(Date MM DD YYYY)

REGISTERED

Named Insured:
Address:
City, Province, Postal Code:

WITHOUT PREJUDICE

Insured(s):
Claim No:
Date of Loss:
Claimant:
Policy No.:

Dear:

Further to your interest in attending a TDI Preferred Provider Network (PPN) clinic, please find enclosed a PPN Disclosure Notice and Consent form to be signed and dated prior to attending your initial visit.

Please sign and date the enclosed consent form and bring it with you to your scheduled visit.

If you have any questions regarding the attached, please do not hesitate to contact your Accident Benefits Analyst.

Encl: PPN Disclosure Notice and Consent Form

TD Insurance Meloche Monnex

PPN Disclosure Notice and Consent Form

Your insurance policy and the Statutory Accident Benefits Schedule – Accidents on or After September 1, 2010 ("Statutory Accidents Benefits Schedule") includes coverage for medical and rehabilitation benefits. The maximum combined amount paid for medical, rehabilitation and attendant care expenses for non-catastrophic claims is $65,000, with a 5 year time limit. If your impairment is predominantly a minor injury, the maximum amount paid for medical and rehabilitation benefits is $3500 with a five year time limit. If you were under 18 years of age at the time of the accident, the duration of these benefits extends until on you attain 28 years of age for non-catastrophic impairments. If your impairment is catastrophic, the maximum combined amount is $1,000,000 for medical, rehabilitation and attendant care expenses, with no time limits. If you have purchased optional benefits these amounts may be increased.

TD Insurance has developed a Preferred Provider Network Program ("PPN") consisting of a group of health care providers TD Insurance has selected and who deliver program of care to claimants who have sustained certain types of injuries in a motor vehicle accident in accordance with applicable provincial regulations. The PPN allows you prompt access to an accredited health care facility, provides you with support in coordination of treatment with your primary health care practitioner (or family doctor if you have one), support with the completion of claims forms (support will not include the actual filling filing out of the form), including guidance on how to submit claims through any extended health coverage.

The health care providers that are part of TD Insurance PPN have entered into a contract with TD Insurance and have been selected based on their experience. TD Insurance has no financial interest in such health care providers and TD Insurance does not receive remuneration, preferential pricing, bulk discounts or referral fees as a result of you using one of the PPN providers of TD Insurance. The providers under the PPN are paid in accordance with the Professional Fee Guidelines as published by the Financial Services Commission of Ontario, the government body that is responsible for regulating auto insurance in Ontario.

You are also encouraged to benefit from the experience and knowledge of your primary care provider.

YOUR DECISION TO ATTEND A PREFERRED CLINIC IS COMPLETELY VOLUNTARY. YOU ARE FREE TO DECLINE TO ATTEND A PREFERRED CLINIC OR YOU MAY REVOKE YOUR CONSENT TO USE THE SERVICES OF THE PREFERRED HEALTH CARE PROVIDER AT ANY TIME WITHOUT PENALTY OR WITHOUT AFFECTING YOUR ENTITLEMENT TO RECEIVE BENEFITS UNDER YOUR INSURANCE POLICY AND THE STATUTORY ACCIDENT BENEFITS SCHEDULE.

YOU ARE FREE TO CHOOSE THE CLINIC OR HEALTHCARE PROVIDER YOU WANT FOR ASSESSMENTS, EXAMINATIONS OR GOODS OR SERVICES AND DOING SO WILL NOT PREJUDICE OR ADVERSELY AFFECT YOUR ENTITLEMENT TO BENEFITS UNDER YOUR INSURANCE POLICY AND THE STATUTORY ACCIDENT BENEFITS SCHEDULE.

I acknowledge that I have received and read the above Disclosure Notice and Consent Form and have considered whether or not to obtain legal, financial and medical advice. By signing this Disclosure Notice and Consent Form I agree to be referred to health care provider part of TD INSURANCE Preferred Provider Network for the purpose of assessing my need for treatment or goods or services arising as a result of my motor vehicle accident.

_____	_____	_____
Participant's Name	Signature	Date
_____	_____	_____
Witness' Name	Signature	Date

Return this form to:

Permission to Disclose Health Information (OCF-5)

Use this form for accidents that occur on or after January 1, 1994. Collection, use and disclosure of this information is subject to all applicable privacy legislation.

Claim Number:	
Policy Number:	
Date of Accident: (YYYYMMDD)	

Part 1 Applicant Information

Last Name		First Name and Initial		Date of Accident	year month day
Address					
City		Province		Postal Code	
Birth Date	year month day	Home Telephone		Work Telephone	Extension

Part 2 Insurance Company Information

Name of Insurance Company			
Name of Insurance Company Representative			
Address		City	
Province	Postal Code	Telephone Number	FAX Number

Part 3 Treating Health Professional

Name of Health Professional		Health Profession	
Address			
City		Province	Postal Code
Telephone Number		FAX Number	

Part 4 Signature

I authorize my treating health professional to collect, use and disclose to my insurer or to a health professional, social worker, or vocational rehabilitation expert properly appointed by my insurer to conduct an examination, only such information relating to my health condition and treatment received as a result of the automobile accident and any pre-existing or subsequently occurring health conditions that may be a barrier to my recovery as a result of the automobile accident, as is reasonably required for the purpose of providing treatment and determining my eligibility for benefits. This authorization is valid until my claim for Statutory Accident Benefits has been concluded or until I withdraw this consent. (Please note withdrawal of this consent may impact your benefit entitlement).

This authorization does not apply to a consultation between my health care provider and the insurer's health professional conducting an examination. Separate express consent is required for this consultation. This consent should be in writing.

Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)

Accident Benefits Application Package

Use this package to apply for benefits if you were injured in an automobile accident on or after November 1, 1996.

About this Application for Accident Benefits

Please note that all automobile accidents involving bodily injury must be reported to the police. Claims for certain accident benefits must be made within 7 days. Please contact your adjuster for further information.

There are five forms in this package:

- **Application for Accident Benefits (OCF-1)**

  Fill out this form when you are applying for benefits **for the first time** as a result of an accident, including if you are injured and are applying for income replacement benefits. You may be eligible for weekly benefits even if you were unemployed or retired at the time of the accident.

  This Application for Accident Benefits form must be returned within 30 days after receiving the package. If you are unable to return it within 30 days, submit it to your insurance company anyway and explain why you were not able to complete it within 30 days. Return the original form to the insurance company and make a copy for your records.

- **Employer's Confirmation of Income (OCF-2)**

  If the insurance company asks you to, please give this form to your employer. This form is completed by you or your representative and by your employer. If you had more than one employer during the past 52 weeks, it is necessary for each employer to complete a separate form. Your insurance company may ask for other proof of income.

- **Disability Certificate (OCF-3)**

  If the insurance company asks you to, please fill out the first section and give this form to your health practitioner (chiropractor, dentist, occupational therapist, nurse practitioner, optometrist, physician, physiotherapist, speech-language pathologist or psychologist). This form is completed by you or your representative and by your health practitioner.

- **Permission to Disclose Health Information (OCF-5)**

  If the insurance company asks you to, please complete this form. The insurance company requires your medical information in order to correctly determine your eligibility for benefits. Health professionals require your written permission to disclose this information to the insurance company.

- **Treatment Confirmation Form (OCF-23)**

  This form must be completed to confirm treatment received under the Minor Injury Guideline for accidents that occurred on or after September 1, 2010. There are exceptions. Please contact your insurance company to find out if this form is required.

After the insurance company reviews your complete application package, you will be contacted about the benefits you are entitled to receive. If your insurance company needs any additional information in order to process your application, they will contact you.

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 federal 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 federal 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.

Where do I send the Application Forms?

Please follow the instructions below.

1. If You Own, Lease, or Have Regular Use of a Company Automobile

As of the date of the accident did you, your spouse or someone you are dependent on (please check all the options that apply to you):

- ☐ Own an automobile?
- ☐ Lease or have a contract to rent an automobile for more than 30 days?
- ☐ Drive a company automobile which was made available for your regular use?

☐ Yes - If you checked only one, send the forms to the insurance company that insures this automobile.

☐ Yes - If you checked more than one, send the forms to the insurance company of the vehicle in which you were an occupant at the time of the accident.

☐ Yes - If you checked more than one and were not an occupant in either of the automobiles, send the forms to the insurer of either vehicle (you choose).

☐ No - If none apply, continue to 2.

2. If You are a Listed Driver

Are you listed as a driver on somebody's insurance policy?

☐ Yes - If yes, send your forms to the insurance company that issued the policy you are listed on.

☐ No - If no, continue to 3.

The following categories only apply if:

- You, your spouse or someone you are dependent upon **does not own, lease, or regularly use a company** automobile.
- You are **not listed** as a driver on a policy.

3. Occupant of Somebody Else's Automobile

Were you an occupant of somebody else's automobile that was insured at the time of the accident?

☐ Yes - If yes, send your forms to the insurance company that insures this automobile.

☐ No - If no, continue to 4.

4. Pedestrian or Bicyclist

Were you a pedestrian or a bicyclist struck by an automobile that was insured at the time of the accident?

☐ Yes - If yes, send your forms to the insurance company of the automobile that struck you.

☐ No - If no, continue to 5.

5. Uninsured Automobile

Were you an occupant of an automobile that was not insured at the time of the accident?

☐ Yes - If yes, send your forms to the insurance company of any other automobile that was involved in the accident.

☐ No - If no, continue to 6.

6. None of the Above Apply

If you do not have automobile insurance and no other automobile involved in the accident has automobile insurance or can be identified, you may be entitled to accident benefits from the Motor Vehicle Accident Claims Fund. Please complete the entire application package and see Part 10.

Return this form to:

Application for Accident Benefits (OCF-1)

Use this form for accidents that occur on or after November 1, 1996.

Claim Number:	
Policy Number:	
Date of Accident: (YYYYMMDD)	

A separate form must be completed for each person who is applying for accident benefits. Completion of ALL sections is mandatory. **Your application may be denied if information is incomplete or incorrect. Please print clearly.**

Part 1 Applicant Information

Last Name	First Name and Initial	Gender ☐ Male ☐ Female	**Marital Status** ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Common-law ☐ Widow(er)
Driver's Licence Number		Birth Date Year Month Day	
Address			**Is anyone dependent on you for financial support or care?** ☐ Yes, how many persons? ☐ No
City	Province	Postal Code	
Home Telephone	Work Telephone	Fax Number	
You can be reached: ☐ by telephone ☐ at home ☐ by personal visit ☐ at work ☐ other	Language Spoken: / E-mail:	**What is the best time to reach you:** Day(s) of the week / Time of day ☐ a.m. ☐ p.m.	

Part 2 Applicant's Representative (if applicable)

Complete this section only if the applicant injured in the accident is deceased, is a minor, is unable to fill out the form on their own, or has retained you as their representative.

Last Name / First Name and Initial		**Relationship with applicant** ☐ Parent ☐ Guardian ☐ Lawyer ☐ Other ☐ Other Paid Representative
Address		
City	Province	Postal Code
Work Telephone	Fax Number	E-mail:

Part 3 Accident Details and Health Information

Date of Accident	Year Month Day	Time of Accident	☐ a.m. ☐ p.m.	You were a:	☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other
Accident Location: Hwy. No./Street Name		City		Province	

Did the accident occur while you were at work?	☐ Yes	☐ No
Did you file a claim with the Workplace Safety and Insurance Board?	☐ Yes	☐ No
Was the accident reported to the police?	☐ Yes (Give details below)	☐ No

Officer Name	Badge No.	Date accident reported to the police	Year Month Day
Police Department/Collision Reporting Centre			
Were you charged? ☐ No ☐ Yes (Give details)			

Give a brief description of the accident. If you suffered any injuries as a result of the accident, describe the cause and extent of the injuries.

Were you able to return to your normal activities following the accident?	☐ Yes	☐ No
Did you go to the hospital?	☐ Yes (Give details)	☐ No
Did you go to see a health professional? (for example: physician, chiropractor, physiotherapist?)	☐ Yes (Give details)	☐ No

☐ Additional sheets attached

Part 3 Accident Details and Health Information (cont'd)

Name of Health Professional	Name of Facility	
Address		
City	Province	Postal Code

Has this Health Professional begun any treatment? ☐ Yes (provide details) ☐ No

☐ Additional sheets attached

Part 4 Details of Automobile Insurance

In order to determine which automobile insurer is responsible for paying benefits, it is necessary to know whether you have your own policy or whether you are covered by somebody else's insurance policy. To help make that determination, please complete the following:

A Are you covered under any of the following automobile insurance policies?

Your own policy	☐ Yes	☐ No
Your spouse's policy	☐ Yes	☐ No
The policy of any person on whom you are dependent (e.g., a parent)	☐ Yes	☐ No
A policy that lists you as a driver (e.g., a friend)	☐ Yes	☐ No
Your employer's policy (e.g., company car) or spouse's employer's policy	☐ Yes	☐ No
A policy insuring long-term rental cars (for rentals exceeding 30 days)	☐ Yes	☐ No

If you answered **"No"** to **all** of the above, go to **B**. If you answered **"Yes"** to **any** of the above, complete the following:

Name of Policyholder	
Insurance Company	Policy Number
Automobile – Make, Model, Year	Licence Plate Number
Were you an occupant of this automobile at the time of the accident? ☐ Yes ☐ No	

If you answered **"Yes"** to more than one box in this part, provide additional insurance details below.

Name of Policyholder	
Insurance Company	Policy Number
Automobile – Make, Model, Year	Licence Plate Number
Were you an occupant of this automobile at the time of the accident? ☐ Yes ☐ No	

B If you checked "**No**" to all of the boxes in **A** **you must send** your application to the insurer of the automobile that you occupied at the time of the accident, or the vehicle that struck you if you were a pedestrian or bicyclist. If this automobile was not insured or was unidentified, describe any other vehicle involved in the accident. **Provide details below.**

The policy you are claiming under insures:

- ☐ The vehicle I was riding in at the time of the accident
- ☐ The vehicle that struck me as a pedestrian/bicyclist
- ☐ Another vehicle that was involved in the accident

Vehicle type covered by this policy:

- ☐ Passenger
- ☐ Motorcycle
- ☐ Taxi/Limousine
- ☐ Other _____
- ☐ Truck
- ☐ Bus
- ☐ Snowmobile

Owner of the Vehicle		Home Telephone
Address		Work Telephone
City	Province	Postal Code
Automobile – Make, Model, Year	Licence Plate Number	
Insurance Company	Policy Number	
Name of Policyholder	Driver's Licence Number	
Did you report the accident to any other insurance company?	☐ Yes (provide details)	☐ No
Insurance Company	Type of Insurance	

Part 5 Applicant Status

Which of the following describes your status at the time of the accident?

Employed	**Not Employed**	
☐ Employed and working	☐ Unemployed	☐ **Student or recent graduate**
☐ Self-Employed	☐ Unemployed **and,**	
	☐ have worked 26 weeks in the past 52 weeks	
	☐ receiving Employment Insurance Benefits	
	☐ Retired	☐ **Caregiver**

Part 6 Student Attending School

Were you attending school on a full-time basis at the time of accident or had you completed your education less than one year before the accident?

☐ Yes (Give details below) ☐ No (Continue to Part 7)

Name of School			Date Last Attended	Year Month Day
Address			Program and Level	
City	Province	Postal Code	Projected Date for Completion of Studies	Year Month Day

Are you now attending school? ☐ Yes (Enter date) Year Month Day ☐ No

Were you able to return to school after the accident? ☐ Yes (Enter date) Year Month Day ☐ No

Part 7 Caregiver

Were you the main caregiver to people living with you, at the time of the accident?

☐ Yes (Complete information below) ☐ No (Continue to part 8)

Were you paid to provide care to these people? ☐ Yes (Continue to part 8) ☐ No

List the people who you were caring for at the time of the accident

Name	Date of Birth Year Month Day	Disabled Yes	No
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

☐ Additional sheets attached

Did your injuries prevent you from performing the caregiving activities you did prior to the accident?

☐ Yes (Explain below) From what date? Year Month Day ☐ No

Explanation:

☐ Additional sheets attached

At any period since the accident, were you able to return to caregiving?

☐ Yes (From what date?) Year Month Day ☐ No

Part 8 Income Replacement Determination

Give details of your employment for the past 52 weeks. Start with your current or most recent employer. If you held more than one position with the same employer, use a separate line for each position. Gross income is before taxes and deductions.

If you were self-employed during the 4 weeks prior to the accident, please consider yourself the employer for the purpose of completing this section.

Date Year/Month/Day	Name and Address of Most Recent Employer	Position/Essential Tasks	No. of Hours Per week	Gross Income for the period
From: To:				$
From: To:				$
From: To:				$
From: To:				$

☐ Additional sheets attached

Did your injuries prevent you from working?

☐ Yes (From what date?) Year Month Day _____ ☐ No (Continue to Part 9)

At any period since the accident, were you able to return to work since the accident?

☐ Yes (From what date?) Year Month Day _____ ☐ No

The amount of your benefit is based on your past income. During which of the following periods did you have the highest average weekly income?

☐ Last 4 weeks (not applicable for self-employed persons)

☐ Last 52 weeks

☐ Last fiscal year (self-employed only)

Part 9 Other Insurance or Collateral Payments

Do you, your spouse or anyone you are dependent on (e.g., parents) have any other benefit plan that covers you (e.g., group or private, union, disability, medical or dental, etc.)?

☐ Yes (Give details below) ☐ No

Name of Benefit Payor	Type of Coverage	Policy or Certificate Number

During the past 52 weeks, did you receive any income from a disability plan? ☐ Yes (Enter dates) ☐ No

From: Year Month Day _____ To: Year Month Day _____ Total Amount Received $ _____

Are you receiving Employment Insurance Benefits? ☐ Yes (Enter date) ☐ No

From: Year Month Day _____ To: Year Month Day _____ Total Amount Received $ _____

☐ Additional sheets attached

Are you receiving Social Assistance Benefits (welfare)? ☐ Yes ☐ No

Part 10 Motor Vehicle Accident Claims Fund

DO NOT FILL OUT UNLESS ITEMS (1) TO (5) ON PAGE 2 DO NOT APPLY AND YOU ARE APPLYING TO THE MOTOR VEHICLE ACCIDENT CLAIMS FUND

You and your representative 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 5160 Yonge Street, P.O. Box 85, Toronto, ON M2N 6L9. 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 www.fsco.gov.on.ca)

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 (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)

Part 11 Direct Payment Assignment by Applicant

(only applicable to applicants obtaining treatment/services 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 on any Treatment Confirmation Form (OCF-23) and/or 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.

Applicant Initials

Part 12 Signature

TO THE INSURER, INCLUDING MVACF, 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 providers;
- 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 permited 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 FEDERAL CRIMINAL CODE for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company. This information will be used for processing payments of claims; identifying and analysing the nature, effects and costs of goods and services that are provided to automobile accident victims, by health care providers; and **PREVENTING, DETECTING AND SUPPRESSING FRAUD.**

To obtain further information about how your consent relates to pooling and data analytics to prevent and detect fraud please visit http://www.ibc.ca/en/privacy-terminology.asp

Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)