



Application for Mediation FORM A FOR MOTOR VEHICLE ACCIDENTS THAT OCCURRED ON OR AFTER NOVEMBER 1, 1996

Mediation file number

Section 1 GENERAL INFORMATION This section MUST be completed.

1. What was the date of the motor vehicle accident? 2. Who is making this application? Claimant, Claimant's representative, Insurance company, Insurance company's representative

3. Have you applied for mediation before? No, Yes

4. Language preferred: English, French, Other, specify. 5. Do you want the mediation to be conducted in French? No, Yes

Do you want an in-person meeting with the other party? No, Yes

Please note that it is within the mediator's discretion to conduct the mediation in person or by telephone conference.

CLAIMANT

Mr. Mrs. Ms. Last name, First name, Middle name, Street address, Apt./Unit, City, Province/State, Postal Code/Zip, Country, Home phone number, Work phone number, Ext., Fax number, Birth date (Year, Month, Day)

1. What is the best way to reach you? phone, mail, fax, through my representative. 2. Where is the best place to reach you? home, work, other, specify

3. When is the best time to reach you? Specify days of the week and time.

4. Is the Claimant under 18 years old? Or mentally incapable? Yes, No. If Yes, the person filing the application on behalf of the claimant must also complete Form P — Representing Minors and Mentally Incapable Persons — and sign this application form.

CLAIMANT'S REPRESENTATIVE

Mr. Mrs. Ms. Last name, First name, File reference number, Title, Firm name, Street address, Apt./Unit, City, Province/State, Postal Code/Zip, Country, Work phone number, Ext., Fax number, Electronic mail address

The representative is a: Lawyer, Non-lawyer who is: employed by a lawyer or law firm that was retained in this matter; and supervised by a lawyer. Non-lawyer's Law Society registration number, Name of supervising lawyer, SABS Representative Commission identification number: S - Person who is not being compensated for his or her services.

Section 1 continued

INSURANCE COMPANY

Company name	
Claim representative name	Claim number
Policyholder name	Policy number

INSURANCE COMPANY'S REPRESENTATIVE

<input type="checkbox"/> Last name Mr. Mrs. Ms.	First name	File reference number	
Title	Firm name		
Street address		Apt./Unit	
City	Province/State	Postal Code/Zip	Country
Work phone number ()	Ext.	Fax number ()	Electronic mail address

Section 2 ISSUES IN DISPUTE

Provide a **full** description of the accident benefits that are in dispute. (Attach extra sheets if necessary)

Does this claim involve catastrophic impairment? <input type="checkbox"/> No <input type="checkbox"/> Yes	Does the Claimant have optional benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes
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WEEKLY BENEFITS

Which weekly benefit are you disputing? <input type="checkbox"/> income replacement <input type="checkbox"/> non-earner	Date submitted to insurer: Year Month Day	Date denied: Year Month Day
	What are you disputing? <input type="checkbox"/> initial entitlement to benefits <input type="checkbox"/> length of time benefits were paid <input type="checkbox"/> amount of weekly benefits <input type="checkbox"/> entitlement to benefits past 104 weeks <input type="checkbox"/> other, specify ▼	
If the Claimant received income benefits, state weekly amount and duration of payments. \$ From To		
Is the insurance company claiming a repayment of benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, amount ▼ \$		

CAREGIVER BENEFITS

Weekly amount in dispute? \$ From To	Date submitted to insurer: Year Month Day	Date denied: Year Month Day
	Name of service provider(s):	
What are you disputing? <input type="checkbox"/> initial entitlement to benefits <input type="checkbox"/> length of time benefits were paid <input type="checkbox"/> amount of benefits <input type="checkbox"/> entitlement to benefits past 104 weeks <input type="checkbox"/> other, specify ▼		

Section 2 continued

ATTENDANT CARE BENEFITS

Monthly amount in dispute? \$	Date submitted to insurer: Year Month Day	Date denied: Year Month Day
	Name of service provider(s):	
	Time period in dispute from: to:	

MEDICAL BENEFITS 1

Amount in dispute? \$	Date submitted to insurer: Year Month Day	Date denied: Year Month Day
	Name of service provider(s):	
	Type of service(s):	
	Time period in dispute from: to:	

MEDICAL BENEFITS 2

Amount in dispute? \$	Date submitted to insurer: Year Month Day	Date denied: Year Month Day
	Name of service provider(s):	
	Time period in dispute from: to:	

MEDICAL BENEFITS 3

Amount in dispute? \$	Date submitted to insurer: Year Month Day	Date denied: Year Month Day
	Name of service provider(s):	
	Time period in dispute from: to:	

MEDICAL BENEFITS 4

Amount in dispute? \$	Date submitted to insurer: Year Month Day	Date denied: Year Month Day
	Name of service provider(s):	
	Time period in dispute from: to:	

REHABILITATION BENEFITS 1

Amount in dispute? \$	Date submitted to insurer: Year Month Day	Date denied: Year Month Day
	Name of service provider(s):	
	Type of service(s):	
	Time period in dispute from: to:	

REHABILITATION BENEFITS 2

Amount in dispute? \$	Date submitted to insurer: Year Month Day	Date denied: Year Month Day
	Name of service provider(s):	
	Time period in dispute from: to:	

REHABILITATION BENEFITS 3

Amount in dispute? \$	Date submitted to insurer: Year Month Day	Date denied: Year Month Day
	Name of service provider(s):	
	Time period in dispute from: to:	

CASE MANAGER SERVICES BENEFITS

Amount in dispute? \$	Date submitted to insurer: Year Month Day	Date denied: Year Month Day
	Name of service provider(s):	
	Time period in dispute from: to:	

Section 2 continued

OTHER EXPENSES

<p>A <input type="checkbox"/> lost educational expenses</p> <p>Amount in dispute? \$ _____</p>	<p>A Date submitted to insurer: Year Month Day Date denied: Year Month Day</p> <p>Detail of expenses:</p> <p>Time period in dispute from: _____ to: _____</p>
<p>B <input type="checkbox"/> expenses of visitors</p> <p>Amount in dispute? \$ _____</p>	<p>B Date submitted to insurer: Year Month Day Date denied: Year Month Day</p> <p>Detail of expenses:</p> <p>Time period in dispute from: _____ to: _____</p>
<p>C <input type="checkbox"/> damage to clothing, glasses, etc.</p> <p>Amount in dispute? \$ _____</p>	<p>C Date submitted to insurer: Year Month Day Date denied: Year Month Day</p> <p>Detail of expenses:</p> <p>Date of replacement expenses: _____</p>
<p>D <input type="checkbox"/> housekeeping and home maintenance</p> <p>Amount in dispute? \$ _____</p>	<p>D Date submitted to insurer: Year Month Day Date denied: Year Month Day</p> <p>Time period in dispute from: _____ to: _____</p> <p>Name of service provider(s): _____</p>
<p>E <input type="checkbox"/> cost of examinations</p> <p>Amount in dispute? \$ _____</p>	<p>E Date submitted to insurer: Year Month Day Date denied: Year Month Day</p> <p>Date of examination or report: _____</p> <p>Type of examination(s): _____</p> <p>Examination(s) provided by: _____</p>
<p>E <input type="checkbox"/> cost of examinations</p> <p>Amount in dispute? \$ _____</p>	<p>E Date submitted to insurer: Year Month Day Date denied: Year Month Day</p> <p>Date of examination or report: _____</p> <p>Type of examination(s): _____</p> <p>Examination(s) provided by: _____</p>
<p>E <input type="checkbox"/> cost of examinations</p> <p>Amount in dispute? \$ _____</p>	<p>E Date submitted to insurer: Year Month Day Date denied: Year Month Day</p> <p>Date of examination or report: _____</p> <p>Type of examination(s): _____</p> <p>Examination(s) provided by: _____</p>

DEATH BENEFITS

<p>Amount in dispute? \$ _____</p>	<p>Date submitted to insurer: Year Month Day Date denied: Year Month Day</p> <p>Name of deceased: _____</p> <p>Relationship of deceased to claimant: _____</p>
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FUNERAL EXPENSES

<p>Amount in dispute? \$ _____</p>	<p>Date submitted to insurer: Year Month Day Date denied: Year Month Day</p> <p>Name of deceased: _____</p> <p>Relationship of deceased to claimant: _____</p>
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OTHER DISPUTES

<p>Amount in dispute? \$ _____</p>	<p>Date submitted to insurer: Year Month Day Date denied: Year Month Day</p> <p>Detail of expenses:</p> <p>Time period in dispute from: _____ to: _____</p>
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INTEREST

<p>Amount in dispute? Set out calculations. \$ _____</p>	
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Section 3 Document List This section MUST be completed (Attach extra sheets if necessary)

It is expected that both parties have exchanged key documents prior to filing this Application for Mediation.

Documents - 1. List key documents in your possession which you will refer to in the mediation.

Extra sheets attached

Documents - 2. List key documents not currently in your possession which you intend to get from other sources.

Extra sheets attached

Personal information requested on this form is collected under the authority of the Insurance Act, R.S.O. 1990, c.1.8 as amended. This information, including documents submitted with this application, will be used in the dispute resolution process for accident benefits.

Signature and Certification

I certify that all information in this Application and attachments is true and complete. I authorize the insurance company to release all medical reports and information relating to the issues in dispute to Mediation Services, Dispute Resolution Services, Financial Services Commission of Ontario. I realize that information filed with this Application may be given to the other party in this dispute.

Claimant name (please print)	Claimant Signature	Date Year Month Day
Representative name (please print)	Representative Signature	Date Year Month Day

If your representative is not a lawyer or a non-lawyer employed by a lawyer or law firm and supervised by a lawyer, the claimant must certify that the representative has full authority to discuss all issues in dispute, to negotiate and to enter into an agreement or settlement of any and all issues in dispute, on your behalf in connection with this Application.

I certify that my representative has full authorization as described above:

Claimant Signature	Date Year Month Day
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Send the **original and one copy** of the **completed** application to Mediation Services at the address noted below. Keep an additional copy of the completed application for yourself.

**Mediation Services
Dispute Resolution Services
Financial Services Commission of Ontario
5160 Yonge Street, 14th Floor, Box 85
Toronto, ON M2N 6L9**

If you have any questions about this application, or want more information, contact:

Mediation Hotline In Toronto at: 416-590-7210 or Toll Free: 1-800-517-2332, ext. 7210 Fax: 416-590-7077
FSCO website: www.fSCO.gov.on.ca