Return this form to:

Notice of Stoppage of Weekly Benefits and Request for Assessment (OCF-17)

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

Address

City | Province | Postal Code

Telephone Number (Area Code) | FAX Number (Area Code)

Signature of Insurance Company Representative | Date (year month day)

Part 3 Reason(s) for Benefit Stoppage

☐ additional sheets attached

The following benefit will be stopped:

☐ **income replacement**
☐ **non-earner**
☐ **caregiver**

Effective Date (year month day)

Explanation:

Part 4 Applicant's Rights

YOUR RIGHT TO DISPUTE THE INSURER'S ASSESSMENT OF YOUR CLAIM FOR STATUTORY ACCIDENT BENEFITS

Your claim for statutory accident benefits under the Insurance Act has been reduced or denied by your insurer.

Under the Insurance Act, you have a right to dispute your insurer's assessment of your claim for statutory accident benefits.

STEP 1: NOTIFY YOUR INSURER AND BE AVAILABLE FOR EXAMINATIONS/ASSESSMENTS
You CANNOT dispute your insurer's assessment of your claim for statutory accident benefits, UNLESS:

(i) You notify your insurer and submit an application for the benefit;

(ii) You are available for any required examination;

(iii) You are available for any required assessment.

Part 4 Applicant's Rights

STEP 2: MEDIATION
To dispute the refusal or reduction you must first mediate your claim through the Financial Services Commission of Ontario (FSCO) within two years of your insurer's refusal to pay, or reduction of, a benefit.

To begin the mediation process, you must complete an application for mediation. The application for mediation is provided to you by your insurance company, or can be obtained from the FSCO's web site at: www.fsco.gov.on.ca or by contacting FSCO at:

Dispute Resolution Services
Mediation - Financial Services Commission of Ontario
Box 85, 14th Floor
North York, Ontario
M2N 6L9

By phone in Toronto: (416) 590-7576
Toll Free: 1-800-517-2332 ext. 7210
Fax: (416) 590-7077
Mediation Hotline: (416) 590-7210

Once you submit a completed application for mediation, FSCO will appoint a mediator to conduct the mediation. At the end of the mediation, the mediator will issue a written report of mediation indicating whether or not the mediation failed to resolve issues between you and your insurer.

STEP 3: ARBITRATION, LAWSUIT OR EVALUATION
If mediation fails, you have the right to:

(i) arbitrate at FSCO or

(ii) commence a lawsuit in court or

(iii) if you and your insurer both agree, you may request a neutral evaluation at FSCO before proceeding to arbitrate or commence a lawsuit in court. If you and your insurer proceed to a neutral evaluation, the neutral evaluator will provide an oral opinion on the likely outcome of a proceeding in court or an arbitration and a written report identifying issues evaluated and still in dispute.

However, you CANNOT arbitrate, commence a lawsuit or request a neutral evaluation UNLESS:

(i) you proceeded with mediation, AND

(ii) the mediation failed.

WARNING: TWO YEAR TIME LIMIT
You have TWO YEARS from the date of your insurer's refusal to pay, or reduction of a benefit, to arbitrate or commence a lawsuit in court. You may have longer than two years if the arbitration or lawsuit is commenced 90 days from the date the mediator provides his or her mediation report, or within 30 days from the date the neutral evaluator provides his or her report.

The rest of this form must be completed by the applicant and returned to the insurance company if the applicant disagrees with the stoppage of benefits.

Part 5 Applicant Request and Signature

I disagree with the stoppage of benefits as described. I request an assessment at a Designated Assessment Centre to determine whether I continue to have a disability that entitles me to receive the benefits. I understand that in order for the insurance company to comply with my request to be assessed, 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 understand that this information will be used to determine my eligibility for benefits.
I also authorize the Designated Assessment Centre to give my insurance company and treating health professionals a copy of its report.

Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)