Return this form to:

Voluntary Consent for Pre-Claim Examination (OCF-26)

Use this form for accidents on or after November 1, 1996.

Claim Number:	
Policy Number:	
Date of Accident: (YYYYMMDD)	

To assist you following your accident, we are seeking your consent to be examined by one or more health care professionals. This examination is voluntary and will only apply if you have not completed an application for accident benefits and are in hospital or have been discharged recently.

The examination is to assist in determining your entitlement to attendant care, assistive devices, or home modifications and devices that you may need as a result of the accident.

Part 1 Claimant Information

Date of Birth (YYYYMMDD)	Age	Gender ☐ Male ☐ Female	Telephone Number Extension
Last Name	First Name	Middle Name	
Address			
City	Province	Postal Code	
Special Needs (if applicable) ☐ Mobility ☐ Interpreter (Type:) ☐ Other (specify)			
Representative (if applicable)	Address		
City	Province	Postal Code	
Telephone Number Extension	Fax Number	Email	

Part 2 Health Care Professionals Conducting the Examination

Name	Profession or Designation	Speciality
Facility Name		
Address		
City	Province	Postal Code
Contact's Last Name	Contact's First Name	
Telephone Number Extension	Fax Number	Email

Part 3 Date and Location of Examination

Date and time of examination:
Location of examination ☐ applicant's home
☐ hospital:
☐ other:

Part 4 Consent

I authorize my insurer or health professional appointed by my insurer to conduct this pre-claim examination, to collect and use personal information and health information related to accessing accident benefits for attendant care, assistive devices or home modifications.

I understand that my consent to this examination is voluntary. Refusing to consent to this pre-claim examination will not affect my right to apply for or receive accident benefits. This examination can only be used to assist me in accessing benefits and cannot be relied upon to determine that I am not entitled to an accident benefit.

I consent to this pre-claim examination in the manner described above.

Applicant or Substitute Decision Maker	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)

The health care professional(s) that conduct the examination will provide you with a copy of the examination report within 5 business days after conducting the examination.

If you have questions or concerns about the examination please contact the adjuster listed below.

Part 5 Insurance Company Information

Adjuster's Name			
Telephone Number	Extension	Fax Number	Email