You will need Acrobat Reader 6.0 or higher in order to complete this form online.

Important Notice About Your Personal Information

# Claim for Disability Benefits

**Form AB-1A**

For accidents that occur on or after **October 1, 2004**

Print

| Send this form to the appropriate insurer: | To be completed by Claimant / Representative or a Medical Doctor | |
|---|---|---|
| **Fax #** (____)_____-_____ | **Insurance Company** | |
| | **Policy Number** | |
| | **Date of Accident: (DD-MM-YYYY)** | |

## Part 1 – Claimant Information

| Last Name | First Name | Middle Name(s) |
|---|---|---|
| Address | | |
| City, Town or County | Province | Postal Code |
| Telephone Number (Home) *(Include area code)* | Telephone Number (Work) *(Include area code)* | Fax Number *(Include area code)* |
| Date Of Birth *(DD/MM/YYYY)* | Gender ☐ Male ☐ Female | |

## Part 2 – Claim for Disability Benefits *(To be completed by Claimant or Agent)*

Are you claiming disability income benefits under the Automobile Accident Insurance Benefits Regulation?

☐ Yes
☐ No

**If Yes, please complete the remainder of this part of the form. Your insurance claims adjuster may request additional information from you or your medical practitioner at a later date to assist with the claims process. If No, then please do not complete or submit this form at this time.**

| Were you employed on the date of the accident? | Date first unable to work *(DD/MM/YYYY)* |
|---|---|
| ☐ Yes<br>☐ No | |

Between what dates are you claiming a Loss of Income?

To

**History of Employment during the 12 months preceding the accident**

| | |
|---|---|
| Name of employer: | Name of employer: |
| Address: | Address: |
| From: To: | From: To: |
| Occupation: | Occupation: |

If you were unemployed at the date of the accident, for how much of the 12 months preceding the accident were you employed and working?

Average gross weekly income

$

Are you entitled to disability or other income benefits from your employer or any other source as a result of this accident?

☐ Yes
☐ No

If yes, from whom?

| | Name | Amount | Per Wk/Month |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

☐ I am the claimant
☐ I am the authorized representative of the claimant

I certify that the information provided is true and correct to the best of my knowledge. I confirm that I have consented to the collection, use and disclosure of my personal information for the determination of my eligibility for accident and/or disability income benefits as outlined on form **AB-1**.

Name (Please Print) _____

Signature _____ Date_____

**Part 3 – Information of Medical Doctor** ***(To be completed by Medical Doctor)***

| Name of Professional | | Profession |
|---|---|---|
| Address | | |
| City, Town or County | Province | Postal Code |
| Administrative Contact Name | Facility Name | |
| Telephone Number *(Include area code)* | Fax Number *(Include area code)* | |

**Part 4 – Signature of Medical Doctor for Disability Benefits Claim**

To the best of my knowledge, the claimant is totally disabled (unable to work)
From_____20_____ to _____20_____ inclusive.
If still disabled give approximate date patient should be able to return to work, _____20_____.

Name (printed)_____

Signature _____ Date_____

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