

Notice to Applicant of Dispute Between Insurers

Name of Applicant

Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/>	Last Name	First Name
Street Address		
City	Province	Postal code
Date of Accident	Day /	Month / Year

This notice is to inform you that the insurer to whom you have applied for accident benefits claims that another insurer is responsible for paying these benefits. You may be required to assist the insurers in resolving their dispute by providing them with any information that may be needed to determine which insurer should be paying your accident benefits claim.

You will continue to receive accident benefits that you are entitled to from the insurer that you applied to while the insurers attempt to resolve their dispute.

You also have the right to object to your claim being transferred to another insurer. If you wish to object please complete Part 5 of this form and send it within 14 days to the insurer that is currently paying you accident benefits. If you object, you are entitled to participate in any proceeding that may take place to determine which insurer is responsible for paying accident benefits to you. If you do not object, you will not be permitted to dispute the transfer of your claim to another insurer.

If you have any questions about this notice, or about the process that insurers use to determine who is responsible for paying your claim, please contact the representative of the insurance company that is paying your accident benefits claim. The name and telephone number of the representative is listed in Part 1.

**Part 1:
Insurer
that You
Applied to
for Accident
Benefits**

Company Name		
Mailing Address		
City	Province	Postal code
Contact Person/Representative	Phone No: ()	

**Part 2:
Insurer(s)
Notified to
Pay Benefits
(by Insurer
Listed in
Part 1)**

First Company Name		
Mailing Address		
City	Province	Postal code
Contact Person/Representative	Phone No: ()	
Attach additional sheets if necessary. <input type="checkbox"/> Additional sheets attached.		

Second Company Name		
Mailing Address		
City	Province	Postal code
Contact Person/Representative	Phone No: ()	
Attach additional sheets if necessary. <input type="checkbox"/> Additional sheets attached.		

**Part 3:
Reasons**
(Why Notice
is Given to
Other
Insurers)

Details

Attach additional sheets if necessary. Additional sheets attached.

**Part 4:
Signature of
Insurer
Representative**

Name

Date

Signature

**Part 5:
Objection to
Transfer of
Claim
(optional)**

You can object to your claim being transferred to the insurer(s) referred to in Part 2 by completing this section and returning the form to the insurer that you applied to in Part 1 within 14 days.

If you object, you are entitled to participate in any proceeding that may take place to determine which insurer is responsible for paying accident benefits to you. If you do not object, you will not be permitted to dispute the transfer of your claim to another insurer.

Please check the box below and return this form to the insurer listed in Part 1 within 14, days only if you wish to object to your claim being transferred to another insurance company.

I Object to the claim being transferred.

Name

Date

Signature