Reset Form Print Form

CLAIM #: _____

AUTOMOBILE ACCIDENT BENEFITS PROOF OF CLAIM FORM

PERSONAL INFORMATION:

Last Name: _____ First Name: _____ Middle: _____

Address: _____Postal Code: _____

Home Phone #:_____Work Phone #:_____Cellular Phone #: _____

E-mail Address: _____

Date of Birth: _____ Sex: _____ Provincial Health Care #:_____

Drivers License #:_____S.I.N. #:_____

ACCIDENT DETAILS*:*

Motor Vehicle Accident Date:_____ Time of day:_____

Details of the accident:

_____

Were you the driver, a passenger, or a pedestrian in this accident?_____

Year, make, model of vehicle you were in:_____

Vehicle owner's name and address:_____

If occupant in the vehicle, were you wearing a seatbelt: _____ If yes, Lap & Shoulder belt_☐_ Lap belt _☐_

If a passenger, your position:_☐_front right_☐_front middle_☐_rear left_☐_rear middle_☐_rear right_☐_

Did you hit any part of your body within the vehicle during the accident?_____

If yes, describe:_____

Were you in the course of employment at the time of the accident?_____

INJURY DETAILS:

Describe injuries sustained in the accident:

_____

Were you taken to the hospital?_____ - If Yes-specify hospital_____

By ambulance? _____

What Medical Doctor are you now seeing?_____Phone #:_____

Doctor's Office Address:_____

Is this your regular doctor?_____ If no, who is your regular Doctor:_____

CLAIM #: _____

Has any treatment been prescribed? ☐ - If yes, give details: _____

Are you a student? ☐ Full-time ☐ Part-time ☐, Institution: _____

Place of employment: _____ Duration with employer: ☐ Years ☐ Months

Employer Address: _____

Occupation and duties of your job: _____

Number of hours worked per week?: ____ Hourly wage: _____ Salary: _____ Weekly: _____ Monthly: _____

What days do you usually work?(check all that apply): ☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

Since the accident, have your job duties been affected? ☐ – if yes, how?

If employed, did you stop working due to this accident? ☐

Date last worked: ☐

What date did you return to work, or when do you expect to return? ☐

If not currently employed, list prior employers over the past 12 months:

Employer: _____ Employer: _____

Address: _____ Address: _____

Phone #: ☐ Phone #: ☐

Period Employed: ☐ to ☐ Period Employed: ☐ to ☐

***If you are claiming wage loss and if you are self employed, on commission, or a casual worker, submit copies of your personal income tax records and a copy of your Revenue Canada Assessment Notice for the prior year, including T4 slips, or Employers Verification of employment and earnings.**

OTHER INSURANCE DETAILS:

Do you have any coverage for sick leave or disability benefits through your employer or a private health plan? ☐ - If yes, Insurance Company: _____

Amount $: ☐ Per week ☐ Per month ☐

Do you have any medical expense coverage through your employer, school, or a private health plan? ☐

Does your spouse (or parents if you are a dependent) have a medical benefit plan that covers you? ☐

CLAIM #: _____

Provide details of medical benefits-treatments covered, limits and deductibles (attach copy of benefits booklet)

Name of Insurance Company: _____

Group Plan Number: _____

Membership Id Number or Certificate Number: _____

Have you been injured in a previous motor vehicle accident, work-related accident, sports-related accident, household accident, or any other incident resulting in injury? - If yes, provide details and dates:

Are you receiving any benefits (wage loss and/or medical expenses) from a previous illness or injury?

If yes, provide insurance company name and file number

CLAIMANT SIGNATURE: _____

DATE:

Reset Form

Print Form