

# Accident Benefits Application Package

*Use this package to apply for benefits if you were injured in an automobile accident on or after November 1, 1996.*

## About this Application for Accident Benefits

Please note that all automobile accidents involving bodily injury must be reported to the police. Claims for certain accident benefits must be made within 7 days. Please contact your adjuster for further information.

There are five forms in this package:

- **Application for Accident Benefits (OCF-1)**

Fill out this form when you are applying for benefits **for the first time** as a result of an accident, including if you are injured and are applying for income replacement benefits. You may be eligible for weekly benefits even if you were unemployed or retired at the time of the accident.

This Application for Accident Benefits form must be returned within 30 days after receiving the package. If you are unable to return it within 30 days, submit it to your insurance company anyway and explain why you were not able to complete it within 30 days. Return the original form to the insurance company and make a copy for your records.

- **Employer's Confirmation of Income (OCF-2)**

If the insurance company asks you to, please give this form to your employer. This form is completed by you or your representative and by your employer. If you had more than one employer during the past 52 weeks, it may be necessary for each employer to complete a separate form. Your insurance company may ask for other proof of income.

- **Disability Certificate (OCF-3)**

If the insurance company asks you to, please fill out the first section and give this form to your health practitioner (chiropractor, dentist, occupational therapist, nurse practitioner, optometrist, physician, physiotherapist, occupational therapist, speech language pathologist or psychologist). This form is completed by you or your representative and by your health practitioner.

- **Permission to Disclose Health Information (OCF-5)**

If the insurance company asks you to, please complete this form. The insurance company requires your medical information in order to correctly determine your eligibility for benefits. Health professionals require your written permission to disclose this information to the insurance company.

- **Pre-approved Framework Treatment Confirmation Form (OCF-23/198)**

This form must be completed to confirm treatment received under a Pre-approved Framework Guideline. There are exceptions. Please contact your insurance company to find out if this form is required.

After the insurance company reviews your complete application package, you will be contacted about the benefits you are entitled to receive. If your insurance company needs any additional information in order to process your application, they will contact you.

### Warning – Offences

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 contract of insurance. The offence is punishable on conviction by a maximum fine of \$100,000 for the first offence and a maximum fine of \$200,000 for any subsequent conviction.

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.

It is an offence under the federal Criminal Code for anyone, by deceit, falsehood or other dishonest act, to defraud or to attempt to defraud an insurance company. The offence is punishable, on conviction, by a maximum of 10 years imprisonment for fraud involving an amount over \$5,000 or otherwise a maximum of 2 years imprisonment.

**Incomplete or incorrect information may result in your application being denied.**

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# Where do I send the Application Forms?

Please follow the instructions below.

## 1. If You Own, Lease, or Have Regular Use of a Company Automobile

As of the date of the accident did you, your spouse or someone you are dependent on (please check all the options that apply to you):

- Own an automobile?
- Lease or have a contract to rent an automobile for more than 30 days?
- Drive a company automobile which was made available for your regular use?

Yes - If you checked only one, send the forms to the insurance company that insures this automobile.

No - If none apply, continue to 2.

Yes - If you checked more than one, send the forms to the insurance company of the vehicle in which you were an occupant at the time of the accident.

Yes - If you checked more than one and were not an occupant in either of the automobiles, send the forms to the insurer of either vehicle (you choose).

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## 2. If You are a Listed Driver

Are you listed as a driver on somebody's insurance policy?

Yes - If yes, send your forms to the insurance company that issued the policy you are listed on.

No - If no, continue to 3.

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### The following categories only apply if:

- You, your spouse or someone that you are dependent upon **does not own, lease, or regularly use a company** automobile.
- You are **not listed** as a driver on a policy.

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## 3. Occupant of Somebody Else's Automobile

Were you an occupant of somebody else's automobile that was insured at the time of the accident?

Yes - If yes, send your forms to the insurance company that insures this automobile.

No - If no, continue to 4.

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## 4. Pedestrian or Bicyclist

Were you a pedestrian or a bicyclist struck by an automobile that was insured at the time of the accident?

Yes - If yes, send your forms to the insurance company of the automobile that struck you.

No - If no, continue to 5.

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## 5. Uninsured Automobile

Were you an occupant of an automobile that was not insured at the time of the accident?

Yes - If yes, send your forms to the insurance company of any other automobile that was involved in the accident.

No - If no, continue to 6.

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## 6. None of the Above Apply

If you do not have automobile insurance and no other automobile involved in the accident either has automobile insurance or can be identified, you may be entitled to obtain accident benefits from the Motor Vehicle Accident Claims Fund. Please complete the entire application package and see Part 11.

Return this form to:

# Application for Accident Benefits (OCF-1)

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

<b>Claim Number:</b>	
<b>Policy Number:</b>	
<b>Date of Accident:</b> (YYYYMMDD)	

A separate form must be completed for each person who is applying for accident benefits. Completion of ALL sections is mandatory. **Your application may be denied if information is incomplete or incorrect. Please print clearly.**

## Part 1 Applicant Information

Last Name				Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Separated	
First Name and Initial			Address			<input type="checkbox"/> Married <input type="checkbox"/> Divorced	
City			Province			<input type="checkbox"/> Common-law <input type="checkbox"/> Widow(er)	
Postal Code		Fax Number	Area Code ( )		Is anyone dependant on you for financial support or care? <input type="checkbox"/> Yes, how many persons? _____ <input type="checkbox"/> No		
Birth Date	Year	Month	Day	Home Telephone	Area Code ( )	Work Telephone	Area Code ( )

**You can be reached:**

- by telephone  at home  
 by personal visit  at work  
 other \_\_\_\_\_

**Language Spoken:**

**What is the best time to reach you:**

Day(s) of the week	
Time of day	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.

## Part 2 Applicant's Representative (if applicable)

**Complete this section only** if the applicant injured in the accident is deceased, is a minor, is unable to fill out the form on their own, or has retained you as their representative.

Last Name				Relationship with applicant <input type="checkbox"/> Parent <input type="checkbox"/> Guardian			
First Name and Initial				<input type="checkbox"/> Lawyer <input type="checkbox"/> Other _____			
Address							
City				Province		Postal Code	
Home Telephone	Area Code ( )	Work Telephone	Area Code ( )	FAX Number	Area Code ( )		

## Part 3 Accident Details and Health Information

Date of Accident	Year	Month	Day	Time of Accident	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	You were a:	<input type="checkbox"/> Driver <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other _____
Accident Location: Hwy. No./Street Name						City	Province
Did the accident occur while you were at work? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Did you file a claim with the Workplace Safety and Insurance Board? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Was the accident reported to the police? <input type="checkbox"/> Yes (Give details below) <input type="checkbox"/> No							
Officer Name			Badge No.		Date accident reported to the police		Year Month Day
Police Department/Collision Reporting Centre							
Were you charged? <input type="checkbox"/> Yes (Give details) <input type="checkbox"/> No							
Give a brief description of the accident. If you suffered any injuries as a result of the accident, describe the cause and extent of the injuries.							
Were you able to return to your normal activities following the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No							

Additional sheets attached

**Part 3  
Accident  
Details and  
Health  
Information  
(cont'd)**

Did you go to the hospital? <span style="float: right;"><input type="checkbox"/> Yes (Give details below) <input type="checkbox"/> No</span>		
Did you go see a health professional? (for example: physician, chiropractor, physiotherapist) <span style="float: right;"><input type="checkbox"/> Yes (Give details below) <input type="checkbox"/> No</span>		
Name of Health Professional	Name of Facility	
Address		
City	Province	Postal Code
Has this Health Professional begun any treatment? <span style="float: right;"><input type="checkbox"/> Yes (Give details below) <input type="checkbox"/> No</span>		

Additional sheets attached

**Part 4  
Details of  
Automobile  
Insurance**

In order to determine which automobile insurer is responsible for paying benefits, it is necessary to know whether you have your own policy or whether you are covered by somebody else's insurance policy. To help make that determination, please complete the following:

**A** Are you covered under any of the following automobile insurance policies?

Your own policy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Your spouse's policy	<input type="checkbox"/> Yes <input type="checkbox"/> No
The policy of any person on whom you are dependent (e.g. a parent)	<input type="checkbox"/> Yes <input type="checkbox"/> No
A policy that lists you as a driver (e.g. a friend)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Your employer's policy (e.g. company car) or spouse's employer's policy	<input type="checkbox"/> Yes <input type="checkbox"/> No
A policy insuring long-term rental cars (for rentals exceeding 30 days)	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered **"No"** to **all** of the above, go to **B** If you answered **"Yes"** to **any** of the above, complete the following:

Name of Policyholder	
Insurance Company	Policy Number
Automobile – Make, Model, Year	Licence Plate Number
Were you an occupant of this automobile at the time of the accident? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	

If you answered **"Yes"** to more than one box in this part, provide additional insurance details below.

Name of Policyholder	
Insurance Company	Policy Number
Automobile – Make, Model, Year	Licence Plate Number
Were you an occupant of this automobile at the time of the accident? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	

**B** If you checked **"No"** to all of the boxes in **A** **you must send** your application to the insurer of the automobile that you occupied at the time of the accident, or the vehicle that struck you if you were a pedestrian or bicyclist. If this automobile was not insured or unidentified, describe any other vehicle involved in the accident. **Provide details below.**

<p><b>The policy you are claiming under insures:</b></p> <p><input type="checkbox"/> The vehicle I was riding in at the time of the accident</p> <p><input type="checkbox"/> The vehicle that struck me as a pedestrian/bicyclist</p> <p><input type="checkbox"/> Another vehicle that was involved in the accident</p>	<p><b>Vehicle type covered by this policy:</b></p> <p><input type="checkbox"/> Passenger <span style="float: right;"><input type="checkbox"/> Truck</span></p> <p><input type="checkbox"/> Motorcycle <span style="float: right;"><input type="checkbox"/> Bus</span></p> <p><input type="checkbox"/> Taxi/Limousine <span style="float: right;"><input type="checkbox"/> Snowmobile</span></p> <p><input type="checkbox"/> Other _____</p>
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**Part 4  
Details of  
Automobile  
Insurance  
(cont'd)**

Owner of the Vehicle	Home Telephone ( )	Area Code ( )
Address	Work Telephone ( )	Area Code ( )
City	Province	Postal Code
Automobile – Make, Model, Year		
Insurance Company	Policy Number	
Name of Policyholder	Licence Plate Number	
<b>Did you report the accident to any other insurance company?</b>	<input type="checkbox"/> Yes (Give details below)	<input type="checkbox"/> No
Insurance Company	Type of Insurance	

**Part 5  
Applicant  
Status**

**Which of the following describes your status at the time of the accident?**

<b>Employed</b> <input type="checkbox"/> Employed and working <input type="checkbox"/> Self-Employed	<b>Not Employed</b> <input type="checkbox"/> Unemployed <input type="checkbox"/> Unemployed and, <input type="checkbox"/> have worked 26 weeks in the past 52 weeks <input type="checkbox"/> receiving Employment Insurance Benefits <input type="checkbox"/> Retired	<input type="checkbox"/> <b>Student or recent graduate</b>  <input type="checkbox"/> <b>Caregiver</b>
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**Part 6  
Student  
Attending  
School**

**Were you attending school on a full-time basis at the time of accident or had you completed your education less than one year before the accident?**

Yes (Give details below)       No (Continue to Part 7)

Name of School		Date Last Attended	Year	Month	Day
Address		Program and Level			
City	Province	Postal Code	Projected Date for Completion of Studies	Year	Month Day

**Are you now attending school?**       Yes (Enter date)      Year      Month      Day       No

**Were you able to return to school after the accident?**       Yes (Enter date)      Year      Month      Day       No

**Part 7  
Caregiver**

You can apply for caregiver benefits if, at the time of the accident, you were primarily responsible for the care of persons who are living with you and are under 16 years of age or over 16 years of age and are physically or mentally disabled. If you qualify for this benefit you are required to submit bills and receipts for expenses incurred for the care of your dependants.

**Were you the main caregiver to people living with you, at the time of the accident?**

Yes (Complete information below)       No (Continue to part 8)

**Were you paid to provide care to these people?**       Yes (Continue to part 8)       No

**List the people who you were caring for at the time of the accident**

Name	Date of Birth			Disabled	
	Year	Month	Day	Yes	No
				<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"/>

Additional sheets attached

**Part 7  
Caregiver  
(cont' d)**

As a result of your injuries were you unable to engage in the caregiving activities in which you engaged at the time of the accident?

Yes (Explain below) From what date? Year Month Day  No

Explanation:

Additional sheets attached

Did you return to caregiving after the accident?

Yes (Enter date) Year Month Day  No

**Part 8  
Income  
Replacement  
Determination**

Give details of your employment for the past 52 weeks. Start with your current or most recent employer. If you held more than one position with the same employer, use a separate line for each position. Gross income is before taxes and deductions. **If you were self-employed during the 4 weeks prior to the accident, please consider yourself the employer for the purpose of completing this section.**

Date Year/Month/Day	Name and Address of Most Recent Employer	Position/Essential Tasks	No. of Hours Per week	Gross Income for the period	<b>DO NOT WRITE HERE Occupational Code</b>
From: To:				\$	
From: To:				\$	
From: To:				\$	
From: To:				\$	

Additional sheets attached

Do your injuries prevent you from working?

Yes (Enter date) Year Month Day  No (Continue to Part 10)

Were you able to return to work after the accident?

Yes (Enter date) Year Month Day  No

The amount of your benefit is based on your past income. During which of the following periods did you have the highest average weekly income?

- Last 4 weeks (not applicable for self-employed persons)
- Last 52 weeks
- Last fiscal year (self-employed only)

**Part 9  
Income  
Tax  
Status**

The amount of the benefit you are eligible for depends on your income tax status. We require the following information to calculate the amount of your benefit. You may be required to provide additional information to help your insurance company calculate your benefit (e.g. pay stubs, tax receipts).

On the date of the accident, were you paying support payments to a spouse or former spouse?

Yes (Enter dates)  No

From: Year Month Day To: Year Month Day Total Amount Paid \$

Additional sheets attached

<b>Marital status for tax purposes?</b> <input type="checkbox"/> Single <input type="checkbox"/> Equivalent to Married <input type="checkbox"/> Married <input type="checkbox"/> Other	If you are married or equivalent to married, what is the expected annual income of your spouse or dependant for the calendar year in which the accident occurred? \$	Did you claim the Disability Amount Non-Refundable Tax Credit on your most recent income tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Part 10  
Other  
Insurance  
Or  
Collateral  
Payments**

Do you, your spouse or anyone you are dependent on (eg. parents) have any other benefit plan that covers you (eg. group or private, union, disability, medical or dental, etc.)?

Yes (Give details below)  No

Name of Benefit Payor	Type of Coverage	Policy or Certificate Number

During the past 52 weeks, did you receive any income from a disability plan?  Yes (Enter dates)  No

From: Year Month Day To: Year Month Day Total Amount Received \$

Are you receiving Employment Insurance Benefits?  Yes (Enter date)  No

From: Year Month Day To: Year Month Day Total Amount Received \$

Additional sheets attached

Are you receiving Social Insurance Benefits (welfare)?  Yes  No

**Part 11  
Motor  
Vehicle  
Accident  
Claims  
Fund**

**DO NOT FILL OUT UNLESS ITEMS (1) TO (5) ON PAGE 2 DO NOT APPLY AND YOU ARE APPLYING TO THE MOTOR VEHICLE ACCIDENT CLAIMS FUND**

You and your representative acknowledge that you have the responsibility to investigate and apply to all potential insurers to which the applicant may have recourse BEFORE submitting an application to the Motor Vehicle Accident Claims Fund (MVACF).

You and your representative acknowledge that the application MUST INCLUDE a completed:

- NOTICE OF COLLECTION OF PERSONAL INFORMATION FORM, signed and attached\*
- Form 3 – Section 6 MVACF Application for Statutory Accident Benefits, signed and attached\*
- Motor Vehicle Accident (Police) Report, attached.

before the applicant can make an application for the payment of accident benefits from the MVACF.  
(\* These forms are available at [www.fscs.gov.on.ca](http://www.fscs.gov.on.ca))

I certify that I have read this part and understand that this application for accident benefits is not complete until the required forms are completed, signed and provided to the MVAC Fund.

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

**Motor Vehicle Accident Claims Fund  
PO Box 85  
5160 Yonge Street  
Toronto, ON M2N 6L9**

**Toronto calling area: (416) 250-1422  
Toll Free: 1- (800) 268-7188**

**Part 12  
Signature**

**TO THE INSURER TO WHOM THIS APPLICATION IS BEING SUBMITTED:**

**I UNDERSTAND** that you, and persons acting for you, will collect and use personal information and personal health information about me that is related to my claims for accident benefits arising out of the accident described in this application, and that all such information will be collected directly from me, or from any other person with my consent.

**I ALSO UNDERSTAND** that this information will be collected and used only as reasonably necessary for the purposes of:

- Investigating my claims and processing my claims as required by law, including the Ontario Automobile Policy;
- Obtaining or verifying information relating to my claims in order to determine entitlement and the proper amount of payment;
- Recovering payment from insurers and others liable in law for amounts that you pay in connection with my claims;
- Identifying and analyzing the nature and costs of goods and services that are provided to automobile accident victims by health care providers;
- Preventing fraud, and detecting fraud where there are reasonable grounds to suspect fraud;
- Compiling anonymized statistics for government agencies; and
- Assessing underwriting risks and claims experience.

**I ALSO UNDERSTAND** that you, and persons acting for you, may disclose this information to the following persons, who may collect and use this information only as reasonably necessary to enable you to carry out the purposes described above:

- Insurers; insurance adjusters, agents and brokers; employers; health care professionals; hospitals; accountants; financial advisors; solicitors; organizations that consolidate claims and underwriting information for the insurance industry; and my agents or representatives as designated by me from time to time.

**I CONSENT** to you collecting, using and disclosing this information in the manner described above, but no more of such information than is reasonably necessary to meet the legitimate purpose of such collection, use or disclosure.

**I UNDERSTAND** that if I have any questions about this consent I am free to consult with my insurance company representative or legal advisor before signing this document.

**I AM ALSO AWARE** that you, and persons acting for you, may be required or permitted by law to disclose this information to others without my knowledge or consent.

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)
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