



FORM 3

THE MOTOR VEHICLE ACCIDENT CLAIMS FUND APPLICATION FOR STATUTORY ACCIDENT BENEFITS (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.

The claimant _____, and his/her solicitor/agent/SABS representative _____, hereby certify:

- 1. the date of the accident is _____;
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 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.