



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

Dispute
Resolution
Services

Response by Insurer to an Application for Arbitration Form E

Arbitration file number

An **Application for Arbitration** has been filed with the Dispute Resolution Services of the Financial Services Commission of Ontario (the "Commission"). A copy of the **Application for Arbitration** is attached. Your company **is named as** a party in this arbitration.

Use this form to respond to the issues raised in the Application. You can add new issues which have been mediated but not settled. You must complete **all** sections of the **Response**, serve a copy on the Applicant and provide proof of service to the Commission within **20** days of receiving this document.

Section 1

APPLICANT

Date of the motor vehicle accident?(yyyy/mm/dd)					
<input type="checkbox"/> Mr.	Last name		First name		Middle name
<input type="checkbox"/> Mrs.					
<input type="checkbox"/> Ms.					

INSURANCE COMPANY

Company name					
Contact person					
<input type="checkbox"/> Mr.	Last name		First name		
<input type="checkbox"/> Mrs.					
<input type="checkbox"/> Ms.					
Street address					Apt./Unit
City	Province/State	Postal Code/Zip	Country		
Phone number	Ext.	Fax number	Email address (required)		
()		()			
Insurer's claim number		Policyholder name		Policy number	

Section 1-continued

LEGAL REPRESENTATIVE

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Last name	First name	File reference number
Title		Firm name	
Street address			Apt./Unit
City	Province/State	Postal Code/Zip	Country
Phone number ())	Ext.	Fax number ())	Email address (required)
The representative is:			
<input type="checkbox"/> Lawyer	Law Society licence number	_____	
<input type="checkbox"/> Licensed paralegal	Law Society licence number	_____	
<input type="checkbox"/> Not required to be licensed			
Specify the type of exemption from the list of exemptions recognized in the Law Society's by-laws _____			

TYPE OF HEARING

1. Does the insurer want an oral hearing? <input type="checkbox"/> No <input type="checkbox"/> Yes
2. Does the insurer require special service such as audio visual equipment? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, describe? ►
3. Will the insurer be arranging for the services of a Court Reporter? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, describe? ►

Section 2 ISSUES IN DISPUTE

Check the benefits that were not resolved in mediation and which the insurer now wants to respond to or now wants arbitrated. The insurer may add new issues which have been mediated at FSCO but not settled. For each benefit disputed, briefly explain the insurer's position. (Attach OCF-9 and extra sheets if necessary.)

WEEKLY BENEFITS

Which weekly benefit are you disputing? <input type="checkbox"/> income replacement <input type="checkbox"/> non-earner What is being disputed? <input type="checkbox"/> initial entitlement to benefits <input type="checkbox"/> amount of weekly benefits <input type="checkbox"/> other, specify ▼	Date (yyyy/mm/dd) Date of insurer's refusal to pay: _____ Reason for refusal: _____
If the insurer paid weekly benefits, state weekly amount and duration of payments. \$ _____	
From: _____ To: _____	

Section 2 –continued

For each benefit checked, briefly explain the insurer’s position on the issues in dispute. *(Attach OCF-9 and extra sheets if necessary.)* ▼

<input type="checkbox"/> CAREGIVER BENEFITS	
Amount in dispute? \$	Date (yyyy/mm/dd) Date of insurer’s refusal to pay:
What is being disputed? <input type="checkbox"/> initial entitlement to benefits <input type="checkbox"/> amount of weekly benefits <input type="checkbox"/> other, specify ▼	Reason for refusal:

<input type="checkbox"/> MEDICAL BENEFITS	
Amount in dispute? \$	Date (yyyy/mm/dd) Date of insurer’s refusal to pay:
	Reason for refusal:

<input type="checkbox"/> MEDICAL BENEFITS	
Amount in dispute? \$	Date (yyyy/mm/dd) Date of insurer’s refusal to pay:
	Reason for refusal:
Extra sheets attached <input type="checkbox"/>	

<input type="checkbox"/> REHABILITATION BENEFITS	
Amount in dispute? \$	Date (yyyy/mm/dd) Date of insurer’s refusal to pay:
	Reason for refusal:

<input type="checkbox"/> REHABILITATION BENEFITS	
Amount in dispute? \$	Date (yyyy/mm/dd) Date of insurer’s refusal to pay:
	Reason for refusal:
Extra sheets attached <input type="checkbox"/>	

<input type="checkbox"/> ATTENDANT CARE BENEFITS	
Amount in dispute? \$	Date (yyyy/mm/dd) Date of insurer’s refusal to pay:
	Reason for refusal:

<input type="checkbox"/> CASE MANAGER SERVICES BENEFITS	
Amount in dispute? \$	Reason for refusal:

Section 2 –continued

For each benefit checked, briefly explain the insurer's position on the issues in dispute. *(Attach OCF-9 and extra sheets if necessary.)* ▼

<input type="checkbox"/> OTHER EXPENSES	
What is being disputed? <input type="checkbox"/> lost educational expenses <input type="checkbox"/> damage to clothing, glasses, etc <input type="checkbox"/> expenses of visitors <input type="checkbox"/> housekeeping and home maintenance Total amount in dispute? \$	
<input type="checkbox"/> cost of examinations \$	

<input type="checkbox"/> DEATH BENEFITS	
Amount in dispute? \$	

<input type="checkbox"/> FUNERAL EXPENSES	
Amount in dispute? \$	

<input type="checkbox"/> OTHER DISPUTES	
Amount in dispute? \$	

<input type="checkbox"/> CLAIM FOR REPAYMENT	
Amount in dispute? \$	Particulars:

<input type="checkbox"/> INTEREST	
[Empty space for interest details]	

<input type="checkbox"/> EXPENSES OF THE HEARING	
[Empty space for hearing expenses details]	

<input type="checkbox"/> ABUSE OF PROCESS, FRIVOLOUS OR VEXATIOUS PROCEEDINGS	
[Empty space for abuse of process details]	

<input type="checkbox"/> RESPONSE TO SPECIAL AWARD CLAIM	
[Empty space for response to special award claim details]	

SECTION 3 DOCUMENT LIST This section MUST be completed

(Attach OCF-9 and extra sheets)

It is expected that the Applicant and the Insurer have exchanged key documents prior to the filing of an Application for Arbitration.

Documents -1. List key documents in your possession to which you will refer in the arbitration.
Identify the type of document (letter, medical report, tax return), the name of the writer or issuing institution and the date of the document.

Extra sheets attached

Documents -2 List key documents not currently in the insurer's possession, which you intend to get from other sources (such as employment records, Ontario Health Insurance records, Revenue Canada Agency records) for use in the arbitration. The insurer should also include any documents requested from the Applicant (such as financial or employment records) which have not yet been provided. *Wherever possible, identify the type of document (letter, medical report, tax return), the name of the writer or issuing institution and date of the document.*

Extra sheets attached

Personal information requested on this form is collected under the authority of the Insurance Act, R.S.O. 1990, c.1.8 as amended. This information, including documents submitted with this application, will be used in the dispute resolution process for accident benefits.

Signature and Certification

I certify that all information in this Response and attachments is true and complete. I realize that copies of all information filed with this Response will be given to the other party in this dispute.

Name	Title	Signature	Date (yyyy/mm/dd)
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Send the **original and one copy** of the **completed** application to Arbitration Services at the address noted below. Keep an additional copy of the completed application for yourself.

**Arbitration Services
Dispute Resolution Services
Financial Services Commission of Ontario
5160 Yonge Street, 14th Floor, Box 85
Toronto, ON M2N 6L9**

If you have any questions about this application, or want more information, contact:

Arbitration Inquiries In Toronto at: 416-590-7202 or Toll Free: 1-800-517-2332, ext. 7202 Fax: 416-590-8462

FSCO website: www.fSCO.gov.on.ca