Return this form to:

Catastrophic Impairment Determination and Request for Assessment (OCF-20)

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

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

Parts 1 through 3 must be completed by the insurance company.

Part 1 Applicant Information

Last Name		First Name and Initial	
Address		City	Province
Postal Code	Home Telephone (Area Code)	Date of Accident (year month day)	

Part 2 Insurance Company Information

Name of Insurance Company	Name of Insurance Company Representative	Title
Address		
City	Province	Postal Code
Work Telephone (Area Code)	FAX Number (Area Code)	

Part 3 Catastrophic Impairment Determination

☐ additional sheets attached

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: (Go to Part 4)

☐ We require you to be assessed by a Designated Assessment Centre to determine whether you have sustained a catastrophic impairment as a result of the accident.

Signature of Insurance Company Representative

Date (year month day)

Part 4 Applicant Rights

If the insurer determines that you have not sustained a catastrophic impairment and you disagree, you have the right to ask for an assessment by a Designated Assessment Centre to determine whether you have sustained a catastrophic impairment. If you ask for an assessment, or if the insurance company requires you to be assessed, the Designated Assessment Centre needs your permission to obtain and discuss your medical history and to release its report. Please sign Part 5 of this form and return the form to the insurance company at the address above.

Part 5 Applicant's Request and Signature

I disagree with the insurer's determination that I have not sustained a catastrophic impairment as described above. I request an assessment at a Designated Assessment Centre to determine whether I have sustained a catastrophic impairment.

I authorize my insurance company and treating health professionals to give the Designated Assessment Centre any information relating to my health condition, treatment and rehabilitation received as a result of the automobile accident, for the purpose of determining my eligibility for benefits.

I authorize the Designated Assessment Centre to consult with my treating health professionals if necessary.

I also authorize the Designated Assessment Centre to give my insurance company and treating health professionals a copy of its report.

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)