Thomson, Rogers in collaboration with the Toronto ABI Network

Back-to-School II

Four Seasons Hotel Toronto | Thursday, September 30, 2010

Tips on Completing the New Accident Benefits Forms

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Barristers and Solicitors

“SABs claims have become a field of game playing and rule manipulation.”

Lee Samis
Principal,
Samis & Company

Canadian Underwriters Magazine – August 2010

Why is that?

How did we get to this point?

(b) shall reimburse the Insurer, upon demand, in the amount which the Insurer has paid by reason of the provisions of any statute relating to automobile insurance and which the Insurer would not otherwise be liable to pay under this policy.

SECTION B — ACCIDENT BENEFITS

The Insurer agrees to pay to or with respect to each insured person as defined in this section who sustains bodily injury or death by an accident arising out of the use or operation of an automobile:

SUBSECTION 1 — MEDICAL, REHABILITATION AND FUNERAL EXPENSES

(1) All reasonable expenses incurred within four years from the date of the accident as a result of such injury for necessary medical, surgical, dental, chiropractic, hospital, professional nursing and ambulance service and for any other service within the meaning of insured services under **The Health Insurance Act** and for such other services and supplies which are, in the opinion of the physician of the insured person's choice and that of the insurer's medical advisor, essential for the treatment, occupational retraining or rehabilitation of said person, to the limit of $25,000 per person.
(2) Funeral expenses incurred up to the amount of $1,000 in respect of the death of any one person.

The Insurer shall not be liable under this subsection for those portions of such expenses payable or recoverable under any medical, surgical, dental, or hospitalization plan or law or, except for similar insurance provided under another automobile insurance contract, under any other insurance contract or certificate issued to or for the benefit of, any insured person.

SUBSECTION 2 — DEATH BENEFITS AND LOSS OF INCOME PAYMENTS

Part I — Death Benefits

A. Subject to the provisions of this Part, for death that ensues within 180 days of the accident or within 104 weeks of the accident if there has been continuous disability during that period, a payment — based on the status at the date of the accident of the deceased in a household where a spouse or dependants survive — of the following amounts:

Head of the Household	$10,000
Spouse of the Head of the Household	10,000
Dependant within the meaning of sub-subparagraph (b) of subparagraph 3 of paragraph B	2,000

In addition, with respect to death of the head of the household, where there are two or more survivors — spouse or dependants — the principal sum payable is increased $1,000 for each survivor other than the first.

B. For the purposes of this Part,

(1) "Spouse of the head of the household" means the spouse with the lesser income from employment in the twelve months preceding the date of the accident.
(2) "Spouse" means either of a man and woman who,
  (a) are married to each other;
  (b) are married to each other by a marriage that is voidable and has not been voided by a judgment of nullity; or
  (c) have gone through a form of marriage with each other, in good faith, that is void and are cohabiting or have cohabited within the preceding year,

  and includes,
  (d) either of a man and woman not being married to each other who have cohabited,
    (i) continuously for a period of not less than five years, or
    (ii) in a relationship of some permanence where there is a child born of whom they are the natural parents,

    and have so cohabited within the preceding year.
(3) "Dependant" means,
  (a) the spouse of the head of the household who resides with the head of the household;
  (b) a person,
    (i) under the age of 18 years who resides with and is principally dependent upon the head of the household or the spouse of the head of the household for financial support,
    (ii) 18 years of age or over who, because of mental or physical infirmity, is principally dependent upon the head of the household or the spouse of the head of the household for financial support, or
    (iii) 18 years of age or over who, because of full-time attendance at a school, college or university is principally dependent upon the head of the household or the spouse of the head of the household for financial support, or

  (c) a parent or relative,
    (i) of the head of the household,
    or
    (ii) of the spouse of the head of the household,

    residing in the same dwelling premises and principally dependent upon the head of the household or the spouse of the head of the household for financial support.
(4) The total amount payable shall be paid to a person who is the head of the household or the spouse of the head of the household, as the case may be, if that person survives the deceased by at least 30 days.
(5) The total amount payable with respect to death where no head of the household or spouse survives the deceased by at least 30 days shall be divided equally among the surviving dependants.
(6) No amount is payable on death, other than incurred funeral expenses, if no head of the household or dependant survives the deceased by at least 30 days.

Part II — Loss of Income

Subject to the provisions of this Part, a weekly payment for the loss of income from employment for the period during which the insured person suffers substantial inability to perform the essential duties of his occupation or employment, provided,

  (a) such person was employed at the date of the accident;
  (b) within 30 days from the date of the accident the insured person suffers substantial inability to perform the essential duties of his occupation or employment;
  (c) no payments shall be made for any period in excess of 104 weeks except that if, at the end of the 104 week period, it has been established that such injury continuously prevents such person from engaging in any occupation or employment for which he is reasonably suited by education, training or experience, the Insurer agrees to make such weekly payments for the duration of such inability to perform the essential duties.

Amount of Weekly Payment — The amount of a weekly payment shall be the lesser of,

  (a) $140 per week; or
  (b) 80 percent of the insured person's gross weekly income from employment, less any payments for loss of income from employment received by or available to such person under,
    (i) the laws of any jurisdiction,
    (ii) wage or salary continuation plans available to the person by reason of his employment, and
    (iii) Part III of this Subsection 2,

    but no deduction shall be made for any increase in such payment due to a cost of living adjustment subsequent to the insured person's substantial inability to perform the essential duties of his occupation or employment or for the first two weeks of such substantial inability.

For the purposes of this Part,

(1) there shall be deducted from an insured person's gross weekly income any payments received by or available to him from part-time or other employment or occupation subsequent to the date of the accident;
(2) a principal unpaid housekeeper residing in the household not otherwise engaged in occupation or employment for wages or profit, if injured, shall be deemed disabled only if completely incapacitated and unable to perform any of his or her household duties and, while so incapacitated, shall receive a benefit at the rate of $70 per week for not more than 12 weeks;
(3) a person shall be deemed to be employed,
  (a) if actively engaged in an occupation or employment for wages or profit at the date of the accident; or
  (b) if 18 years of age or over and under the age of 65 years, so engaged for any six months out of the preceding 12 months;
(4) a person receiving a weekly payment who, within 30 days of resuming his occupation or employment is unable to continue such occupation or employment as a result of such injury, is not precluded from receiving further weekly payments;
(5) except for the first two weeks of disability, where the payments for loss of income payable hereunder, together with payments for loss of income under another contract of insurance other than a contract of insurance relating to any wage or salary continuation plan available to an insured person by reason of his employment, exceed the actual loss of income of the insured person, the Insurer is liable only for that proportion of the payments for loss of income stated in this policy that the actual loss of income of the person insured bears to the aggregate of the payments for loss of income payable under all such contracts.

4. Accidents Involving Unidentified Automobiles

Where an unidentified automobile has caused bodily injury or death to a person insured under the contract,

(a) the person insured under the contract, or someone on his behalf, shall report the accident within twenty-four hours, or as soon as practicable thereafter, to a police, peace or judicial officer or to an administrator of motor vehicle laws and shall file with the Insurer within thirty days, or as soon as practicable thereafter, a written statement that the person insured under the contract or his representative has a cause or causes of action arising out of such accident for damages against a person or persons whose identity cannot be ascertained and setting forth the facts in support thereof, and

(b) at the request of the Insurer, the person insured under the contract or his representative referred to in paragraph (a) shall make available for inspection the automobile of which the person insured under the contract was an occupant at the time of the accident.

5. Determination of Legal Liability and Amount of Damages

(1) The determination as to whether the person insured under the contract is legally entitled to recover damages and, if so entitled, the amount thereof shall be determined,

(a) by agreement between the person insured under the contract and the Insurer;

(b) at the request of the person insured under the contract, and with the consent of the Insurer, by arbitration by some person to be chosen by both parties, or if they cannot agree on one person, then by two persons, one to be chosen by the person insured under the contract and the other by the Insurer and a third person to be appointed by the persons so chosen; or

(c) by a court of competent jurisdiction in Ontario in an action brought against the Insurer by the person insured under the contract, and unless the determination has been previously made in a contested action by a court of competent jurisdiction in Ontario, the Insurer may include in its defence the determination of liability and the amount thereof.

(2) **The Arbitrations Act** applies to every arbitration under paragraph (b) of subclause (1) of this Clause.

6. Notice of Legal Action

(1) Where the person insured under the contract or his representative commences a legal action for damages against any other person owning or operating an automobile involved in the accident, a copy of the writ or summons or other proceeding shall be delivered or sent by registered mail immediately to the chief agency or head office of the Insurer in Ontario.

(2) Subject to Clause 3 of this Subsection 3, where the person insured under the contract or his representative obtains a judgment against the other person referred to in subclause (1) of this clause but is unable to recover, or to recover fully the amount of that judgment, the Insurer shall, on request, pay the amount of that judgment or, as the case may be, the difference between what he has recovered under that judgment and the amount of that judgment.

(3) Before making any payment under subclause (2) of this clause, the Insurer may require that the person insured under the contract or his representative assign his judgment, or the balance of his judgment, as the case may be, to the Insurer and the Insurer shall account to the person insured under the contract for any recovery it makes under that judgment for any amount in excess of what it has paid to that person and its costs.

7. Notice and Proof of Claim

(1) In respect of a claim for bodily injuries or death, the person insured under the contract or his representative, or the person otherwise entitled to make claim or his representative, shall,

(a) give written notice of claim to the Insurer by delivery thereof or by sending it by registered mail to the chief agency or head office of the Insurer in Ontario, within thirty days from the date of the accident or as soon as practicable thereafter;

(b) within ninety days from the date of the accident for which the claim is made, or as soon as practicable thereafter, furnish to the Insurer such proof of claim as is reasonably possible in the circumstances of the happening of the accident and the loss occasioned thereby;

(c) if so required by the Insurer, furnish a certificate as to the cause and nature of the accident for which the claim is made and as to the duration of the disability caused thereby from a medical practitioner legally qualified to practise;
and

(d) give details to the Insurer of any policies of insurance, other than policies of life insurance, to which such person may have recourse.

(2) In respect of a claim for damage to the insured automobile or its contents, or to both the insured automobile and its contents, the provisions of statutory condition 4 of subsection 2 of section 207 of **The Insurance Act** apply with necessary modifications to the insured automobile and to any contents with respect to which a claim is made.

8. Medical Reports

(1) The Insurer has the right and the claimant shall afford to the Insurer an opportunity to examine the person of the person insured under the contract when and as often as it reasonably requires while the claim is pending, and also, in the case of the death of the person insured under the contract, to make an autopsy subject to the law relating to autopsies.

(2) At the request of the claimant or his representative, the Insurer shall supply to the claimant or his representative, as the case may be, a copy of any medical or autopsy report obtained as a result of an examination or autopsy under subclause (1) of this clause.

9. When Moneys Payable

(1) No person shall bring an action to recover the amount of a claim provided for under the contract pursuant to subsection 1 of section 231 of **The Insurance Act** unless the requirements of this subsection 3 have been complied with.

(2) Every action or proceeding against the Insurer for the recovery of a claim shall be commenced within two years from the date on which the cause of action against the Insurer arose and not afterwards.

10. Limitation of Benefit Payable

Where a person is entitled to benefits under more than one contract providing insurance of the type set forth in subsection 1 of Section 231 of **The Insurance Act,** he or his representative or any person claiming through or under him or by virtue of **The Family Law Reform Act, 1978** may recover only an amount equal to one benefit.

11. Application of General Provisions

(1) In so far as applicable the general provisions, definitions, exclusions and statutory conditions of this policy also apply to payments under this subsection 3.

(2) Special Provisions, Definitions and Exclusions of Section B of this policy do not apply to the insurance provided by this subsection 3.

SPECIAL PROVISIONS, DEFINITIONS, AND EXCLUSIONS OF SECTION B

(1) "INSURED PERSON" DEFINED

In this section, the words "insured person" mean,

(a) any person while an occupant of the described automobile or of a newly acquired or temporary substitute automobile as defined in this policy;

(b) the insured and, if residing in the same dwelling premises as the insured, his or her spouse and any dependent relative of either while an occupant of any other automobile; provided that,

(i) the insured is an individual or are husband and wife;

(ii) such person is not engaged in the business of selling, repairing, maintaining, servicing, storing, or parking automobiles at the time of the accident;

(iii) such other automobile is not owned or regularly or frequently used by the insured or by any person or persons residing in the same dwelling premises as the insured;

(iv) such other automobile is not owned, hired, or leased by an employer of the insured or by an employer of any person or persons residing in the same dwelling premises as the insured;

(v) such other automobile is not used for carrying passengers for compensation or hire or for commercial delivery;

(c) in subsections 1 and 2 of this section only, any person, not the occupant of an automobile or of railway rolling-stock that runs on rails, who is struck, in Canada, by the described automobile or a newly acquired or temporary substitute automobile as defined in the policy;

(d) in subsections 1 and 2 of this section only, the named insured, if an individual and his or her spouse and any dependent rela-

tive residing in the same dwelling premises as the named insured, not the occupant of an automobile or of railway rolling-stock that runs on rails, who is struck by any other automobile; provided that,

(i) such person is not engaged in the business of selling, repairing, maintaining, servicing, storing, or parking automobiles at the time of the accident;

(ii) that automobile is not owned or regularly or frequently used by the insured or by any person or persons residing in the same dwelling premises as the named insured;

(iii) that automobile is not owned, hired, or leased by an employer of the insured or by an employer of any person or persons residing in the same dwelling premises as the named insured;

(e) if the insured is a corporation, unincorporated association, or partnership, any employee or partner of the insured for whose regular use the described automobile is furnished, and his or her spouse and any dependent relative of either, residing in the same dwelling premises as such employee or partner, while an occupant of any other automobile of the private passenger or station wagon type; and

(f) in subsections 1 and 2 of this section only, any employee or partner of the insured, for whose regular use the described automobile is furnished, and his or her spouse and any dependent relative of either, residing in the same dwelling premises as such employee or partner, while not the occupant of an automobile or of railway rolling-stock that runs on rails, who is struck by any other automobile; provided that,

in respect of (e) and (f) above,

(i) neither such employee nor partner or his or her spouse is the owner of an automobile of the private passenger or station wagon type;

(ii) the described automobile is of the private passenger or station wagon type;

(iii) such person is not engaged in the business of selling, repairing, maintaining, servicing, storing, or parking automobiles at the time of the accident;

(iv) such other automobile is not owned or regularly or frequently used by the employee or partner, or by any person or persons residing in the same dwelling premises as such employee or partner;

(v) such other automobile is not owned, hired, or leased by the insured or by an employer of any person or persons residing in the same dwelling premises as such employee or partner of the insured;

in respect of (e) above only,

(vi) such other automobile is not used for carrying passengers for compensation or hire or for commercial delivery.

(2) EXCLUSIONS

(a) Except as provided in Part III of Subsection 2, the Insurer shall not be liable under this section for bodily injury to or death of any person,

(i) resulting from the suicide of such person or attempt thereat, whether sane or insane; or

(ii) who is entitled to receive the benefits of any workmen's compensation law or plan; or

(iii) caused directly or indirectly by radioactive material;

(b) The insurer shall not be liable under subsection 1 or Part II of subsection 2 of this section for bodily injury or death,

(i) sustained by any person who is convicted of drunken or impaired driving or of driving while under the influence of drugs at the time of the accident; or

(ii) sustained by any person driving the automobile who is not for the time being either authorized by law or qualified to drive the automobile.

(3) NOTICE AND PROOF OF CLAIM

The insured person or his agent, or the person otherwise entitled to make claim or his agent, shall,

(a) give written notice of claim to the Insurer by delivery thereof or by sending it by registered mail to the chief agency or head office of the Insurer in the Province, within 30 days from the date of the accident or as soon as practicable thereafter;

(b) within 90 days from the date of the accident for which the claim is made, or as soon as practicable thereafter, furnish to the Insurer such proof of claim as is reasonably possible in the circumstances of the happening of the accident and the loss occasioned thereby;

(c) if so required by the Insurer, furnish a certificate as to the cause and nature of the accident for which the claim is made and as to the duration of the disability caused thereby from a medical practitioner legally qualified to practise.

(4) MEDICAL REPORTS

The Insurer has the right and the claimant shall afford to the Insurer, an opportunity to examine the person of the insured person when and as often as it reasonably requires while the claim is pending, and also, in the case of the death of the insured person, to make an autopsy subject to the law relating to autopsies.

(5) "PHYSICIAN" DEFINED

"Physician" means a legally qualified medical practitioner.

(6) RELEASE

Notwithstanding any release provided for under the relevant sections of **The Insurance Act** the Insurer may demand, as a condition precedent to payment of any amount under this section of the policy, a release in favour of the insured and the Insurer from liability to the extent of such payment from the insured person or his personal representative or any other person.

(7) WHEN MONEYS PAYABLE

(a) All amounts payable under this section, other than benefits under Part II of subsection 2, shall be paid by the Insurer within 30 days after it has received proof of claim. The initial benefits for loss of time under Part II of subsection 2 shall be paid within 30 days after it has received proof of claim, and payments shall be made thereafter within each 30-day period while the Insurer remains liable for payments if the insured person, whenever required to do so, furnishes prior to payment proof of continuing disability.

(b) No person shall bring an action to recover the amount of a claim under this section unless the requirements of provisions 3 and 4 are complied with, nor until the amount of the loss has been ascertained as provided in this section.

(c) Every action or proceeding against the Insurer for the recovery of a claim under this section shall be commenced within one year from the date on which the cause of action arose and not afterwards.

(8) LIMITATION ON BENEFIT PAYABLE

Where a person is entitled to benefits under more than one contract providing insurance of the type set forth in subsection 1 or 2, he or his personal representative or any person claiming through or under him or by virtue of **The Fatal Accidents Act,** may recover only an amount equal to one benefit.

In so far as applicable the general provisions, definitions, exclusions and statutory conditions of the policy also apply.

SECTION C — LOSS OF OR DAMAGE TO INSURED AUTOMOBILE

The Insurer agrees to indemnify the insured against direct and accidental loss of or damage to the automobile, including its equipment

Subsection 1 — ALL PERILS — from all perils;

Subsection 2 — COLLISION OR UPSET — caused by collision with another object or by upset;

Subsection 3 — COMPREHENSIVE — from any peril other than by collision with another object or by upset;

The words "another object" as used in this subsection 3 shall be deemed to include (a) a vehicle to which the automobile is attached and (b) the surface of the ground and any object therein or thereon. Loss or damage caused by missiles, falling or flying objects, fire, theft, explosion, earthquake, windstorm, hail, rising water, malicious mischief, riot or civil commotion shall be deemed loss or damage caused by perils for which insurance is provided under this subsection 3.

Subsection 4 — SPECIFIED PERILS — caused by fire, lightning, theft or attempt thereat, windstorm, earthquake, hail, explosion, riot or civil commotion, falling or forced landing of aircraft or of parts thereof, rising water, or the stranding, sinking, burning, derailment or collision of any conveyance in or upon which the automobile is being transported on land or water;

DEDUCTIBLE CLAUSE

Each occurrence causing loss or damage covered under any subsection of section C except loss or damage caused by fire or lightning or theft of the entire automobile covered by such subsection, shall give rise to a separate claim in respect of which the Insurer's liability shall be limited to the amount of loss or damage in excess of the amount deductible, if any, stated in the applicable subsection of section C of item 4 of the application.

EXCLUSIONS

The Insurer shall not be liable,

(1) under any subsection of section C for loss or damage

(a) to tires or consisting of or caused by mechanical fracture or breakdown of any part of the automobile or by rusting, corrosion, wear and tear, freezing, or explosion within the combustion chamber, unless the loss or damage is coincident with other loss or damage covered by such subsection or is caused by fire, theft or malicious mischief covered by such subsection; or

ifc forms service | MISCELLANEOUS | Form No.: 75024A | Edition Date: 1-84 | Size: 8½" x 11"

I.B.C. CLAIM FORM NO. 12A

AUTOMOBILE POLICY — SECTION B — ACCIDENT BENEFITS

(For use in Quebec with Q.E.F. 34 & 78)

INITIAL CLAIM

		Claim No./Policy No.	
YOUR NAME		Date of Birth	Telephone No.
YOUR ADDRESS			
EMPLOYERS	Name	Name	
	Address	Address	
	If you were unemployed at the date of the accident, for how much of the 12 months preceding the accident were you employed and working?		
OCCUPATION OR DUTIES			
ACCIDENT	Date	Details	
INJURIES YOU RECEIVED			
DOCTORS	Name	Name	
	Address	Address	
WORKERS' COMPENSATION AND OTHER COMPENSATION	a) Were you in the course of your employment at the time of the accident? ☐ Yes ☐ No		
	b) Are Workers' Compensation, Quebec Crime Victims Compensation or Quebec Automobile Insurance (Regie) benefits payable as a result of this accident? ☐ Yes ☐ No		
U.I.C.	Are U.I.C. benefits payable as a result of this accident? ☐ Yes ☐ No		
OTHER BENEFITS	Are you entitled to any other income benefit as a result of this accident? ☐ Yes ☐ No If "Yes" from whom? Name ..... Amount $ ..... Per Wk./Mon. ..... Name ..... Amount $ ..... Per Wk./Mon.		
INCOME	State your average gross weekly income $		
TIME LOST	a) State date you were first unable to work		
	b) Have you returned to work since the accident? ☐ Yes ☐ No if "YES", when did you return? ..... For how long?		
BENEFITS CLAIMED	LOSS OF INCOME from ..... 19 ..... to ..... 19 ..... I hereby state that during the period for which I am claiming loss of income benefits I have been unable to perform the essential duties of my employment. ..... Date ..... Signature		

ifc 75024A (1-84)

I.B.C. No. 12A

(ALL PROVINCES)

ifc forms service

MISCELLANEOUS

Form No.: 75024B
Edition Date: 1-84
Size: 8½" x 11"

ACCIDENT BENEFITS MEDICAL REPORT

(For use in Quebec with Q.E.F. 34 & 78)

I.B.C. CLAIM FORM NO. 12B

Your patient has completed the attached authorization. Your co-operation in completing and returning this form will be appreciated.

PATIENT		Claim No./Policy No.
AUTO ACCIDENT DATE	Date First Treated	Date Last Seen
OCCUPATION		
NATURE OF INJURIES		
TREATMENT AND SURGICAL PROCEDURES (including dates)		
PROVISIONAL PROGNOSIS		

To the best of my knowledge the patient has been unable to perform the essential duties of his/her occupation.

From ..... To .....

To the best of my knowledge the patient has been able to perform some of the essential duties of his/her occupation.

From ..... To .....

Were the injuries sustained in this accident the sole cause of complaints? ☐ Yes ☐ No

If "No" explain

.....

.....

Have you completed any other medical reports relating to this injury?

If "Yes" to whom? ☐ Yes ☐ No

.....

.....

OTHER COMMENTS		
DATE RETURN TO WORK	Provisional	Definite

DOCTOR	Name (Please Print)	
	Signature	Date

ifc 75024B (1-84)

I.B.C. No 12B

(ALL PROVINCES)

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I.B.C. CLAIM FORM NO. 15

EMPLOYER'S CONFIRMATION OF INCOME & BENEFITS

TO	Employer		
	Your employee has authorized us, by the attached, to obtain details of his/her pay and benefits in order that we may determine the amount of disability payments. Your co-operation in completing and returning this form will be appreciated.		
CLAIMANT	Employee		Claim No., Policy No.
OCCUPATION			
PHYSICAL REQUIREMENTS OF JOB	☐ Heavy Manual ☐ Light Manual ☐ Sedentary		Accident Date
IF ON SALARY	Rate (Gross) $	☐ Per week ☐ Per Month ☐ Per Year	
IF ON HOURLY RATE	Basic hours worked per week	Basic Rate per hour (Gross) $	Cost of Living Bonus (Gross) $
	Shift Bonus paid in last three months preceding accident $	Overtime paid in last three months preceding accident $	
Last Day Worked	Date salary or wages ceased	Length of time employed	
INCOME REPLACEMENT PAID WHILE OFF WORK	Amount $	per wk./mon.	
	By whom Paid?	Length of time payable	
WORKERS' COMPENSATION	Is this employee eligible for Workers' Compensation as a result of the accident?	☐ Yes ☐ No	
MEDICAL EXPENSE RECOVERY PLAN IN FORCE	☐ Yes ☐ No	If "Yes" with what company?	
If returned to work Give Date			
Date	Signature	Title	

ifc 75030 (9-81)

I.B.C. CLAIM FORM NO. 15

(ALL PROVINCES EXCEPT QUEBEC)

ifc forms service | MISCELLANEOUS | Form No.: 75026 | Edition Date: 1-84 | Size: 8½" x 11"

I.B.C. CLAIM FORM NO. 13

AUTOMOBILE POLICY — SECTION B — ACCIDENT BENEFITS

CONTINUING CLAIM

(For use in Quebec with Q.E.F. 34 & 78)

Please return immediately after you resume work or after ..... Date
if you are still off work.

NAME	Claim No./Policy No.
ADDRESS	Telephone No.
Date of Accident	Are you working now? ☐ Yes ☐ No — If back at work, give date of return.

WORKERS' COMPENSATION AND OTHER BENEFITS

If still off work, answer the following questions.

Are Workers' Compensation, Quebec Crime Victims Compensation or Quebec Automobile Insurance (Regie) benefits payable as a result of this accident? ☐ Yes ☐ No

Are U.I.C. benefits payable as a result of this accident? ☐ Yes ☐ No

Are you entitled to any other benefits as a result of this accident? ☐ Yes ☐ No

If "Yes" from whom?
Name ..... Amount $ ..... Per Wk./Mon. .....

Name ..... Amount $ ..... Per Wk./Mon. .....

LOSS OF INCOME BENEFITS CLAIMED

Date From ..... 19 To 19

I hereby state that, during the period for which I am claiming loss of income benefits I have been unable to perform the essential duties of my employment.

..... Date ..... Signature

Please complete and return this form

ifc 75026 (1-84)

	Then	Now
Legislation	2 pages	39 pages
Forms	4	+ 18 -
Med / Rehab	$25,000	$50,000 or $1 million
Attendant Care	$0.00	$36,000 or $1 million
IRB's	$140	$400

Return this form to:

Disability Certificate (OCF-3)

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

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

Use this form for accidents that occur on or after November 1, 1996. If your insurance company asks you to complete this form, fill out Parts 1 to 3 and give the form to your **health practitioner (chiropractor, dentist, nurse practitioner, occupational therapist, optometrist, physician, physiotherapist, psychologist, speech language pathologist).** After your health practitioner has explained your accident-related injury to you, sign Part 4. Your health practitioner will complete the rest of the form, based on his/her most recent assessment, and return it to the insurance company.

If this disability certificate is being completed to support your application for accident benefits, it must be completed by your health practitioner no earlier than 10 business days of the date of your application. If your insurer has requested a new disability certificate, it must be provided within 15 business days of this request. Only an authorized health practitioner can complete this form. The health practitioner's opinion will be relied upon by people who review the certificate to make important decisions. Accordingly, it is necessary to be accurate and complete. Please print clearly and provide all information requested. This form may not be materially altered.

Confidentiality: Collection, use and disclosure of this information is subject to all applicable privacy legislation.

Part 1 Applicant Information

To be completed by the applicant

Date Of Birth (YYYYMMDD)	Gender ☐ Male ☐ Female	Telephone Number Extension
Last Name	First Name	
Middle Name	E-mail (optional)	
Address		
City	Province	Postal Code

Are you currently working? ☐ Yes ☐ No If No, when was the last date that you worked? Year Month Day

Were you working at the time of the accident? ☐ Yes ☐ No

If Yes, what type of work were you doing?

Were you the primary caregiver for anyone you lived with at the time of the accident? (see Part 6 for definition) ☐ Yes ☐ No

Were you enrolled in an education program (elementary, secondary, post-secondary or continuing education) at the time of the accident? ☐ Yes ☐ No

Part 2 Insurance Company Information

To be completed by the applicant

Name of Insurance Company		City or Town of Branch Office (if applicable)
Name of Insurance Company Representative	E-mail (optional)	
Telephone		Fax
Name of Policy Holder same as: ☐ Applicant OR	Policy Holder Last Name	Policy Holder First Name

Part 3 Accident Description

To be completed by the applicant

Give a brief description of the accident and what happened to you. Please describe any injuries you sustained as a direct result of the accident.

☐ additional sheets attached

Part 4 Applicant Signature

I authorize my treating health professional to collect, use and disclose to my insurer or to a health professional, social worker, or rehabilitation expert properly identified by my insurer to conduct an examination, only such information relating to my health condition and treatment received as a result of the automobile accident and any pre-existing or subsequently occurring health conditions that may be barriers to my recovery as a result of the automobile accident, as is reasonably required for the purpose of providing treatment and determining my eligibility for benefits. I authorize the health practitioner who completes this form to contact my employer, if this is necessary, to confirm the essential tasks of my employment and the nature and extent of any available work with modified hours or duties.

This authorization does not apply to a consultation between my health care provider and the insurer's health professional conducting an examination Separate express consent is required for this consultation. This consent should be in writing.

I certify that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.

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

To the Health Practitioner:
Please complete the following information based on your most recent examination of the applicant named in Part 1 and return the form to the insurance company listed in Part 2. **Please print clearly.**

Part 5 Injury and Sequelae Information

This part and the rest of this form must be completed by your Health Practitioner

Provide a description (list most significant first) and associated ICD-10-CA* code for any injuries and sequelae that are the direct result of the automobile accident. (Refer to the User manual at www.hcaiinfo.ca for ICD-10-CA coding information.)

Description	Code

Part #6 – Relevant Dates

Part 6 Disability Tests and Information

To be completed by the health practitioner

Date symptoms first appeared: / / (YYYYMMDD)
Date of most recent examination: / / (YYYYMMDD)
Date of first post-accident examination: / / (YYYYMMDD)

Is the applicant substantially unable to perform the essential tasks of his/her employment at the time of the accident as a result of and within 104 weeks of the accident? ☐ Yes ☐ No ☐ N/A

Can the applicant return to work on modified hours and/or duties? ☐ Yes ☐ No ☐ N/A

If yes, please explain:

Benefits Categories

Date of Onset

Does the applicant suffer a complete inability to carry on a normal life? (i.e., Has the applicant sustained an impairment that continuously prevents the person from engaging in substantially all of the activities in which the person ordinarily engaged before the accident?) ☐ Yes ☐ No

As the Primary Caregiver, does the applicant suffer a substantial inability to engage in the caregiving activities in which he/she engaged at the time of the accident? (Primary Caregiver means that, at the time of the accident, the applicant was residing with a person in need of care and the applicant was the primary caregiver for the person in need of care and did not receive any remuneration for engaging in caregiver activities.) ☐ Yes ☐ No

Unemployed 26/52

Is the applicant, as a result of the accident, unable to continue in an elementary, secondary, post-secondary or continuing education program that the applicant was enrolled in at the time of the accident? ☐ Yes ☐ No

Does the applicant suffer a substantial inability to perform the housekeeping and home maintenance services that he/she normally performed before the accident? ☐ Yes ☐ No

Please explain:

If you responded 'Yes' to any disability test above, what is the anticipated duration?

☐ 1-4 weeks
☐ 5-8 weeks
☐ 9-12 weeks
☐ more than 12 weeks

If you responded Anticipated Duration 'more than 12 weeks' to any disability test above, please explain why the task/activity limitations are likely to persist beyond 12 weeks.

Please explain:

Part 7 Further Investigations or Consultations

a) Have there been any examinations, investigations, or consultations not previously reported by you?
☐ No ☐ Yes (please specify findings and results)

b) Are further examinations, investigations or consultations contemplated or required?
☐ No ☐ Yes (please specify)

Part 8 Prior and Concurrent Conditions

a) Prior to the accident, did the applicant have any disease, condition or injury that affected his/her ability to perform the activities listed in Part 6?

☐ No ☐ Unknown ☐ Yes (please explain)

If yes, is the applicant currently receiving any disability benefits for the pre-existing disease, condition or injury?

☐ No ☐ Unknown ☐ Yes (please explain)

If you treated the applicant for similar conditions prior to the accident, please describe (include date of onset, any subsequent interventions, and status at the time of the accident).

b) Since the automobile accident, has the applicant developed any disease, condition or injury, not related to the accident, that could affect his/her disability?

☐ No ☐ Unknown ☐ Yes (please explain)

Part 9 Medications

a) Please list any medications (including dosage and frequency) that the applicant is currently taking for injuries related to the automobile accident.

Were these medications prescribed by you? ☐ No ☐ Yes

b) Please list any medications (including dosage and frequency) that the applicant is currently taking as a result of prior or concurrent conditions identified in Part 8.

Were these medications prescribed by you? ☐ No ☐ Yes

Part 10 Health Practitioner Signature

Name of Health Practitioner	College Registration Number	You are a: ☐ Chiropractor ☐ Dentist ☐ Nurse Practitioner ☐ Occupational Therapist ☐ Optometrist ☐ Physician ☐ Physiotherapist ☐ Psychologist ☐ Speech-Language Pathologist
Facility Name (if applicable)	AISI Facility Number (if applicable)	
Address		
City	Province / Postal Code	
Telephone Number / Extension	Fax Number	
Email Address		

I confirm that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.

Name of Health Practitioner (please print)	Signature of Health Practitioner	Date (YYYY/MM/DD)

Note: The fee for completing this certificate is not a health care benefit of the Ontario Ministry of Health and Long-Term Care. This fee should be billed to the insurer directly.

Return this form to:

Application for Determination of Catastrophic Impairment (OCF-19)

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

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

Note to the Applicant:

This form must be completed in full and submitted to your auto insurer if you wish to establish that you have suffered a catastrophic impairment as a result of your motor vehicle accident. Persons determined to have a catastrophic impairment are entitled to request extended medical, rehabilitation and/or attendant care benefits and other expenses. On the basis of this Application, your insurer may designate you as catastrophically impaired.

To the Physician*:

Consent: It is the responsibility of the physician to ensure that their collection, use and disclosure of information submitted are authorized by a consent form. The Ontario Claims Form 5 (OCF-5) Permission to Disclose Health Information may be used as a consent form, although additional disclosure and consent may be required depending on the manner in which the information is used and disclosed.

*If impairment is only a brain impairment, this form may be filled out by a neuropsychologist.

Part 1

Applicant Information (completed by the applicant or substitute decision maker)

Last Name		First Name and Initial	
Address		Date of Accident (YYYYMMDD)	
City		Province	Postal Code
Home Telephone	Work Telephone Ext		Email (Optional)

Applicant Status:

- ☐ Applicant is currently in a general hospital, rehabilitation centre, nursing home or chronic care facility.
- ☐ This is the first application for catastrophic determination.
- ☐ This is a reapplication for catastrophic determination.

Reason for Reapplication:

I authorize my treating physician* to collect, use, and disclose to my insurer or to a health professional, social worker, or vocational rehabilitation expert properly identified by my insurer to conduct an examination only such information relating to my health condition or injuries arising as a result of the automobile accident as is reasonably required for the purpose of determining whether I have a catastrophic impairment.

This authorization does not apply to a consultation between my health care provider and the insurer's physician* conducting an examination. Separate express consent is required for this consultation. This consent should be in writing.

I confirm that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.

Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)

The rest of this form must be completed by your physician*.

Part 2

Physician* Information

Name of Physician			College Registration Number
Facility Name (if applicable)			AISI Facility Number (if applicable)
Address			
City	Province	Postal Code	
Telephone Number Extension	Fax Number		Email (Optional)

Effective (2010-09-01)
FSCO (1229E)

Type of Practitioner

Knowledge of Applicant

Part 3

Physician's* Report of Catastrophic Impairment

- ☐ Applicant is currently in my care and most recently seen on _____ (YYYYMMDD) Number of years in my care _____
- ☐ Applicant was seen for the purpose of preparing this application, on _____ (YYYYMMDD)
- ☐ Applicant was in my care but no longer actively followed. Date last seen by me: _____ (YYYYMMDD)
- ☐ I have reviewed the file but have not seen the applicant. The most relevant material reviewed is dated _____ (YYYYMMDD)
- ☐ I have seen this person _____ time(s) for the purpose of evaluating impairment.

Please refer to the following criteria for catastrophic impairment when completing this form.

Part 4

Criteria

Criteria

Based on my assessment, I believe the following criteria are applicable to this applicant. Please check all that apply.

- ☐ 1. paraplegia or quadriplegia;
- ☐ 2. if the accident occurred on or after September 1, 2010, the amputation or other impairment causing the total and permanent loss of an arm or a leg;
- ☐ 3. if the accident occurred between October 1, 2003 and before September 1, 2010, amputation or other impairment causing the total and permanent loss of use of both arms or both legs, or one or both arms and one or both legs;
- ☐ 4. if the accident occurred between November 1, 1996 and September 30, 2003, amputation or other impairment causing the total and permanent loss of use of both arms or both an arm and a leg;
- ☐ 5. the total loss of vision in both eyes;
- ☐ 6. brain impairment that, in respect of an accident, results in
  - (i) a score of 9 or less on the Glasgow Coma Scale according to a test administered within a reasonable period of time after the accident by a person trained for that purpose, or
  - (ii) a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale according to a test administered more than six months after the accident by a person trained for that purpose,
- ☐ 7. an impairment or combination of impairments that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in 55 per cent or more impairment of the whole person; or
- ☐ 8. an impairment that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder.

Note:

If an insured person is under the age of 16 years at the time of the accident and none of the Glasgow Coma Scale, the Glasgow Outcome Scale or the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, referred to in sections (6), (7) and (8) of the above criteria, can be applied by reason of the age of the insured person, then an impairment sustained in an accident by the insured person that can reasonably be believed to be a catastrophic impairment shall be deemed to be the impairment that is most analogous to the impairment referred to in sections (6), (7) and (8) of the above criteria, after taking into consideration the developmental implications of the impairment.

For the purpose of sections (7) and (8) of the above criteria, an impairment that is sustained by an insured person but is not listed in the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, shall be deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person.

If the accident occurred after September 30, 2003, sections (7) and (8) of the above criteria do not apply to the applicant unless,

- ☐ the insured person's physician* (or health practitioner if the accident occurred before September 1, 2010) states in writing that the insured person's condition is unlikely to cease to be a catastrophic impairment; or
- ☐ two years have elapsed since the accident

Physician* Explanation or Comments for Criteria Selected Above:

Please provide a description of the impairment(s) sustained in the automobile accident. Use the applicable definition of catastrophic impairment as a guide. If you are able, and it's relevant, refer to the whole person impairment rating based on the AMA Guides.

☐ Further findings you deem relevant are attached.

Part 5

Signature of Physician*

I confirm that the applicant suffered a catastrophic impairment as described in the relevant definition attached to this application. It is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer in connection with the person's entitlement to a benefit under a contract of insurance. It is an offence under the federal Criminal Code for anyone to knowingly make or use a false document with the intent it be acted on as genuine and the offence is punishable, on conviction, by a maximum of 10 years imprisonment.

Name of Physician* (please print)	Signature of Physician*	Date (YYYYMMDD)

Note: The fee for completing this form is not a health care benefit of the Ontario Ministry of Health. The fee and the cost of any examination(s) necessary to complete this form should be billed to the insurance company.

of use

Part 5 Criteria

Publication Data

Before 2003??

Ontario Claims Forms (OCF)

As of September 1, 2010

Karen Rucas

KAREN RUCAS & ASSOCIATES

OCCUPATIONAL & PHYSICAL THERAPY

IN-HOME & WORK ASSESSMENTS

What's new?

- OCF-22 is gone!
- All requests for assessments and treatment are placed on an OCF-18

- What do I get paid to complete the OCF-18?

Old form fees - Professional Services Guideline (June 2010) Superintendent's Guideline No. 04/10

"These maximums do not apply to the assessments related to the completion of these forms"

Form	Maximum Payable for Completion of Form
Disability Certificate (OCF-3)	$63.72
Treatment Plan Form (OCF-18)	$63.72
Treatment Plan Form (OCF-18)- HCAI Electronic Version	$70.00
Form 1 – Assessment of Attendant Care Needs	$63.72
Auto Insurance Standard Invoice (OCF-21)	$0.00
Application for Approval of an Assessment or Examination (OCF-22)	$63.72
Application for Approval of an Assessment or Examination (OCF-22) - HCAI Electronic Version	$70.00

New Form Fees - Professional Services Guideline (July 2010) Superintendent's Guideline No. 06/10

"The maximum fees payable for the listed forms include all examinations, assessments and expenses related to professional services (as referred to below) that are involved in such examinations and assessments, and all other activities, tasks and expenses involved in the completion and submission of the forms, whether they are made through the HCAI."

Form	Maximum Payable
Disability Certificate (OCF-3)	$200.00
Treatment and Assessment Plan (OCF-18)	$200.00
Auto Insurance Standard Invoice (OCF-21)	$0.00

Form Fees

- There is no fee to complete a Form 1
- You may consider bundling this time into your report fee

Payment to complete the OCF-18

- When you do a clinical intake/screening (e.g., by telephone or in person) to gather information prior to proposing an assessment, you may charge $200 for the intake/screening + OCF-18 form completion.

- The next Treatment Plans are billed at the time it takes to complete the form itself (i.e., "expenses related to professional services")

  - Example: If it takes the OT 45 minutes to prepare the OCF-18, charge 0.75 hour of your professional time or $70

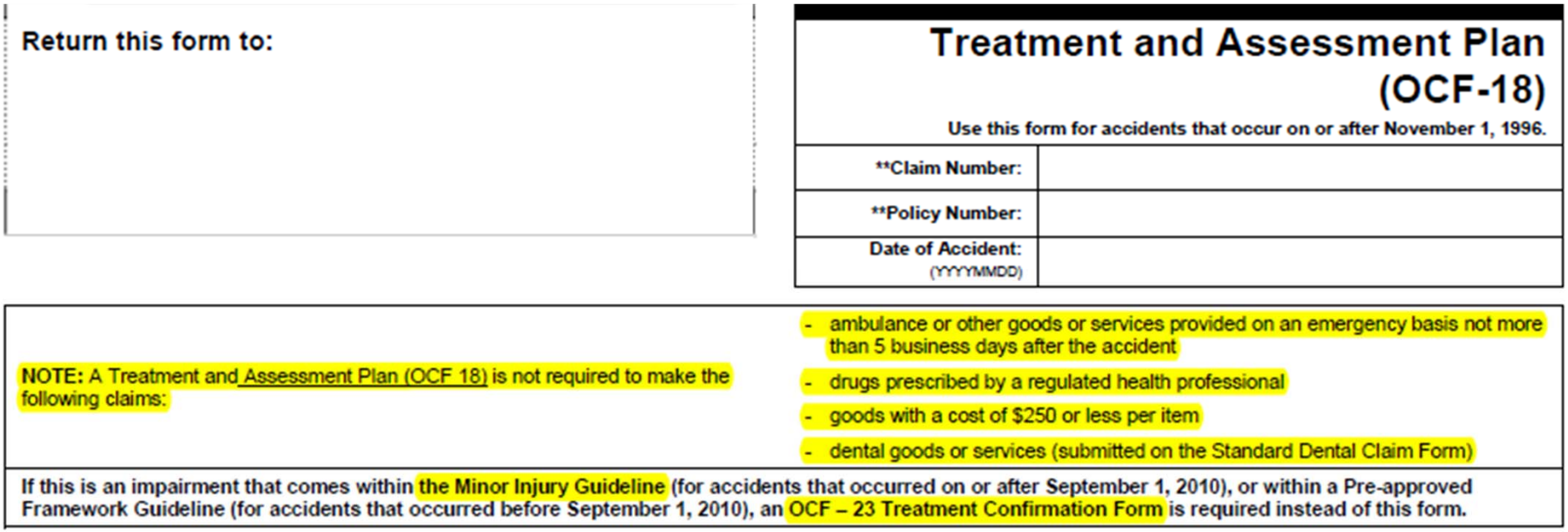
What’s new on the OCF-18?

OCF-18 – page one

→ No plan number, yet reference is made to the "Plan Number" on the OCF-21 ???

→ HCAI will assign a unique document number which is matched to the invoice.

→ *If this impairment comes within the Minor Injury Guideline…*, there is a reminder to complete an OCF-23 and not an OCF-18.



Return this form to:

Treatment and Assessment Plan (OCF-18)

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

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

NOTE: A Treatment and Assessment Plan (OCF 18) is not required to make the following claims:

- ambulance or other goods or services provided on an emergency basis not more than 5 business days after the accident
- drugs prescribed by a regulated health professional
- goods with a cost of $250 or less per item
- dental goods or services (submitted on the Standard Dental Claim Form)

If this is an impairment that comes within the Minor Injury Guideline (for accidents that occurred on or after September 1, 2010), or within a Pre-approved Framework Guideline (for accidents that occurred before September 1, 2010), an OCF – 23 Treatment Confirmation Form is required instead of this form.

Section 38 (2) - when an OCF-18 is *not* required

(2) (a) the insurer gives the insured person a notice under subsection 39 (1) stating that the insurer will pay the expense without a treatment and assessment plan;

(b) the expense is for an **ambulance or other goods or services provided on an emergency basis not more than five business days after the accident to** which the application relates; or

(c) the expense is reasonable and necessary as a result of the impairment sustained by the insured person for,

(i) **drugs** prescribed by a regulated health professional, or

(ii) **goods with a cost of $250 or less per item.**

IMPORTANT: The good(s) and/or service(s) can still be challenged; the "reasonable and necessary" test still applies.

OCF-18, page two

(1) provide compelling information that the person's pre-existing medical condition impacts recovery or (2) if the person has completed the MIG and now needs to access the remainder of the $3500 funding

For accidents that occurred before September 1, 2010:

Is this an impairment referred to in a Pre-approved Framework (PAF) Guideline? ☐ Yes ☐ No

If yes, please explain, in accordance with the PAF Guideline, and with express reference to the provisions of the PAF Guideline on which you rely, why this OCF-18 Treatment and Assessment Plan is being submitted instead of an OCF 23 Treatment Confirmation Form:

For accidents that occur on or after September 1, 2010:

Is this impairment predominantly a minor injury as referred to in the Minor Injury Guideline? ☐ Yes ☐ No

If yes, please explain and provide compelling evidence why the applicant does not come within the Minor Injury Guideline due to a pre-existing medical condition that will prevent the applicant from achieving maximal recovery from the minor injury if the applicant is subject to the $3,500 limit or is limited to the goods and services authorized under the Minor Injury Guideline.

Send any attachments directly to the insurer

Part 6 – Injury and Sequelae Information

How do I complete this section if the assessment has not yet been done?

- If the assessment is meant to establish a diagnosis (e.g., psychological ax), use the ICD-10 codes for symptoms such as insomnia, restlessness, etc…

Part 6 Injury and Sequelae Information	Provide a description (list most significant first) and associated ICD-10-CA code for complaints, injuries and sequelae that are the direct result of the automobile accident (refer to the User manual at www.hcaiinfo.ca for ICD-10-CA coding information).	
	Description	**Code**

Is your OCF-18 ‘adjuster ready’?

Part 8 Activity Limitations

a) Does the applicant's impairment(s) from the injuries identified in Part 6 affect his/her ability to carry out:

His/her tasks of employment	☐ Not employed	☐ No	☐ Unknown	☐ Yes
His/her activities of normal life		☐ No	☐ Unknown	☐ Yes

b) If Yes to either of the questions above, briefly describe the activities limited by the impairment and their impacts on the applicant's ability to function.

Is your OCF-18 ‘adjuster ready’?

Part 9
Plan Goals, Outcome Evaluation Methods and Barriers to Recovery

a) Goals:

(i) Identify the goal(s) in regard to the applicant's impairment(s), symptom(s) or pathology that this Treatment and Assessment Plan seeks to achieve:

- ☐ pain reduction
- ☐ increase in strength
- ☐ increased range of motion
- ☐ other(s)/not applicable (please specify)

and

(ii) Select the functional goal(s) that this Treatment and Assessment Plan seeks to achieve:

- ☐ return to activities of normal living
- ☐ return to modified work activities
- ☐ return to pre-accident work activities
- ☐ other(s)/not applicable (please specify)

b) Evaluation:

(i) How will progress on the goal(s) in a) (i) and a) (ii) be evaluated?

(ii) *If this is a subsequent Treatment and Assessment Plan, what was the applicant's improvement at the end of the previous plan based on your evaluation method?

Send any attachments directly to the insurer

Preparing your OCF-18

- Give solid rationale as to why the assessment or treatment should be performed
- What will happen if the assessment or treatment does not occur? e.g., the client is at risk of injury without the home modification assessment
- Avoid cookie-cutter forms, particularly if you are charging for a “screening” assessment to complete the OCF-18; make sure the information contained on the OCF-18 is individualized

Preparing your OCF-18

- If you are using HCAI, you can provide your clinical rationale under the “Additional Comments” section to explain your rationale further; otherwise, fax attachments directly to the adjuster.

- If you know you will be providing treatment after the assessment, include a few sessions of treatment to avoid the unnecessary delays of submitting a second treatment plan

Coding

FYI

- Both injury and intervention codes are **not** meant to inform the adjuster about the diagnosis or your intervention

- Codes will be used ONLY for data analysis

- All health care associations will be providing pick-lists of commonly used codes.

Why is it important to have detailed rationale and individualized forms?

- The rationale on your OCF-18 must convince the adjuster that your assessment/treatment is required and, if you are already providing treatment, that your patient has made some gains as a result
- With greater insurer discretion, your OCF-18 may not be sent for an Insurer Examination (peer review)
- If your OCF-18 is sent for an IE, it may not be reviewed by someone of the same discipline; there are no timelines for the completion of the IE

Unfair Denial of a Treatment Plan

Your treatment plan cannot be denied with the explanation that it was not “reasonable or necessary”. The adjuster must provide a medical and other reason for denial.

What to do next?

1. Communicate with the adjuster.
2. Contact the Ombudsmen of the Insurance Company: http://www.giocanada.org/giomember.html

AND

FSCO Market Conduct Branch, Financial Services Commission of Ontario (FSCO)
5160 Yonge Street
P.O. Box 85
Toronto, Ontario, M2N 6L9

Assessment of Attendant Care Needs (Form 1)

What form do I use after September 1st?

What's new on the Form 1?

Return this form to:

Assessment of Attendant Care Needs
(Form 1)
Use this form for accidents that occur on or after March 31, 2008

Policy No.:	
Claim No.:	

Use this form to report the future needs for attendant care required by the applicant as a result of an automobile accident. This form must be completed by an occupational therapist or a registered nurse (in this form referred to as the Assessor). This form has five parts:

The Form 1 – *what's new?*

- The new Form 1 is used for all accidents occurring after March 31, 2008
- (http://www.fsco.gov.on.ca/english/forms/autoforms/claims/1223E.pdf)

- Only OTs and nurses can complete the Form 1 after Sept 1st, both for new and old accidents.

The Form 1 – *what's new?*

Hourly rates: check the last page of the Form 1 for instructions

Rates for accidents between March 31, 2008 and August 31, 2010:

Level 1: $11.23

Level 2: $ 8.75

Leve 3: $ 17.98

Part 3 Total – Add all Part 3 Subtotals. Fill in total here and below

Part 4: Calculation of Attendant Care Costs

This part must be completed by the Assessor. Calculate the monthly attendant care allowance for Part 1, 2 and 3. The sum of all three parts will be the Total Assessed Monthly Attendant Care Benefit.

	Total Minutes per Week		Total Weekly Hours		Total Monthly Hours		Hourly Rate		Monthly Care Benefit
Part 1 (from Pg.3)		÷ 60 =		X 4.3 =		X	A*	=	$
Part 2 (from Pg.3)		÷ 60 =		X 4.3 =		X	B*	=	$
Part 3 (from Pg.6)		÷ 60 =		X 4.3 =		X	C*	=	$

Total Assessed Monthly Attendant Care Benefit $

(This amount is subject to the limits allowed under the Statutory Accident Benefits Schedule)

*For amounts to be used in the above table, please refer to the following chart:

	Accidents occurring between March 31, 2008 and August 31, 2010	Accidents occurring on or after September 1, 2010
A	$11.23	Please refer to the hourly rates as set out in the Superintendent's Guideline issued under s. 19 (2) (a) of the SABS
B	$8.75	
C	$17.98	

For accidents occurring on or after September 1st, 2010

Attendant Care Costs	Maximum Hourly Rate
Part 1: Hourly Rate A Level 1 Attendant Care is for routine personal care.	**$13.19**
Part 2: Hourly Rate B Level 2 Attendant Care is for basic supervisory functions.	**$10.25**
Part 3: Hourly Rate C Level 3 Attendant Care is for complex health/care and hygiene functions.	**$19.35**

Thomson, Rogers in collaboration with the Toronto ABI Network

Back-to-School II

Four Seasons Hotel Toronto | Thursday, September 30, 2010

THANK YOU!

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