Return form to*

For insurance companies: Add your contact and return instructions

Application for Accident Benefits (OCF-1)

Claim Number

Policy Number

Date of Accident (yyyy/mm/dd)

Fill out this form if you are applying for benefits as a result of an automobile accident, and you haven't applied for benefits related to this incident before. You need to tell your insurance company within 7 days of your accident you plan to apply for benefits. If you can't do that within 7 days, let your insurance company know as soon as possible.

This Application for Accident Benefits form must be returned within 30 days after receipt. If you are unable to return it within 30 days, submit it to your insurance company and explain reason for the delay. Return the original form to the insurance company and make a copy for your records. If you require more information about the claims process, please visit FSRA's webpage.

Part 1 - Applicant Information

First Name	Last Name	Date of Birth (yyyy/mm/dd)	Driver's Licence Number

Address

Unit Number	Street Number	Street Name	City

Province	Postal Code	Phone Number	E-mail Address

Gender	Languages Used

Marital Status

◯ Separated ◯ Common-Law ◯ Married ◯ Single ◯ Divorced ◯ Widow(er)

If offered by your insurer, do you consent to the use of electronic communication? ◯ Yes ◯ No

Note: Your insurer may not offer electronic communication

Part 2 - Policy Details

What is your relationship to the policyholder? (Select all that apply)

☐ I am the Policyholder
☐ Spouse of Policyholder
☐ Listed Driver
☐ Employee of the Policyholder
☐ A vehicle you rented or leased for more than 30 days
☐ Dependent of the Policyholder or the Policyholder's spouse
☐ I have no relationship to the Policyholder

Are you aware of any coverage under any other automobile policies that would apply to you?

◯ Yes ◯ No ◯ I don't know

If yes, list insurer(s) and policy number(s)

How were you involved in the accident?

◯ Driver of Vehicle Insured under this Policy ◯ Passenger of Vehicle Insured under this Policy

◯ Pedestrian or Cyclist ◯ Driver or Passenger of a vehicle not insured under this Policy

◯ Other, please provide details

Part 3 - Accident Details

Location of the Accident (Intersection, City, Province/State)	Date (yyyy/mm/dd) and Time of Accident ◯ AM ◯ PM

Give a brief description of the accident. Describe all injuries sustained as a result of the accident.

Select all that apply

☐ Went to collision reporting centre ☐ Police attended ☐ Ambulance attended ☐ Went to the hospital

☐ Went to doctor/nurse practitioner/other Regulated Healthcare Provider (e.g., Physiotherapist, Chiropractor etc.)

If you have additional information such as a police report, medical report please include with this form or send once received.

Were you charged?

◯ Yes ◯ No If yes, list charge:

Did the accident happen while you were working? ◯ Yes ◯ No

Did the accident happen while you were travelling to and/or from work? ◯ Yes ◯ No

Part 4 - Applicant Status

At the time of the accident were you engaged in any of the following (Select all that apply)

Working ☐ Full-Time ☐ Part-Time ☐ Self-Employed

Not Currently Working ☐ Unemployed ☐ Receiving Employment Insurance ☐ Retired ☐ Student ☐ Caregiver ☐ Worked 26 weeks in the past 52 weeks ☐ Receiving Workplace Safety and Insurance Board Benefits

Select Yes, No or Not Applicable (N/A) for each of the following

I have missed time from pre-accident activities as a result of the accident	◯ Yes	◯ No	◯ N/A	Date returned to pre-accident activities (yyyy/mm/dd)	
I have missed time from work as a result of the accident	◯ Yes	◯ No	◯ N/A	Date returned to work (yyyy/mm/dd)	
I have missed time from school as a result of the accident	◯ Yes	◯ No	◯ N/A	Date returned to school (yyyy/mm/dd)	

Part 5 - Other Insurance

Do you, your spouse or anyone you are dependent on have any other benefit plan that covers you (e.g. group benefits, extended health coverage, etc.)? ◯ Yes ◯ No

Name of benefit companies and policy number(s)

Type of Coverage (Select all that apply)

☐ Medical ☐ Dental ☐ Short Term Disability ☐ Long Term Disability ☐ Other

Part 6 - Authorization for Insurance to Directly Pay Service Provider

(Only applicable to applicants obtaining treatment/service from a licensed service provider)

☐ I direct the insurer, including the Motor Vehicle Accident Claims Fund, to pay the licensed service provider directly for that portion of the approved goods and services specified in separate forms,Treatment Confirmation Form (OCF-23) and Treatment and Assessment Plan (OCF-18), that are not covered by extended/supplementary health insurance.

Applicants that have extended/supplementary health insurance responding to a claim may need to provide payment out of pocket before the extended/ supplementary health insurer reimburses the claimant.

Initials of Applicant or Substitute Decision Maker

Part 7- Motor Vehicle Accident Claims Fund

The insurer that first receives your completed application for accident benefits is responsible for paying you the benefits to which you are entitled without delay. If you have not applied to the correct insurer your benefits will not be affected. It is the responsibility of the insurer to take the necessary steps to get the correct insurance company to respond to your claim. You should apply to the Motor Vehicle Accident Claims Fund **only if no other insurance is available**.

You and your substitute decision maker 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) at 222 Jarvis St., 7th Floor, Toronto, ON M7A 0B6. If you have any questions about your MVACF application contact: MVACF in Toronto at (416) 250-1422 or Toll Free at 1-(800) 268-7188.

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 Motor Vehicle Accident Claims Fund)

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 MVACF.

Name of Applicant or Substitute Decision Maker	Signature of Applicant or Substitute Decision Maker	Date Signed (yyyy/mm/dd)

To the insurer to whom this application is being submitted

I UNDERSTAND that you, and persons acting for you, will collect 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 you and persons acting for you will collect information about my driving record, automobile insurance policy history and automobile insurance claims history if they exist.

I ALSO UNDERSTAND that if I am the holder of an automobile insurance policy, you, and persons acting for you, will collect the driving record, automobile insurance policy history and automobile insurance claims history of any listed drivers on my automobile insurance policy or other drivers whom I have permitted to drive my automobile.

I ALSO UNDERSTAND that the information described above 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 provider;
- Preventing, detecting and suppressing 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 or organizations, who may collect and use this information only as reasonably necessary to enable you or them 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; fraud prevention organizations; other insurance companies; the police; databases or registers used by the insurance industry to analyze and check information provided against existing information; and my agents or representatives as designated by me from time to time.

I ALSO UNDERSTAND that you, and persons acting for you, may pool this information with information from other sources and may analyze this information for the limited purpose of preventing, detecting or suppressing fraud.

I CONSENT and, if I am the holder of an automobile insurance policy, declare that I have obtained consent from the listed drivers on my policy and any other drivers whom I have permitted to drive my automobile, 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 Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.

To obtain further information about how your consent relates to pooling and data analytics to prevent and detect fraud please visit: Insurance Bureau of Canada

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 $250,000 for the first offence and a maximum fine of $500,000 for any subsequent conviction.

It is an offence under the 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 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 14 years imprisonment for fraud involving an amount over $5,000 or otherwise a maximum of 2 years imprisonment.

Name of Applicant or Substitute Decision Maker	Signature of Applicant or Substitute Decision Maker	Date Signed (yyyy/mm/dd)

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