Ontario

Financial Services Commission of Ontario
5160 Yonge Street,
Box 85
Toronto ON M2N 6L9

Motor Vehicle Accident Claims Fund
Application For Statutory Accident Benefits
Form 3
Under section 6 of the Motor Vehicle Accident Claims Act

This application form must be completed, signed and delivered to the Motor Vehicle Accident Claims Fund (the "Fund") together with your Application for Accident Benefits Package (including OCF 1). Failure to complete this form will delay or jeopardize your right to apply to the Minister of Finance for payment out of the Fund.

Claimant	and his/her claimant's solicitor/agent/SABS representative

Hereby certify:

1. Date of the accident: _____

2. The claimant was:
   - ☐ a pedestrian; or
   - ☐ occupant of an insured vehicle; or
   - ☐ occupant of an uninsured vehicle; or
   - ☐ a cyclist;

3. the claimant has investigated and determined that the following vehicles were involved in the accident:

a) vehicle which struck me

plate number _____ make _____
owner name _____ insurer name _____
driver name _____ policy no. _____
expiry/cancellation _____

b) vehicle in which I was an occupant

plate number _____ make _____
owner name _____ insurer name _____
driver name _____ policy no. _____
expiry/cancellation _____

c) vehicle(s) involved in accident other than above **(attach a separate sheet if required);**

plate number _____ make _____
owner name _____ insurer name _____
driver name _____ policy no. _____
expiry/cancellation _____

4. ☐ a copy of the police report is attached;

5. on the date of the accident the claimant
   - ☐ did reside in Ontario; or
   - ☐ did reside outside Ontario in ; _____ (jurisdiction)

6. the claimant has investigated and determined that he/she does NOT have access to a motor vehicle liability policy
   - ☐ in his/her name; or
   - ☐ as a listed driver; or
   - ☐ as a spouse or former spouse; or
   - ☐ as a dependant; or
   - ☐ as someone who had access to a business or employer's vehicle;

7. the claimant has investigated and determined that the vehicle which he/she occupied or which struck him/her was

leased from _____, and was insured by _____
under policy number _____ from _____ to _____.

8. a claim has been made against _____ (name of insurance company),

under policy number

BUT the claim has been denied for these reasons: _____ (Attach a copy of the Insurer's Assessment Form)

9. the first application for accident benefits was submitted to _____ (Name of Insurer)

,on _____; (date)

10. subsequent applications were submitted to _____ (Name of Insurer)

,on _____; (date)

11. ☐ a completed* Application for Accident Benefits Package is attached;

12. ☐ the Notice of Collection of Personal Information – Applicants for Statutory Accident Benefits form is signed and attached;

13. ☐ my SABS Representative (if applicable) has completed the necessary filing requirements of the Financial Services Commission of Ontario;

14. ☐ **that I/we acknowledge it as an offence to make a false or misleading statement or representation.**

_____ Claimant's Signature

_____ Solicitor / Agent / SABS Representative

_____ date

_____ date

***Completed means all form parts filled out and signed by Claimant, Employers and Health Practitioners**

Print Reset Save