# ALBERTA ACCIDENT BENEFITS CLAIMS FORMS PACKAGE

***Use this package to claim for benefits if you were injured in an automobile accident on or after October 1, 2004. Please note that all automobile accidents involving bodily injury are required to be reported to the police.***

**There are 4 forms in this package:**

**Notice of Loss & Proof of Claim Form (Form AB-1)**
Fill out this form when you are claiming for benefits **for the first time,** as a result of an accident, including if you are injured and are applying for disability benefits.

- If your injury is diagnosed as a sprain, strain or a whiplash associated disorder (I or II), this form needs to be submitted within 10 days after the date of the accident so that you can access accident benefits described as the "Diagnostic and Treatment Protocols."
- If you have other types of injuries or you choose not to access the accident benefits described as the "Diagnostic and Treatment Protocols" then the form should be submitted within 30 days of the accident.

If you are unable to return the form within these time frames, submit it to your insurance company as soon as practicable and explain the reason for the delay.

**Claim for Disability Benefits (Form AB – 1a)**
If the insurance company asks you to, please fill out the first section (Parts 1, 2 and 3) and give this form to your medical doctor to complete. You may be required to pay the medical doctor for the completion of this form. The insurer is required to reimburse you for this expense.

**Treatment Plan (Form AB – 2) and Confirmation of Services Provided (Form AB – 2a)**
You and/or your primary health care practitioner(s) may claim for planned or incurred services in relation to your injury. Insurance companies require completed Forms 2 and 2a, signed by you and your practitioner, to process the claim.

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## Next Steps:

Make a copy of the form(s) for your records, if desired, and return the original signed form(s) to the insurance company. After the insurance company reviews your completed form(s), 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.

***Important Notice Concerning Your Personal Information***

The personal information you provide in your Accident Claims Benefit Package (i.e. AB-1, AB-1a, AB-2, AB-2a) is collected under the authority of the Insurance Act, Alberta's Automobile Insurance Accident Benefits Regulation, Diagnostic and Treatment Protocols Regulation and all applicable privacy legislation.

- Your primary health care practitioner or dentist will need to collect personal information from you and from other health service providers and will need to use and disclose your personal information to provide you with appropriate diagnosis, treatment and care.
- Your insurance company and its agents will need to collect, use and disclose personal information from you, your primary health care practitioner, and other health service providers concerning the accident, your injuries, any pre-existing conditions that may impede your recovery progress, the amount of treatment and care provided to you, and any assessments of your injuries and indications as to your treatment progress in order to facilitate contact with you, to determine your eligibility for accident and/or disability income benefits, and to administer your claim.

Under applicable privacy legislation, it is necessary to obtain your consent to authorize the sharing of your personal information as specified above. The legislation also regulates how primary health care practitioners, dentists, other health service providers, and insurance companies can use and disclose your information once they have it. Section 3 of form AB-1 will ask for your consent or that of your agent. Refusal to provide your authorization and consent could result in an inability to provide you with the treatment and care you require (if not covered by Alberta Health Care Insurance) and may result in an inability for your insurance company to process your claim, in whole or in part.

Your primary health care practitioner, dentist or other health service provider and insurance company will retain and rely on a copy of your consent for the period of time that your treatment and care is ongoing and your claim is active. You may revoke your consent at any time in writing to your primary health care practitioner or dentist and your insurer or any other person to whom you give consent, subject to continuing legal obligations. If you have any questions concerning the collection, use or disclosure of your personal information, please ask your primary health care practitioner, dentist, or your insurance claims representative or adjuster.

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

**Send this form to the appropriate insurer:**

**Fax # _____**

Important Notice About Your Personal Information

# Notice of Loss & Proof of Claim
## (Form AB-1)

Use this form for accidents that occur on or after October 1, 2004.

| This part is to be completed by your Insurer | |
|---|---|
| **Claim Number:** | |
| **Insurance Company** | |
| **Claim Representative** | |
| **Policy Number:** | |
| **Date of Accident:** (DD MM YYYY) | |

## Section 1: Claimant Information

(This section is to be completed by the injured person (the claimant) or the claimant's authorized representative (agent))

### 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 | You can best be reached: ☐ By telephone ☐ By personal visit ☐ At home ☐ At work ☐ Other |
| When is the best time to reach you? Day(s) of the week | Time of day.: | |
| Insurance Company | Policy Number | |

| | | | |
|---|---|---|---|
| Will this be an Alberta Workers' Compensation Board Claim? ☐ Yes ☐ No | Are Extended Health Care Benefits Available? (e.g., Blue Cross or similar Employee benefits plans) ☐ Yes ☐ No Details: | Have you been diagnosed and treated by another practitioner for this injury? ☐ Yes ☐ No Details: | If you are making a claim for disability benefits, please also complete Form AB- 1b. |

### Part 2 Claimant's Authorized Representative Information

| | | |
|---|---|---|
| Last Name | First Name | Middle Name(s) |
| Address | | |
| City, town or county | Province | Postal Code |
| Relationship with Claimant ☐ Parent ☐ Guardian ☐ Other | Relevant Documentation Attached? If no, please authorize your representative by completing part 7 of this form. ☐ Yes ☐ No ☐ Not Applicable | Authorize your representative |
| Home Telephone Number (Include area code) | Work Telephone Number (Include area code) | Fax Number (Include area code) |

### Part 3 Claimant's Accident Details

(If more space is required please continue on back side of this page)

| | | |
|---|---|---|
| You were a: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other | | |
| Location of Accident | City/Town/Municipality | Province AB |
| Time of Accident: _____ | Was the Accident Reported to the Police? ☐ Yes ☐ No | Date Reported: (DD-MM-YYYY) |
| Brief description of how the accident occurred and how you were injured | | |

## Section 2: Summary of Injury, Diagnosis and Treatment

(This section is to be completed by a Primary Health Care Practitioner (Chiropractor, Physical Therapist or Medical Doctor) or by a Dentist)

**Part 4**

**Information of Primary Health Care Practitioner or Dentist**

| | | | |
|---|---|---|---|
| Name of Primary Health Care Practitioner or Dentist | | | 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 5**

**Injury and Diagnosis**

(To be completed with reference to the Diagnostic and Treatment Protocols Regulation, if applicable)

Location of Examination: ☐ Emergency Department ☐ Primary Health Care Practitioner's Office ☐

Other (please provide details)

Date of Examination: (DDMMYYYY)

### History

**(Please Provide Relevant Details For The Following Questions)**

Describe the mechanism of injury

What are the current symptoms the claimant is experiencing?

Please provide relevant details of the claimant's past history, including physical, psychological, emotional, cognitive and social history.

Is the claimant employed or engaged in training activities?

☐ Full time ☐ Part Time ☐ Self-employed ☐ Retired ☐ Student ☐ Not employed ☐ Unable to work

Normal activities of daily living

Has the Patient/Claimant seen any other Primary Health Care Practitioners or Dentist regarding this injury?

Which health professionals has the claimant seen in the last five years (Name and Date)?

What medications are being taken presently and for what purposes (pl ease describe)?

List any alerting factors (please describe)

How have the claimant's physical functions been affected by the injury?

## Examination

**(Please Provide Details of All Relevant Findings)**

General exam

Neurological exam

Musculoskeletal exam

Pain Assessment and Functional Limitations (e.g., activities of daily living)

Ancillary Investigations

| Diagnosis | ICD-10-CA Injury Code* |
|---|---|
| Sprain<br>1☐ 2☐ 3☐<br>Strain<br>1☐ 2☐ 3☐<br>WAD<br>1☐ 2☐ 3☐ 4☐<br>Other | |

Part 6

**Treatment**

(To be completed with reference to the Diagnostic and Treatment Protocols Regulation)

Treatment Provided

Ongoing Treatment to be provided:

☐ I will continue providing treatment and will not submit a Treatment Plan (Form AB-2).

☐ I will continue providing treatment and submit a Treatment Plan (Form AB-2) with this form (AB-1) at this time.

☐ I will refer the claimant to a different Primary Health Care Practitioner and I <u>will not</u> submit a Treatment Plan (Form AB-2).

☐ Physical Therapist ☐ Chiropractor ☐ Medical Doctor

Name: _____ Phone Number:

Have the claimant and the Primary Health Care Practitioner chosen to follow the *Diagnostic and Treatment Protocols Regulation*?

☐ Yes ☐ No

Do you expect the claimant to return to normal & essential activities?

☐ Yes ☐ Unable to determine ☐ No If yes, Date Expected?

* ICD-10-CA injury codes are only required for Sprains, Strains and WAD injuries. It is recommended, not required, that ICD-10-CA injury codes be used for other injuries when practical.

## Section 3: Certification and Consent to Share Information

**Part 7**

Authority to act on Claimant's behalf

(This section should be completed only when the claimant chooses not to act on his or her own behalf)

I, _____, hereby authorize _____ to act as my representative concerning the treatment and care of my injury, the submission and ongoing handling of my claim for accident and/or disability income benefits and the collection, use and disclosure of information concerning my injury, diagnosis, assessment, treatment or care resulting from the automobile accident referred to in Section 1 of this form.

I authorize my primary health care practitioner(s), dentist(s), other health service provider(s) and my insurance company, _____ and their agents, to collect relevant information concerning me and my accident from my representative as required. I further authorize primary health care practitioner(s), dentist(s), other health service provider(s) and my insurance company to disclose relevant information concerning my injury, diagnosis, assessment, treatment and care and my claim for accident and/or disability income benefits to my representative.

Signature of Claimant _____ Date_____

Signature of Authorized Representative _____ Date_____

**Part 8**

Certification and Consent to Share information

(To be completed by the Claimant or their authorized representative)

I certify that the information provided is true and correct to the best of my knowledge.

I authorize all assessing or treating Primary Health Care Practitioners, dentist(s) or other health service provider(s) to collect, use and disclose any relevant information concerning my injury, including diagnosis, assessment, treatment or care resulting from the automobile accident referred to in Section 1 herein, for the purpose of providing ongoing treatment and care.

I further authorize all assessing or treating Primary Health Care Practitioners, dentist(s) or other health service providers to disclose my personal information to my insurance company,

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and their agents that is relevant for the purpose of determining my eligibility for accident and disability benefits as outlined on Form AB-1 and for the purpose of administering my claim.

I further authorize my insurance company and its agents to collect, use and disclose relevant information concerning my injury, diagnosis, assessment, treatment or care received as a result of the automobile accident referred to in Section 1 herein, including a treatment plan and services provided, for the purpose of determining my eligibility for accident and disability benefits as outlined on Form AB-1 and administering my claim.

☐ I am the claimant or ☐ I am the authorized representative of the claimant

Signature _____ Date_____

**Part 9**

Signature of Primary Health Care Practitioner or Dentist

I certify that the information provided is true and correct to the best of my knowledge.

Signature _____ Date_____

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