

**AUTOMOBILE ACCIDENT BENEFITS PROOF OF CLAIM FORM**

(For use in provinces except Alberta, Ontario, and Nova Scotia; In Quebec, used with Q.E.F. 34 &amp; 4-34)

*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.....

Driver's Name ..... Date of Birth .....  
 | 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.....