AUTOMOBILE ACCIDENT BENEFITS PROOF OF CLAIM FORM

(For use in Quebec with Q.E.F. 34 & 78, not for use in Ontario. Ontario has regulated AB forms.)

This claim form to be completed by the Claimant and his/her Doctor and should be returned immediately to the Insurance Company.

THIS SIDE TO BE COMPLETED BY CLAIMANT ONLY. **CLAIM NO. .....**

I, ..., residing at .....

Telephone .....Do hereby make claim under Policy No. ..... Issued by .....to .....

based on the following:

INJURED PERSON

Name ..... Address .....

Marital Status .....Sex Date of Birth .....

Occupation .....Length of Employment .....

Weekly Earnings .....Employer's Name .....

Employer's Address .....Telephone .....

Were you in the course of your employment when the accident occurred? .....

Are you covered by any Workers' Compensation? .....

Are you covered by any Workers' Compensation Act, the Quebec Crime Victims Compensation Act or by the Quebec Automobile Insurance Act (Regie benefits)? .....

If presently unemployed give history of employment for previous 12 months ....

.....

Are you entitled to Employment Insurance Benefits? .....

Any weekly indemnity coverage or medical expense coverage provided by any other Insurer?(for example, through employment private disability plan etc.) If so, give details:

Name of Insurer	Policy No.	Type	Amount payable weekly
.....			
.....			

INJURIES SUSTAINED

Nature of injuries .....

When did you first receive treatment from a Doctor? ..... When did you first cease to work? .....

When do you expect to return to work? ....

If you have returned to work, when did you do so? ....

Who is your attending Doctor(s)? ....

Address: .....Name of Hospital attended .....

Period of confinement .....

CAR INVOLVED

Make ..... Year Type of Body .....

License No. .....VIN # | | | | | | | | | | | | | | | | |

Owner's Name ..... Owner's Address .....

Date of Birth

Driver's Name ..... | M | D | Y | Driver's Address .....

.....

ACCIDENT DETAILS

Date ..... Time Location .....

Were you in the car described above? .....

Were you a pedestrian when struck by the car described above? ....

.....

Date Claimant's Signature

To Be Completed By Attending Doctor

Please complete this Form in every detail and return it to your patient

PATIENT

Name ..... Age .....

Address..... .....

Date of Auto Accident..... .....

X-RAY

Date taken.....Where taken .....

DESCRIPTION OF INJURY AND TREATMENT

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

Evidence of Prior Injury or disease .....

.....

Is disability solely a result of the above described injury? .....

.....

Date of First Treatment.....Date of Last or Final Treatment.....

PROGNOSIS

(Indicate if the Patient will be left with a permanent disability) .....

.....

.....

.....

To the best of my knowledge, the patient has been 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.....

Address.....

Date..... Signed.....

Any Fee for the above report to be paid by the Claimant