Insurer Identification (Name and Address)	**Ontario Automobile Insurance Application for Accident Benefits**	
	Insurer No.	Claim No.
Name of Policy Holder		Policy No. Claiming Under

Instructions

- This form is to be completed by or on behalf of any person injured and claiming statutory accident benefits as a result of an automobile accident.
- This form must be sent to the insurance company you are claiming against.
- Be sure to include the name of the person whose policy you are claiming under and their policy number, particularly if it is not your own policy.
- In answering the questions about your employment, be sure to include both your income for the last four weeks and for the last 52 weeks, since your entitlement is based on the better of each of these.

1 Identity of Claimant – To be completed by person injured in automobile accident

☐ Mr. ☐ Mrs. ☐ Ms. Last name	First name Mid. Init.	Date of Birth Year Month Day

Street Address P.O. Box or Rural Route Apt.

City, Town, Village	Province or State	Country	Postal / Zip Code

Area Code - Home Telephone No.	Area Code - Work Telephone No.	Language Preferred ☐ English ☐ French ☐ Other (specify)

What is the best way to reach you?			Between the hours of:	Days Available
☐ by telephone ☐ by personal visit ☐ other (specify):	☐ at home ☐ at work ☐ other place (specify):		a.m. p.m. and a.m. p.m.	

2 Claimant's Representative

To be completed only if the applicant is deceased, a minor or unable to file an application on his or her own or has retained a representative

Representing the Claimant as
☐ Parent ☐ Guardian ☐ Lawyer ☐ Executor, Administrator or Trustee ☐ Other – specify:

☐ Mr. ☐ Mrs. ☐ Ms. Last name	First name Mid. Init.	Area Code – Work Telephone No.
Name of Firm/Organization		Area Code - Fax no.
Street Address P.O. Box or Rural Route		Representative's File Reference

City, Town, Village	Province or State	Country	Postal / Zip Code

3 Details of Accident

Date of Accident Year Month Day	Time of Accident ☐ A.M. ☐ P.M.	The Claimant was ☐ A Driver ☐ A Passenger ☐ Other Specify

To your knowledge did a Police Officer investigate accident? ☐ Yes ☐ No

If yes, Name of Police Force Detachment or Division Officer Name Badge No.

Did the accident occur while you were in the course of your employment? ☐ Yes ☐ No

Was a claim filed with the Workers' Compensation Board or an agency outside Ontario responsible for compensating victims of work related accidents? ☐ Yes ☐ No

Precise Location of Accident – Highway No., name of Street/Road Near the intersection of

City, Town, Village	Province or State	Country

Brief Description of Accident

4 Insurance Details or Automobile Information

Were you insured under any automobile insurance policy on the date of the accident?
☐ **Yes (Complete the next two lines below then go to Section 5)**

Automobile	Licence Plate no.	Insurer	Policy No.
1			
2			

☐ **No - Complete vehicle Information below**

You were: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other (Specify):

You are claiming against:
☐ your own policy (see above)
☐ the vehicle in which you were a passenger (fill in below) ☐ another vehicle (fill in below)
☐ the vehicle that hit you (fill in below) ☐ an unidentified or uninsured vehicle

☐ Mr. ☐ Mrs. ☐ Ms. Automobile Owner - Last name	First name	Middle Initial	Area Code – Home Telephone No.
Street Address P.O. Box or Rural Route		Apt.	Area Code - Work Telephone No.

City, Town, Village	Province or State	Country	Postal / Zip Code
Insurer		Policy Number	

Automobile Description - Make	Model	Model Year	Licence Plate No.	Province/State

Automobile Type
☐ Passenger Automobile ☐ Motorcycle ☐ Motorized Snow Vehicle ☐ Off Road Vehicle ☐ Truck ☐ Taxi or Limousine ☐ Bus ☐ Other (Specify)

Did you report this accident to any other insurer?
☐ Yes ☐ No If Yes, give details

5 Claimant's Medical Condition as a Result of Accident

Did you receive medical attention following the accident? ☐ Yes ☐ No

If Yes, Facility where you were treated

Street Address

City, Town, Village	Province or State	Country	Postal / Zip Code
Treating Physician – Last Name		First Name	

Street Address, P.O. Box or Rural Route

City, Town, Village Province or State Country Postal / Zip Code

Nature and Extent of Injuries Sustained as a Result of Accident

If you were Employed at Time of Accident – Do injuries sustained prevent you from performing the essential tasks of your employment? Explain

If you were Not Employed at Time of Accident – Do you suffer a substantial inability to perform the essential task in which you would normally engage? Explain

Were you unable to continue your work/studies/ normal activities as a result of the accident? ☐ Yes ☐ No	If yes, from what date? Year Month Day	Have you returned to work/studies/ normal activities? ☐ Yes ☐ No	If yes, state when Year Month Day	If Claimant died as a result of accident	Time of Death Year Month Day Hour ☐ A.M. ☐ P.M.

6 Claimant's Employment

At the time of the accident you were:
☐ Employed ☐ On a Temporary Lay-Off ☐ Unemployed ☐ Full-Time Student
☐ Self-Employed ☐ Was Entitled to Start Work within 1 Year ☐ Unpaid Homemaker ☐ Retired

If unemployed, have you worked 180 days out of the last 12 months?
If Yes, complete the employment section

Most Recent Employer

Name or Business Name	Contact Person	Area Code – Work Telephone No.
Street Address, P.O. Box or Rural Route		Area Code – Fax Number

City, Town, Village	Province or State	Country	Postal / Zip Code

Type of Employment: ☐ Full-Time ☐ Part-Time ☐ Casual ☐ Seasonal ☐ Self-Employed ☐ Other (specify)

Occupation

Brief Job Description (Essential Tasks)

Description of Physical Tasks

Income from Employment How are you paid? ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other (specify)

	Gross Weekly Income Last 4 Weeks Preceding Accident				Gross Income for 52 Weeks Preceding Accident	
	Week 1	Week 2	Weeks 3	Week 4	No. of Weeks Worked	Gross Income
Salary						
Tips, Commissions						
Other Monetary Compensation						
Total						

Other Employer (if any)

Name or Business Name	Contact Person	Area Code – Work Telephone No.
Street Address P.O. Box or Rural Route		Area Code – Fax Number

City, Town, Village	Province or State	Country	Postal / Zip Code

Type of Employment: ☐ Full-Time ☐ Part-Time ☐ Casual ☐ Seasonal ☐ Self-Employed ☐ Other (specify)

Occupation

Brief Job Description (Essential Tasks)

Description of Physical Tasks

Income from Employment How are you paid? ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other (specify)

	Gross Weekly Income Last 4 Weeks Preceding Accident				Gross Income for 52 Weeks Preceding Accident	
	Week 1	Week 2	Weeks 3	Week 4	No. of Weeks Worked	Gross Income
Salary						
Tips, Commissions						
Other Monetary Compensation						
Total						

Are you insured under any other sick leave plan or income continuation benefit plan?
☐ Yes ☐ No If yes, please explain:

7 Declaration

An application for accident benefits must be signed by the claimant or the claimant's representative where the claimant is a minor or is unable to sign.
I certify in good faith that the information provided is true.

Signature of Claimant or Representative	Name of Person Signing (Please Print)	Date