name of Health Professional Social Worker or Authorized Signatory (please print)		Signature of Health Professional Social Worker or Authorized Signatory	Date (YYYYMMDD)

This form may not be used for Pre-approved Frameworks (use Version C - pages 2 and 3) or goods and services that have not been previously approved (use Version B - pages 2 and 3).

Providers				Regulated (College Registration Number)	Unregulated (AISI Number if applicable, or blank)	Hourly Rate	For Insurer's Use
Ref	Type	Last Name	First Name				
A							
B							
C							
D							
E							
F							

Provider details are not required if they are the same as those on an approved plan.
¹ Refer to the User Manual at www.hcailinfo.ca for coding.

Other Insurance (for goods and services on this invoice)		MOH	Insurer 1	Insurer 2	Account Activity Since Last Invoice (if Interest is being charged)		Sub-Total:		
	Chiropractic:						MOH:		
	Physiotherapy:				Prior Balance:		Other Insurer 1 + 2:		
	Massage Therapy:				Payment Received		GST (if applicable):		
	¹ Other Service Type:				from Auto Insurer:		PST (if applicable):		
	Total:				² Overdue Amount:		² Interest:		
	¹ Please Specify Other Service Type:				² The insurer shall pay interest on overdue outstanding balances as required by the Statutory Accident Benefits Schedule.		Auto Insurer Total:		

For insurer's use only			
Reviewed By:			
Approved By:			
Payee Name:			
Payment Amount:	Total	Interest	Grand Total

Version B - pages 2 and 3 are used together for billing goods and services that have not been previously approved by the insurer through an OCF-18 or OCF-22. They may be used, at the discretion of the provider, for billing any goods or services except Pre-approved Frameworks (use Version C - pages 2 and 3).

Providers				Regulated (College Registration Number)	Unregulated (AIS1 Number if applicable, or blank)	Hourly Rate	For Insurer's Use
Ref	Type	Last Name	First Name				
A							
B							
C							
D							
E							
F							
Provider details are not required if they are the same as those on a previously approved plan. * Refer to the User Manual at www.hcaiinfo.ca.ca for coding.							

☐ Additional sheets attached

Version B - pages 2 and 3 are used together for billing goods and services that have not been previously approved by the insurer through an OCF-18 or OCF-22. They may be used, at the discretion of the provider, for billing any goods or services except Pre-approved Frameworks (use Version C - pages 2 and 3).

OTHER INSURANCE: I have made reasonable enquiries of the claimant and have determined that:		
☐ NO <i>There is no other insurance coverage identified for these goods and services</i> ☐ YES <i>There is other insurance coverage that is potentially available to cover/partially cover these goods and services.</i>		
MOH	Is there Ministry of Health and Long-Term Care (MOH) coverage for goods and services included in this invoice? ☐ Yes ☐ No ☐ Not applicable	
Other Insurer 1	Other Insurer Name	Other Insurance Plan Or Policy Number
	Name of Plan Member	Other Insurer's Identifier
Other Insurer 2	Other Insurer Name	Other Insurance Plan Or Policy Number
	Name of Plan Member	Other Insurer's Identifier
Other Insurance details are not required if they are the same as those on a pre-approved plan.		

Conflict of Interest Definition		
A person has a conflict of interest relating to an invoice if:		
i.	The person or a related person may receive a financial benefit, directly or indirectly, as a result of the provision, by the related person, of the goods or services, and	
ii.	The person who may receive the financial benefit is not the employee of the person who will provide the goods or services and does not have a contract with the person who will provide the goods or services or under which goods or services of that kind are provided.	

Other Insurance (for goods and services on this invoice)		MOH	Insurer 1	Insurer 2	Account Activity Since Last Invoice (if Interest is being charged)	Sub-Total:	
	Chiropractic:					MOH:	
	Physiotherapy:				Prior Balance:	Other Insurer 1 + 2:	
	Massage Therapy:				Payment Received from Auto Insurer:	GST (if applicable):	
	¹ Other Service Type:					PST (if applicable):	
	Total:				² Overdue Amount:	² Interest:	
	¹ Please Specify Other Service Type:				² The insurer shall pay interest on overdue outstanding balances as required by the Statutory Accident Benefits Schedule.	Auto Insurer Total:	

Make cheque payable to:	
Other Information:	

For insurer's use only		
Reviewed By:		
Approved By:		
Payee Name:		
Payment Amount:	Total	Interest Grand Total

Version C, pages 2 and 3 are attached to OCF-21 page 1 and used to bill for goods and services within the guidelines of a Pre-approved Framework. For all other goods and services attach Version A or B.

Providers				Regulated (College Registration Number)	Unregulated (AISI Number if applicable, or blank)	Hourly Rate	For Insurer's Use
Ref	Type	Last Name	First Name				
A							
B							
C							
D							
E							
F							

[†] Refer to the User Manual at www.hcaiinfo.ca for coding.

[†] Refer to the User Manual at www.hcaiinfo.ca for coding.

OCF-21 (03/06)
Page 5 of 6

OCF-21 - Version C - page 3

Version C, pages 2 and 3 are attached to OCF-21 page 1 and used to bill for goods and services within the guidelines of a Pre-approved Framework.
For all other goods and services attach Version A or B.

Reimbursable Fees Within the PAF Guidelines:			
Description	'Code	'Attribute	Cost
'Refer to the User Manual at www.hcaiinfo.ca for coding.		PAF Fee Totals:	

Other Reimbursable Goods and Services Approved by the Insurer:											
Date of Service			Description	'Code	'Attribute	Provider Reference	Quantity	'Measure	GST (4)	PST (4)	Cost
YYYY	MM	DD									
*Refer to the User Manual at www.hcaiinfo.ca for coding.							Other Goods and Services Total:				

Other Insurance (for goods and services on this invoice)		MOH	Insurer 1	Insurer 2	Account Activity Since Last Invoice (if Interest is being charged)		Sub-Total:	
	Chiropractic:						MOH:	
	Physiotherapy:				Prior Balance:		Other Insurer 1 + 2:	
	Massage Therapy:				Payment Received from Auto Insurer:		GST (if applicable):	
	¹ Other Service Type:						PST (if applicable):	
	Total:				² Overdue Amount:		² Interest:	
	¹ Please Specify Other Service Type:				² The insurer shall pay interest on overdue outstanding balances as required by the Statutory Accident Benefits Schedule.		Auto Insurer Total:	

Make cheque payable to:

Other Information:

For insurer's use only

Reviewed By:

Approved By:

Payee Name:

Payment Amount:

Total

Interest

Grand Total

Application for Approval of an Assessment or Examination (OCF-22)

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

Claim Number:

Policy Number:

Date of Accident:
(YYYYMMDD)

To the Applicant:

Use this form to request prior approval for payment of an assessment or examination fee for which prior approval is required.

Please provide all information requested.

Collection, use and disclosure of this information is subject to all applicable privacy legislation. Additional disclosure and consent may be required depending on the manner in which the information is used and disclosed.

To the Health Professional/Facility or Social Worker:

Consent: It is the responsibility of the health professional/facility or social worker to ensure that their collection, use and disclosure of information submitted is authorized by a consent form. Health professionals/facilities or social workers can use the Ontario Claims Form 5 (OCF-5) *Permission to Disclose Health Information* as a consent form.

A submission for insurer approval/payment of an expense for an assessment or examination may be made either with this form or a Treatment Plan (OCF-18) form.

Part 1 Applicant Information

To be completed
by the applicant

Date Of Birth (YYYYMMDD)	Gender ☐ Male ☐ Female	Telephone Number	Extension
Last Name			
First Name		Middle Name	
Address			
City	Province	Postal Code	

Part 2 Insurance Company Information

To be completed
by the applicant

Company Name		City or Town of Branch Office (if applicable)	
Adjuster Last Name		Adjuster First Name	
Adjuster Telephone	Extension	Adjuster Fax	
Name of policy holder same as: ☐ Applicant OR	Policy Holder Last Name	Policy Holder First Name	

Part 3 Signature of Regulated Health Professional or Social Worker

Name of Regulated Health Professional/Social Worker		College Registration Number	
Facility Name (if applicable)		AISI Facility Number (if applicable)	
Address			
City	Province	Postal Code	
Telephone Number		Extension	Fax Number
Email Address			
☐ I wish to declare that I have no conflicts of interest relating to this form and I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this form on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this form, or ☐ I am declaring the following conflicts of interest relating to this Application:			
I confirm that, to the best of my knowledge, the information in this form is accurate, and the services contemplated are reasonable for the assessment or examination of the applicant. In addition, I confirm that I have obtained the appropriate consent from the applicant for the collection, use and disclosure of information submitted.			
Name of Regulated Health Professional/Social Worker (please print)		Signature of Regulated Health Professional/ Social Worker	Date (YYYYMMDD)

Part 4
Nature of
Assessment
or
Examination

Except those assessments and examinations that are payable without insurer approval pursuant to a PAF Guideline, payment for all assessments and examinations is dependent upon approval by the insurer or if disputed by an arbitration or by the courts. In addition, prior approval for payment of an assessment or examination is not required in some situations as outlined below. Please ✓ the appropriate box in the chart below to indicate what situation applies to this application.

PRIOR APPROVAL IS NOT REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO COMPLETE TREATMENT PLANS FOR THE FOLLOWING :

- ☐ an assessment or examination where an immediate risk of harm to the insured person or a person in the insured person's care makes obtaining the insurer's prior approval of the assessment or examination impractical;
- ☐ not more than three assessments or examinations if:
 - the cost of each assessment or examination does not exceed \$200.00, and
 - not more than one assessment or examination is done by the same person;
- ☐ an assessment or examination conducted after the insurer notifies the insured person that, before the examination is conducted, it does not require the submission of a Treatment Plan or an application under s. 38.2 of the SABS.

PRIOR APPROVAL IS REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO COMPLETE TREATMENT PLANS FOR:

- ☐ all other assessments or examinations to complete Treatment Plans, not outlined above.

PRIOR APPROVAL MAY BE REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO COMPLETE DISABILITY CERTIFICATES:

- ☐ prior approval is not required in respect of an assessment or examination for a disability certificate if the cost of the assessment for the certificate does not exceed \$200.00;
- ☐ prior approval is required for assessments to complete disability certificates that exceed \$200.00.

PRIOR APPROVAL IS NOT REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO PREPARE A FORM 1:

- ☐ prior approval is not required in respect of an assessment or examination for the purposes of preparing a Form 1.

PRIOR APPROVAL MAY BE REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO DETERMINE CATASTROPHIC IMPAIRMENT:

- ☐ prior approval is not required in respect of an assessment or examination for a determination of catastrophic impairment if the insured person is hospitalized or in a long-term care facility at the time of the assessment or examination;
- ☐ prior approval is required in respect of an assessment or examination for a determination of catastrophic impairment if the insured person is not hospitalized or in a long-term care facility at the time of the assessment or examination.

ALL OTHER ASSESSMENTS OR EXAMINATIONS REQUIRING PRIOR APPROVAL:

- ☐ prior approval is required for all other assessments not outlined.

Part 5
Provisional
Clinical
Information

a) Clinical Information:

- i. Provide a brief description of the present complaints.

- ii. Has the applicant already been provided treatment under your care?

☐ No ☐ Yes

b) Assessment Information:

- i. Describe the details of the assessment requested and the rationale for it.

- If you have already provided treatment to this applicant, include clinical indicators to substantiate the reasonableness of the proposed assessment.
- For multi-disciplinary assessments, include the detail and rationale for each component of the assessment.

- ii. After making reasonable inquiries, are you aware of a prior assessment of this type completed for this applicant?

☐ No ☐ Yes

If yes, provide date if possible (YYYYMMDD) ____/____/____

Applicant Name:		OCF-22 - FAX BACK	Policy Number:	
Provider Name:			Claim Number:	
Provider Fax:			Date of Accident:	

Part 6

Health Providers

Provider Reference	Provider Type	Provider		Regulated (College Registration Number)	Unregulated (AISI Number if applicable, or blank)	Hourly Rate (if applicable)
		Last Name	First Name			
A						
B						
C						
D						
E						
F						

Part 7

Proposed Goods and Services

This Assessment Plan should include **all goods and services (G/S)** contemplated by the Health Professional/Facility.

G/S Ref	Description	Code	Attribute	Provider Ref	Estimated		
					Quantity	Measure	Total Cost
1							
2							
3							
4							
5							
7							
8							
9							
10							
11							
12							
13							
14							
15							
Note *: Refer to the User Manual coding guidelines posted at www.hcaiinfo.ca . Attribute codes are used to further qualify the service codes and are described in the manual. Payment by auto insurer is secondary to available collateral benefits.					Sub-Total:		
					*MOH:		
					*Other Insurer 1 + 2:		
					GST (if applicable):		
					PST (if applicable):		
					Auto Insurer Total:		

Part 8

Signature of Insurer

☐ I waive the requirement for the applicant's signature on a OCF 18 Treatment Plan.
I have reviewed this form and based upon the information provided, I

☐ Approve
☐ Partially approve
☐ Do not approve

The Statutory Accident Benefits Schedule states that subject to the conflict of interest provisions, the insurer shall, within 3 business days of receiving the completed form for proposed assessments:

- Give the health professional or social worker and the applicant a notice approving the assessment or
- Advise the applicant that the insurer is not agreeing to pay part or all assessments and advising the applicant that an examination is required.

Insurer response is required within the timeframes of the SABS or payment for proposed assessment or examination is deemed approved.

Name of Adjuster (please print)

Signature of Adjuster

Date (YYYYMMDD)

The fee for completing this form is not a health care benefit of the Ontario Ministry of Health and Long-Term Care. This fee should be billed to the insurer directly.

Part 9
Signature of
Applicant
(Optional)

If not completed,
the Health
Professional or
Social Worker in
Part 3 assumes
responsibility for
obtaining
applicant's
consent

I have reviewed and confirm the information set out in this form is accurate. I understand that payment for these services may be subject to the approval of the insurer. In the event that my insurer seeks a further review of the application, my insurance company may require that I be examined by a health professional, social worker, or vocational rehabilitation expert identified by the insurer to review the application.

In the event that an examination is requested, I authorize my insurer and my treating health professional or social worker, to give the health professional, social worker, or vocational rehabilitation expert properly identified by the insurer to review this application, only such information relating to my health condition, treatment and rehabilitation received as a result of the accident, as is reasonably required for the purposes of determining my eligibility to benefits.

As required by law, a copy of the examination report by the health professional, social worker, or vocational rehabilitation expert identified by the insurer to conduct the examination as well as the insurance company's determination will be sent to me.

Subject to the Statutory Accident Benefits Schedule, in those circumstances, where prior approval is required, I understand that, if I undertake any of the proposed services prior to approval by the insurer, I may be responsible for payment to my provider for any of the services rendered on my behalf.

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)

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

Use this form for accidents that occur on or after October 1, 2003

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

To the Applicant:

Please complete Parts 1 and 2. After your health practitioner has reviewed your Treatment Confirmation Form with you, sign Part 13.

Your health practitioner will complete all other parts of the form. **A health practitioner (chiropractor, dentist, occupational therapist, optometrist, physician, physiotherapist, nurse practitioner, psychologist, speech language pathologist) must sign Part 5.**

Collection, use and disclosure of this information is subject to all applicable privacy legislation. Additional disclosure and consent may be required depending on the manner in which the information is used and disclosed.

Please provide all information requested.

Part 1 Applicant Information

To be completed
by the applicant

Date Of Birth (YYYYMMDD)	Gender ☐ Male ☐ Female	Telephone Number	Extension
Last Name			
First Name		Middle Name	
Address			
City	Province	Postal Code	

Part 2 Insurance Company Information

To be completed
by the applicant

Company Name		City or Town of Branch Office (if applicable)	
Adjuster Last Name		Adjuster First Name	
Adjuster Telephone	Extension	Adjuster Fax	
Name of policy holder: Same as Applicant ☐ , OR:	Policy Holder Last Name	Policy Holder First Name	

Part 3 Other Insurance Information

To be completed
by the Initiating
Health
Practitioner with
Information from
the Applicant

OTHER INSURANCE: Is there other insurance coverage for any goods and services listed in this Pre-approved Framework Treatment Confirmation Form? I have made reasonable enquiries of the applicant and have determined that:			
☐ NO <i>There is no other insurance coverage identified for these goods and services</i> ☐ YES <i>There is other insurance coverage that is potentially available to cover/partially cover these goods and services.</i>			
MOH	Is there Ministry of Health and Long-Term Care (MOH) coverage for any goods and services included in this Treatment Confirmation Form? ☐ Yes ☐ No ☐ Not applicable		
Other Insurer 1	Other Insurer Name		Other Insurance Plan Or Policy Number
	Name of Plan Member		Other Insurer's Identifier
Other Insurer 2	Other Insurer Name		Other Insurance Plan Or Policy Number
	Name of Plan Member		Other Insurer's Identifier

Part 4 Conflict of Interest Definition

A person has a conflict of interest relating to a Pre-approved Framework Treatment Confirmation Form if,

- the person or a related person may receive a financial benefit, directly or indirectly, as a result of the provision, by the related person or another person, of goods or services contemplated by the Pre-approved Framework Treatment Confirmation Form, and
- the person who may receive the financial benefit is not the employee of the person who will provide the goods or services and does not have a contract with the person who will provide the goods or services or under which goods or services of that kind are provided.

Part 5 Signature of Initiating Health Practitioner

Name of Initiating Health Practitioner (please print)		College Registration Number	You are a: ☐ Chiropractor ☐ Dentist ☐ Nurse Practitioner ☐ Occupational Therapist ☐ Optometrist ☐ Physician ☐ Physiotherapist ☐ Psychologist ☐ Speech-Language Pathologist
Facility Name (if applicable)		AlSI Facility Number (if applicable)	
Address			
City	Province	Postal Code	
Telephone Number	Extension	Fax Number	
Email Address			
☐ I am not the first Initiating Health Practitioner Conflict of Interest Declaration ☐ I wish to declare that I have no conflicts of interest relating to this Pre-approved Framework Treatment Confirmation Form, and I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this form on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this form; or ☐ I am declaring the following conflicts of interest relating to this Pre-approved Framework Treatment Confirmation Form:			
I certify that the goods and services contemplated are reasonable and necessary for the treatment and rehabilitation of the applicant for the injuries identified in Part 6, and the treatment proposed is in accordance with a PAF Guideline. I have reviewed the proposed treatment with the applicant. 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. This information will be used for processing payments of claims; identifying and analysing the nature, effects and costs of goods and services that are provided to automobile accident victims, by health care providers; and detecting and preventing fraud.			
Name of Initiating Health Practitioner (please print)		Signature of Initiating Health Practitioner	Date (YYYYMMDD)

To the Health Professional:

Please complete the following information based on your most recent examination of the applicant named above and return the form to the insurance company listed in Part 2. **Please print clearly.**

Part 6 Injury and Sequelae Information

Provide a description (list most significant first) and associated ICD-10-CA code for injuries and sequelae that are the direct result of the automobile accident.	
Injury Description	*Injury Code
Note *: Refer to the User manual at www.hcaiinfo.ca for ICD-10-CA coding information.	

Part 7 Prior and Concurrent Conditions

a) Was the applicant employed at the time of the accident? ☐ Yes ☐ No
b) Prior to the accident, did the applicant have any disease, condition or injury that could affect his/her response to treatment for the injuries identified in Part 6? ☐ No ☐ Unknown ☐ Yes (please explain)
c) If Yes to "b" above, did the applicant undergo investigation or receive treatment for this disease, condition or injury in the past year? ☐ No ☐ Unknown ☐ Yes (please explain and identify provider, if known)

Part 8 Barriers to Recovery

a) Have you identified any barriers to recovery that may affect the success of this treatment for this particular applicant? (For assistance in identifying barriers to recovery, please refer to the user manual at www.hcaiinfo.ca .) ☐ No ☐ Yes (please explain)

Applicant Name:		OCF23/198 - FAX BACK	Policy Number:	
Provider Name:			Claim Number:	
Provider Fax:			Date of Accident:	

Part 9 PAF Pre-approved Services			
Category	Description	Maximum Fee	Estimated Fee
PAF (identify which PAF Guideline)			
Supplementary Goods & Services			
Other Pre-approved Services (including radiology)			
Part 9 Sub-Total			

**Part 10
Other Health
Providers**
(required only if
Part 11 Services
are rendered by
Other Providers)

Provider Reference	†Provider Type	Provider		Regulated (College Registration Number)	Unregulated (AISI Number if applicable, or blank)	Hourly Rate (if applicable)
		Last Name	First Name			
A						
B						
C						
D						

Part 11 Other Goods or Services Within the PAF Guidelines Requiring Insurer Approval						
Description	†Code	†Attribute	Provider Reference	Estimated		
				Quantity	†Measure	Cost
Note †: Refer to the User Manual coding guidelines posted at www.hcaiinfo.ca . Attributes codes are used to further qualify the service codes and are described in the manual.				Part 11 Sub-Total:		
Payment by auto insurer is secondary to available collateral benefits.				Total:		
Briefly explain why the goods and services in Part 11 are being proposed and the treatment goal:						

**Part 12
Signature
of Insurer**

☐ I waive the requirement of the Applicant's signature.		
☐ I have reviewed this Pre-approved Framework Treatment Confirmation Form, and based upon the information provided, I confirm that the policy referred to in Part 2 was in force at the time of the accident.		
If other goods or services requiring insurer approval have been proposed in Part 11, I		
☐ Approve	☐ Partially approve (explanation to follow or attached)	☐ Do not approve (explanation to follow or attached)
Name of Adjuster (please print)	Signature of Adjuster	Date (YYYYMMDD)
To the insurer: Please provide a copy of this page to the Applicant and the Initiating Health Practitioner indicated in Part 5.		

Part 13
Signature
of
Applicant

I have reviewed this form. I have been informed about and agree with the proposed treatment. I certify that, to the best of my knowledge, the information I have provided is accurate. Payment for this treatment is pre-approved, and/or subject to the approval of the insurer. For services requiring insurer approval, I understand that, if I undertake those services prior to approval by the insurer, I may be responsible to my provider for any goods or services provided. All services are subject to coverage issues or exclusions.

I consent to sharing of personal information between my Initiating Health Practitioner and my insurer. If this OCF-23/198 is not being completed by the first Initiating Health Practitioner, I consent to the insurer contacting the first Initiating Health Practitioner to determine the amount of the PAF goods and services that have been consumed.

TO THE INSURER TO WHOM THIS APPLICATION IS BEING SUBMITTED:

I UNDERSTAND that you, and persons acting for you, will collect and use personal information and personal health information about me that is related to my claims for accident benefits arising out of the accident described in this application, and that all such information will be collected directly from me, or from any other person with my consent.

I ALSO UNDERSTAND that this information will be collected and used only as reasonably necessary for the purposes of:

- Investigating my claims and processing my claims as required by law, including the Ontario Automobile Policy;
- Obtaining or verifying information relating to my claims in order to determine entitlement and the proper amount of payment;
- Recovering payment from insurers and others liable in law for amounts that you pay in connection with my claims;
- Identifying and analyzing the nature and costs of goods and services that are provided to automobile accident victims by health care providers;
- Preventing fraud, and detecting fraud where there are reasonable grounds to suspect fraud;
- Compiling anonymized statistics for government agencies; and
- Assessing underwriting risks and claims experience.

I ALSO UNDERSTAND that you, and persons acting for you, may disclose this information to the following persons, who may collect and use this information only as reasonably necessary to enable you to carry out the purposes described above:

- Insurers; insurance adjusters; agents and brokers; employers; health care professionals; hospitals; accountants; financial advisors; solicitors; organizations that consolidate claims and underwriting information for the insurance industry; and my agents or representatives as designated by me from time to time.

I CONSENT to you collecting, using and disclosing this information in the manner described above, but no more of such information than is reasonably necessary to meet the legitimate purpose of such collection, use or disclosure.

I UNDERSTAND that if I have questions about this consent I am free to consult my insurance company representative or legal advisor before signing this document.

I AM ALSO AWARE that you, and persons acting for you, may be required or permitted by law to disclose this information to others without my knowledge or consent.

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)

Return this form to:

Notice of Examination (OCF-25)

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

Claim Number:

Policy Number:

Date of Accident:
(YYYYMMDD)

In response to your recent application for accident benefits or catastrophic impairment determination or as part of our review of entitlement to benefits that are currently being paid to you, we will be conducting an examination of you by one or more health professionals or a social worker or a person who has vocational rehabilitation expertise. The information listed below outlines the:

- type of examination that will be conducted;
- reasons for the examination;
- the name, professions and designations of the persons conducting the examination;
- whether your personal attendance is required; and
- the date time and location of the examination.

Within 5 business days of receiving this notice, you are required to provide all reasonably available information and documents that are relevant or necessary for the review of your medical condition prior to your examination to the person or persons conducting the examination identified in Part 4 of this form.

Not participating in an examination may result in the application being rejected or benefits being suspended. A copy of the examination report and determination with respect to the application for accident benefits or your entitlement to ongoing benefits will be sent to you.

Part 1 Claimant Information

Date of Birth (YYYYMMDD)	Age	Gender ☐ Male ☐ Female	Telephone Number	Extension
Last Name		First Name	Middle Name	
Address				
City		Province	Postal Code	
Special Needs (if applicable) ☐ Mobility ☐ Interpreter (Type:) ☐ Other (specify)				
Representative (if applicable)			Address	
City		Province	Postal Code	
Telephone Number	Extension	Fax Number	Email	

Part 2 Type(s) and Reasons for the Examination

Type(s) of Examination		
☐ Income Replacement Benefits ☐ Employed ☐ Unemployed ☐ Post-104 Weeks Disability	☐ Non-Earner Benefits ☐ Caregiver Benefits ☐ Medical and Rehabilitation Benefits ☐ Application for Approval of an Assessment	☐ Applicability of Pre-Approved Framework Guideline ☐ Attendant Care ☐ Catastrophic Impairment ☐ Housekeeping and Home Maintenance ☐ Other Benefits
Reasons and Description of the Examination		

Part 3
Arrangements
for
Examination

Arrangements for Examination are: ☐ Listed Below ☐ Will Follow

Part 4
Health
Professional(s)
Conducting
the
Examination /
Date /Location

Name	Profession or Designation	Speciality
Facility Name		
Address		
City	Province	Postal Code
Contact's Last Name		Contact's First Name
Telephone Number	Extension	Fax Number
Email		
Are You Required to Attend the Examination; ☐ Yes ☐ Not Required to Attend – File Review		
If yes, date and time of Examination;		
Location of Examination ☐ At Address Listed Above or at:		

Part 5
Insurance
Information

Insurance Company Name	City or Town of Branch Office (if applicable)	
Address		
City	Province	Postal Code
Adjuster's Name		
Telephone Number	Fax Number	Email

Part 6
Insurer
Signature

If you have any questions or concerns about the examination or conflicts with the examination date or time, please contact your adjuster listed in Part 5.		
Name of Insurance Company Representative (please print)	Signature of Insurance Company Representative	Date (YYYYMMDD)

Return this form to:

Voluntary Consent for Pre-Claim Examination (OCF-26)

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

Claim Number:

Policy Number:

Date of Accident:
(YYYYMMDD)

To assist you following your accident, we are seeking your consent to be examined by one or more health care professionals. This examination is voluntary and will only apply if you have not completed an application for accident benefits and are in hospital or have been discharged recently.

The examination is to assist in determining your entitlement to attendant care, assistive devices, or home modifications and devices that you may need as a result of the accident.

Part 1 Claimant Information

Date of Birth (YYYYMMDD)	Age	Gender ☐ Male ☐ Female	Telephone Number	Extension
Last Name		First Name	Middle Name	
Address				
City		Province	Postal Code	
Special Needs (if applicable) ☐ Mobility ☐ Interpreter (Type:) ☐ Other (specify)				
Representative (if applicable)			Address	
City		Province	Postal Code	
Telephone Number	Extension	Fax Number	Email	

Part 2 Health Care Professionals Conducting the Examination

Name	Profession or Designation	Speciality	
Facility Name			
Address			
City	Province	Postal Code	
Contact's Last Name		Contact's First Name	
Telephone Number	Extension	Fax Number	Email

Part 3 Date and Location of Examination

Date and time of examination:
Location of examination ☐ applicant's home
☐ hospital:
☐ other:

Part 4 Consent

I authorize my insurer or health professional appointed by my insurer to conduct this pre-claim examination, to collect and use personal information and health information related to accessing accident benefits for attendant care, assistive devices or home modifications.

I understand that my consent to this examination is voluntary. Refusing to consent to this pre-claim examination will not affect my right to apply for or receive accident benefits. This examination can only be used to assist me in accessing benefits and cannot be relied upon to determine that I am not entitled to an accident benefit.

I consent to this pre-claim examination in the manner described above.

Applicant or Substitute Decision Maker	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)
--	---	-----------------

The health care professional(s) that conduct the examination will provide you with a copy of the examination report within 5 business days after conducting the examination.

If you have questions or concerns about the examination please contact the adjuster listed below.

Part 5 Insurance Company Information

Adjuster's Name			
Telephone Number	Extension	Fax Number	Email

Return this form to:

Assessment of Attendant Care Needs (Form 1)

Policy No.

Claim No.

Use this form to report the future needs for attendant care required by the applicant as a result of an automobile accident on or after March 1, 2006. This form must be completed by a member of a health profession who is authorized by law to treat the person's impairment (in this form referred to as a regulated health professional). This form has five parts:

- Part 1: Level 1 Attendant Care
- Part 2: Level 2 Attendant Care
- Part 3: Level 3 Attendant Care
- Part 4: Calculation of Attendant Care Costs
- Part 5: Signature of Assessor(s)

Please complete all relevant parts. You will have to make copies and give one to:

- the applicant
- the applicant's health practitioner
- the applicant's insurance company

Please note: Users of Form 1 should also review other accident benefits available under the Statutory Accident Benefits Schedule for possible reimbursement of other losses and expenses (such as housekeeping and home maintenance, transportation, home modifications and other medical and rehabilitation expenses).

Applicant's Name

Applicant's Name	Date of Birth	
Street Address	Date of Accident	
City	Province	Postal Code
Name of Policyholder (if different than above)	Policy No.	

What is the date of this assessment?

Is this the first assessment of this applicant?

Yes ☐

No ☐

Date of Last Assessment

Current Monthly Allowance

Applicant's Health Practitioner

Name of Health Practitioner	Telephone No.	
Facility or Institution		
Street Address		
City	Province	Postal Code

Insurance Company

Name	Telephone No.	
Street Address		
City	Province	Postal Code
Name of Policyholder	Policy No.	

Part 1:
Level 1
Attendant Care

Level 1 attendant care is for routine personal care. Please assess the care requirements of the applicant for each activity listed. Estimate the time it takes to perform each activity, and the number of times each week it should be performed. Multiply the number of minutes by the number of times each week the activity should be performed to get the total number of minutes per week for each activity.

		Number of Minutes	X Times per week	= Total minutes per week
Dress	Upper Body (for example, underwear, shirt/blouse, sweater, tie, jacket, gloves, jewelry)			
	Lower Body (for example, underwear, disposable briefs, skirt/pants, socks, panty hose, slippers, shoes)			
	Subtotal			
Undress	Upper Body (for example, underwear, shirt/blouse, sweater, tie, jacket, gloves, jewelry)			
	Lower Body (for example, underwear, disposable briefs, skirt/pants, socks, panty hose, slippers, shoes)			
	Subtotal			
Prosthetics	applies upper/lower limb prosthesis and stump sock(s)			
	exchanges terminal devices and adjusts prosthesis as required			
	ensures prosthesis is properly maintained and in good working condition			
	Subtotal			
Orthotics	assists dressing applicant using prescribed orthotics (for example, burn garment(s), brace(s), supports, splints, elastic stockings)			
	Subtotal			
Grooming	Face: wash, rinse, dry, morning and evening			
	Hands: wash, rinse, dry, morning and evening, before and after meals, and after elimination			
	Shaving: shaves applicant using an electric/safety razor			
	Cosmetics: applies makeup as desired or required			
	Hair:			
	brushes/combs as required			
	shampoos, blow/towel dries			
	performs styling, set and comb-out			
	Fingernails: cleans and manicures as required			
	Toenails: cleans and trims as required			
Subtotal				

Part 1 continued ...

		Number of Minutes X	Times per week =	Total minutes per week
Feeding	prepares applicant for meals (includes transfer to appropriate location)			
	provides assistance, either in whole or in part, in preparing, serving and feeding meals			
	Subtotal			
Mobility (location change)	assists applicant from a sitting position (for example, wheelchair, chair, sofa)			
	supervises/assists in walking			
	performs transfer needs as required (for example, bed to wheelchair, wheelchair to bed)			
Subtotal				
Extra Laundering	launders applicant's bedding and clothing as a result of incontinence/spillage			
	launders/cleans orthotic supplies that require special care			
	Subtotal			

Part 1 Total – Add all Part 1 Subtotals. Fill in total here and in Part 4 on Page 7.

**Part 2:
Level 2
Attendant Care**

Level 2 Attendant Care is for basic supervisory functions. Please assess the care requirements of the applicant for each activity listed. Estimate the time it takes to perform each activity, and the number of times each week it should be performed. Multiply the number of minutes by the number of times each week the activity should be performed to get the total number of minutes per week for each activity.

		Number of Minutes X	Times per week =	Total minutes per week
Hygiene	Bathroom			
	cleans tub/shower/sink/toilet after applicant's use			
	Bedroom			
	changes applicant's bedding, makes bed, cleans bedroom, including Hoyer lifts, overhead bars, bedside tables			
	ensures comfort, safety and security in this environment			
	Clothing Care			
	assists in preparing daily wearing apparel			
	hangs clothes and sorts clothing to be laundered/cleaned			
Subtotal				

Part 2 continued...

**Basic Supervisory
Care**

	Number of Minutes X	Times per week =	Total minutes per week
applicant lacks the capacity to reattach tubing if it becomes detached from the trachea			
applicant requires assistance to transfer from wheelchair, periodic turning, genitourinary care			
applicant lacks the ability to independently get in and out of a wheelchair or to be self-sufficient in an emergency			
applicant lacks ability to respond to an emergency or needs custodial care due to changes in behaviour			
Subtotal			

**Co-ordination of
Attendant Care**

	Number of Minutes X	Times per week =	Total minutes per week
applicant requires assistance in co-ordinating/scheduling attendant care (maximum 1 hour per week)			
Subtotal			

Part 2 Total – Add all Part 2 Subtotals. Fill in total here and in Part 4 on Page 7.

Part 3:
Level 3
Attendant Care

Level 3 attendant care is for complex health/care and hygiene functions. Please assess the care requirements of the applicant for each activity listed. Estimate the time it takes to perform each activity, and the number of times each week it should be performed. Multiply the number of minutes by the number of times each week the activity should be performed to get the total number of minutes per week for each activity.

		Number of Minutes	X Times per week	= Total minutes per week
Genitourinary Tracts	performs catheterizations			
	positions, empties and cleans drainage systems			
	cleans applicant and equipment after procedure/incontinence			
	uses disposable briefs as required			
	attends to menstrual cycle needs as required			
	monitors residuals			
	Subtotal			
Bowel Care	administers enemas or suppositories and performs stimulation or disimpaction			
	performs colostomy and/or ileostomy care			
	positions, empties and cleans drainage systems, including ilio-conduits			
	uses disposable briefs as required			
	cleans applicant and equipment after procedure/evacuation			
Subtotal				
Tracheostomy Care	changes and cleans inner and outer cannulae as needed			
	changes tapes as required			
	performs suctioning as required			
	cleans and maintains suction equipment			
Subtotal				
Ventilator Care	ensures volume rate and pressure are maintained as prescribed			
	maintains humidification as specified			
	changes and cleans tubing and filters as required			
	cleans humidification system as required			
	adjusts settings according to client needs (for example, colds, congestion)			
	reattaches tubing if it becomes detached			
Subtotal				
Exercise	assists applicant with prescribed exercise/stretching program			
	assists applicant with walking activities using crutches, canes, braces and/or walker			
Subtotal				

Number
of
Minutes **X** Times
per
week **=** Total
minutes
per week

Skin Care
(excluding
bathing)

attends to skin care needs – wounds, sores, eruptions, (amputees, severe burns, spinal cord injuries, etc.)			
applies medication and prescribed dressings			
applies creams, lotions, pastes, ointments, powders as prescribed or required			
checks body area(s) for evidence of pressure sores, skin breakdown or eruptions			
periodic turning to prevent or minimize pressure sores and skin breakdown/shearing			
Subtotal			

Medication

Oral			
administers prescribed medications			
monitors medication intake and effect			
maintains and controls medication supply			
Injections			
administers prescribed medications			
monitors medication intake and effect			
maintains and controls medication supply			
Inhalation/Oxygen Therapy			
administers prescribed dosage as required			
maintains and controls inhalation supplies			
cleans and maintains equipment			
Subtotal			

Bathing

Bathtub or Shower			
transfers applicant to and from bed, wheelchair or Hoyer lifts to bathtub or shower			
bathes and dries client			
applies creams, lotions, pastes, ointments, powders as prescribed or required			
Bed Bath			
prepares equipment			
bathes and dries applicant			
applies creams, lotions, pastes, ointments, powders as prescribed or required			
cleans and maintains bed/bath equipment			
Oral Hygiene			
brushes and flosses			
cleanses mouth as required			
cleans dentures as required			
Subtotal			

Number of Minutes **X** Times per week **=** Total minutes per week

Other Therapy

Transcutaneous Electrical Nerve Stimulation (TENS)			
prepares equipment			
administers treatment as prescribed or required			
Dorsal Column Stimulation (DCS)			
monitors skin			
maintains equipment			
Subtotal			

Maintenance of Supplies and Equipment

monitors, orders and maintains required supplies/equipment			
ensures wheelchairs, prosthetic devices, Hoyer lifts, shower commodes and other specialized medical equipment and assistive devices are safe and secure			
Subtotal			

Skilled Supervisory Care

applicant requires skilled supervisory care for violent behaviour that may result in physical harm to themselves or others			
Subtotal			

Part 3 Total – Add all Part 3 Subtotals. Fill in total here and below.

**Part 4:
Calculation of
Attendant Care
Costs**

This part must be completed by the assessor. Calculate the monthly attendant care allowance for Part 1, 2 and 3. The sum of all three parts will be the Total Assessed Monthly Attendant Care Benefit.

	Total Minutes per Week		Total Weekly Hours		Total Monthly Hours		Hourly Rate		Monthly Care Benefit
Part 1 (from Pg. 3)		÷ 60 =		X 4.3 =		X	\$ 11.23	=	\$
Part 2 (from Pg. 4)		÷ 60 =		X 4.3 =		X	\$ 7.75	=	\$
Part 3 (from Pg. 7)		÷ 60 =		X 4.3 =		X	\$ 17.98	=	\$

Total Assessed Monthly Attendant Care Benefit

(This amount is subject to the limits allowed under the Statutory Accident Benefits Schedule)

\$

**Part 5:
Signature(s) of
Assessor(s)
(Regulated
Health
Professional(s))**

Name of Regulated Health Professional			Registration Number			You are a: ☐ Chiropractor ☐ Dentist ☐ Massage Therapist ☐ Nurse ☐ Occupational Therapist ☐ Optometrist ☐ Physician ☐ Physiotherapist ☐ Psychologist ☐ Speech Language Pathologist ☐ Other _____
Facility Name (if applicable)			AISI number (if applicable)			
Address						
City	Province	Postal Code				
Telephone Number	Extension	Fax Number				
Email Address						
I confirm that, to the best of my knowledge, the information in this form is accurate. I have obtained the appropriate consent from the applicant for the collection, use and disclosure of the information submitted.						
Signature of Regulated Health Professional					Date (YYYYMMDD)	