

Section 1 continued

INSURANCE COMPANY

Company name

Claim representative name

Claim number

Policyholder name

Policy number

NEUTRAL EVALUATION

Do you want Neutral Evaluation through the Commission?

No

Yes

If Yes,

1. do you have the consent of the insurance company? No Yes

Yes

2. do you certify that all documents or reports listed in the Report of Mediator have been exchanged and that no other documents are required for the purpose of evaluating the issues in dispute? ▼

Yes **Signature ►**

ARBITRATION HEARING

1. Do you want to have an oral arbitration hearing? No Yes

2. Do you want the arbitration hearing to be conducted in French?

No

Yes

3. Will you require the services of an interpreter at the arbitration hearing?

No

Yes

If Yes, what language? ►

4. Do you require other special services such as wheelchair access or sign language interpreter?

No

Yes

If Yes, describe? ►

5. Do you want the hearing to be outside the Greater Metropolitan Toronto Area?

No

Yes

If Yes, where? ►

Section 2 ISSUES IN DISPUTE

Check the benefits that were not resolved in mediation and which you now want arbitrated.

You cannot add new issues at this stage until they have been mediated.

For each benefit claimed, briefly explain the details, adding extra sheets or a Schedule if necessary.

WEEKLY BENEFITS

Which weekly benefit are you disputing?

income replacement

non-earner

amount

Year Month Day
From:

Year Month Day
To:

CAREGIVER BENEFITS

Weekly amount in dispute?

\$

Year Month Day
From:

Year Month Day
To:

ATTENDANT CARE BENEFITS

Weekly amount in dispute?

\$

Year Month Day
From:

Year Month Day
To:

Section 2 continued

<input type="checkbox"/> MEDICAL BENEFITS 1			Year	Month	Day
Amount	Date of Treatment Plan:				
\$					
Does this claim involve catastrophic impairment?	Type of service(s) provided:				
<input type="checkbox"/> No <input type="checkbox"/> Yes					
<input type="checkbox"/> MEDICAL BENEFITS 2			Year	Month	Day
Amount in dispute?	Date of Treatment Plan:				
\$					
	Type of service(s) provided:				
<input type="checkbox"/> MEDICAL BENEFITS 3			Year	Month	Day
Amount in dispute?	Date of Treatment Plan:				
\$					
	Type of service(s) provided:				
<input type="checkbox"/> MEDICAL BENEFITS 4			Year	Month	Day
Amount in dispute?	Date of Treatment Plan:				
\$					
	Type of service(s) provided:				
<input type="checkbox"/> REHABILITATION BENEFITS 1			Year	Month	Day
Amount in dispute?	Date of Treatment Plan:				
\$					
	Type of service(s) provided:				
<input type="checkbox"/> REHABILITATION BENEFITS 2			Year	Month	Day
Amount in dispute?	Date of Treatment Plan:				
\$					
	Type of service(s) provided:				
<input type="checkbox"/> REHABILITATION BENEFITS 3			Year	Month	Day
Amount in dispute?	Date of Treatment Plan:				
\$					
	Type of service(s) provided:				
<input type="checkbox"/> CASE MANAGER SERVICES BENEFITS					
Amount in dispute?	Name of service provider(s):				
\$					
from : to:	Year Month Day		Year Month Day		
	Service(s) provided from:		to:		

Section 2 continued

For each benefit claimed, briefly explain the details. *(Attach extra sheets if necessary.)* ▼

<input type="checkbox"/> OTHER EXPENSES	
What is being disputed? <input type="checkbox"/> lost educational expenses <input type="checkbox"/> expenses of visitors <input type="checkbox"/> damage to clothing, glasses, etc.	Amount in dispute? \$ _____
<input type="checkbox"/> housekeeping and home maintenance Total Amount in dispute? \$ _____	Weekly amount in dispute: _____ Year _____ Month _____ Day to: _____ Year _____ Month _____ Day Service(s) provided from: _____ to: _____ Name of service provider(s): _____
<input type="checkbox"/> cost of examinations Amount in dispute? \$ _____	Date of examination or report: _____ Year _____ Month _____ Day Type of examination(s): _____ Examination(s) provided by: _____
Amount in dispute? \$ _____	Date of examination or report: _____ Year _____ Month _____ Day Type of examination(s): _____ Examination(s) provided by: _____
Amount in dispute? \$ _____	Date of examination or report: _____ Year _____ Month _____ Day Type of examination(s): _____ Examination(s) provided by: _____
<input type="checkbox"/> DEATH BENEFITS	
Amount claimed? \$ _____	
<input type="checkbox"/> FUNERAL EXPENSES	
Amount claimed? \$ _____	
<input type="checkbox"/> OTHER DISPUTES	
Amount claimed? \$ _____	
<input type="checkbox"/> INTEREST	
_____ _____ _____	
<input type="checkbox"/> EXPENSES OF THE HEARING	
_____ _____ _____	
<input type="checkbox"/> SPECIAL AWARD -PROVIDE PARTICULARS	
_____ _____ _____	

Section 3 Document List**This section MUST be completed**

(Attach extra sheets if necessary)

It is expected that the Applicant and the Insurer have exchanged key documents prior to the filing of an Application for Arbitration.

Documents -1. List key documents in your possession to which you will refer in the arbitration.
Identify the type of document (letter, medical report, tax return), the name of the writer or issuing institution and the date of the document.

Extra sheets attached

Documents -2. List key documents not currently in your possession, which you intend to get from other sources (such as employers, doctors, Revenue Canada) for use in the arbitration. You should also include any documents requested from the other party (such as surveillance evidence, a summary of benefits paid) which have not yet been provided. *Wherever possible, identify the type of document (letter, medical report, tax return), the name of the writer or issuing institution and the date of the document.*

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 Arbitration 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.

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

Send the **original and one copy** of the **completed** application to Arbitration Services at the address noted below. Keep an additional copy of the completed application for yourself.

**Arbitration 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:

Arbitration Hotline In Toronto at: 416-590-7202 or Toll Free: 1-800-517-2332, ext. 7202 Fax: 416-590-8462

FSCO website: www.fsco.gov.on.ca