You will need Acrobat Reader 6.0 or higher in order to complete this form online.

Important Notice About Your Personal Information

Claim for Disability Benefits

Form AB-1A

For accidents that occur on or after **October 1, 2004**

Print

Send this form to the appropriate insurer:	To be completed by Claimant / Representative or a Medical Doctor	
Fax # (____)_____-_____	**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 ☐ Male ☐ 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?	Date first unable to work *(DD/MM/YYYY)*
☐ Yes ☐ No	

Between what dates are you claiming a Loss of Income?

To

History of Employment during the 12 months preceding the accident

Name of employer:	Name of employer:
Address:	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_____

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