

Claim for Disability Benefits

Form AB-1A

For accidents that occur on or after October 1, 2004

Send this form to the appropriate insurer:

Fax # (____) _____ - _____

To be completed by Claimant / Representative or a Medical Doctor	
Insurance Company	
Policy Number	
Date of Accident: (DD-MM-YYYY)	

Part 1 - Claimant Information

Last Name		First Name		Middle Name(s)	
Address					
City, Town or County			Province		Postal Code
Telephone Number (Home) (Include area code)		Telephone Number (Work) (Include area code)		Fax Number (Include area code)	
Date Of Birth (DD/MM/YYYY)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female				

Part 2 - Claim for Disability Benefits (To be completed by Claimant or Agent)

Are you claiming disability income benefits under the Automobile Accident Insurance Benefits Regulation?

Yes
 No

If Yes, please complete the remainder of this part of the form. Your insurance claims adjuster may request additional information from you or your medical practitioner at a later date to assist with the claims process. If No, then please do not complete or submit this form at this time.

Were you employed on the date of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date first unable to work (DD/MM/YYYY)
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Between what dates are you claiming a Loss of Income?
To _____

History of Employment during the 12 months preceding the accident			
Name of employer: Address:		Name of employer: Address:	
From:	To:	From:	To:
Occupation:		Occupation:	

If you were unemployed at the date of the accident, for how much of the 12 months preceding the accident were you employed and working?

Average gross weekly income
\$ _____

Are you entitled to disability or other income benefits from your employer or any other source as a result of this accident?
 Yes
 No

If yes, from whom?

Name	Amount	Per Wk/Month
1.		
2.		
3.		

- I am the claimant
 I am the authorized representative of the claimant

I certify that the information provided is true and correct to the best of my knowledge. I confirm that I have consented to the collection, use and disclosure of my personal information for the determination of my eligibility for accident and/or disability income benefits as outlined on form **AB-1**.

Name (Please Print) _____

Signature _____ Date _____

Part 3 – Information of Medical Doctor (To be completed by Medical Doctor)

Name of Professional		Profession
Address		
City, Town or County	Province	Postal Code
Administrative Contact Name	Facility Name	
Telephone Number (Include area code)	Fax Number (Include area code)	

Part 4 – Signature of Medical Doctor for Disability Benefits Claim

To the best of my knowledge, the claimant is totally disabled (unable to work)
 From _____ 20____ to _____ 20____ inclusive.
 If still disabled give approximate date patient should be able to return to work, _____ 20____.

Name (printed) _____

Signature _____ Date _____