

Return this form to:

# Explanation of Benefits Payable by Insurance Company (OCF-9)

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

Claim Number:

Policy Number:

Date of Accident:  
(YYYYMMDD)

We have reviewed your application for benefits. This form tells you which benefits are approved and the amounts payable. Where a benefit has not been approved, an explanation has been provided. If you disagree with our assessment, you have the right to dispute it according to the procedure described in Part 6 of this form.

## Part 1 Applicant Information

|            |      |       |     |                        |           |                |           |
|------------|------|-------|-----|------------------------|-----------|----------------|-----------|
| Last Name  |      |       |     | First Name and Initial |           |                |           |
| Address    |      |       |     |                        |           |                |           |
| City       |      |       |     | Province               |           | Postal Code    |           |
| Birth Date | year | month | day | Home Telephone         | Area Code | Work Telephone | Area Code |

## Part 2 Income Replacement Benefits

additional sheets attached

We have reviewed your application for income replacement benefits and have determined you are:

|   |  |                      |
|---|--|----------------------|
| <input type="checkbox"/> <b>A. Eligible</b>                       | Details of how we calculated your income replacement benefit, including adjustments for income or payments from other sources. |                      |
| <b>Calculation</b>  |  |                      |
| Gross Weekly Income   |  | <input type="text"/> |
| Net Income  |  | <input type="text"/> |
| 80% of Net Weekly Income  |  | <input type="text"/> |
| Minus Post-Accident Net Weekly Income/Payments from Other Sources |  | <input type="text"/> |
| Income Replacement Benefit Payable                                | <input type="text"/>   |                      |

|   |
|---|
| <input type="checkbox"/> <b>B. Not Eligible</b> |
|---|

## Part 3 Non-Earner Benefit or Caregiver Benefit

additional sheets attached

|                                   |                                       |
|-----------------------------------|---------------------------------------|
| <b>Non-Earner Benefit</b>         |                                       |
| <input type="checkbox"/> Eligible | <input type="checkbox"/> Not eligible |
| <b>Caregiver Benefit</b>          |                                       |
| <input type="checkbox"/> Eligible | <input type="checkbox"/> Not eligible |

**Part 4  
Other  
Benefits**

additional sheets attached

| Benefit Identification | Benefit Description  |
|------------------------|--|
| MR                     | Medical and Rehabilitation Expenses  |
| AC                     | Attendant Care Expenses  |
| CM                     | Case Manager Expenses  |
| LE                     | Lost Educational Expenses  |
| HH                     | Housekeeping and Home Maintenance Expenses                                 |
| RR                     | Expenses to Repair or Replace Lost or Damaged Clothing, Hearing Aids, etc. |
| FE                     | Funeral Expenses   |
| DB                     | Death Benefits   |

| Item | Details | Amount Claimed | Amount Payable | Interest Payable | Item Not Payable         |
|------|---------|----------------|----------------|------------------|--------------------------|
|      |         | \$             | \$             | \$               | <input type="checkbox"/> |
|      |         | \$             | \$             | \$               | <input type="checkbox"/> |
|      |         | \$             | \$             | \$               | <input type="checkbox"/> |
|      |         | \$             | \$             | \$               | <input type="checkbox"/> |
|      |         | \$             | \$             | \$               | <input type="checkbox"/> |
|      |         | \$             | \$             | \$               | <input type="checkbox"/> |
|      |         | \$             | \$             | \$               | <input type="checkbox"/> |
|      |         | \$             | \$             | \$               | <input type="checkbox"/> |
|      |         | \$             | \$             | \$               | <input type="checkbox"/> |
|      |         | \$             | \$             | \$               | <input type="checkbox"/> |
|      |         | \$             | \$             | \$               | <input type="checkbox"/> |
|      |         | \$             | \$             | \$               | <input type="checkbox"/> |

**Reasons why expenses are not payable:**

Additional Sheets Attached

**Part 5  
Insurance  
Company  
Information**

|   |           |            |           |                 |  |
|---|-----------|------------|-----------|-----------------|--|
| Name of Insurance Company Representative      |           |            |           | Title           |  |
| Name of Insurance Company                     |           |            |           |                 |  |
| Telephone Number                              | Area Code | FAX Number | Area Code |                 |  |
| Signature of Insurance Company Representative |           |            |           | Date (YYYYMMDD) |  |

**Part 6  
Applicant's  
Rights to  
Dispute**

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

Under the *Insurance Act* if your claim for statutory accident benefits under the *Insurance Act* has been reduced or denied by your insurer, 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 ASSESSMENT/EXAMINATIONS**

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 assessments and/or examinations.

**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 FSCO's web site at [www.fSCO.gov.on.ca](http://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

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.