Notice of Loss and Proof of Claim

Form AB-1

This form is effective on **November 20, 2004** for accidents that occur on or after **October 1, 2004**

Send this form to the appropriate insurer:
Fax # (____)_____-_____

To be completed by Insurer	
Claim Number	
Insurance Company	
Claim Representative	
Policy Number	
Date of Accident: (DD-MM-YYYY)	

Section 1: Claimant Information

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	You can best be reached:
	☐ Male ☐ Female	☐ By telephone ☐ At home ☐ By personal visit ☐ At work ☐ Other

When is the best time to reach you?	Day(s) of the week:
Insurance Company	Policy Number

Will this be an Alberta Workers' Compensation Board Claim?	Are Extended Health Care Benefits Available? (e.g., Blue Cross or similar Employee benefits plans)
☐ Yes ☐ No	☐ Yes ☐ No Details:

Are you currently employed or engaged in training activities?			If you are making a claim for disability benefits, please also complete Form AB- 1a.
☐ Full Time	☐ Self-employed	☐ Student	
☐ Part Time	☐ Retired	☐ Not employed	

Part 2 – Claimant's Authorized Representative Information (if applicable)

Last Name	First Name	Middle Name(s)
Address		
City, Town or County	Province	Postal Code

Relationship with Claimant	Relevant Documentation Attached? If no, please authorize your representative by completing Part 5 of this form.
☐ Parent ☐ Guardian ☐ Other	☐ Yes ☐ No ☐ Not Applicable

Telephone Number (Home) *(Include area code)*	Telephone Number (Work) *(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 or County	Province

Time of Accident: _____ : _____ ☐ a.m. ☐ p.m.	Date of Accident *(DD/MM/YYYY)*	Was Accident Reported to the Police? ☐ Yes ☐ No	Date Reported *(DD/MM/YYYY)*

Please provide a brief description of how the accident occurred and how you were injured:

Have you seen a Medical Doctor, Physical Therapist, Chiropractor, Dentist or other health service provider for diagnosis, treatment and care for an injury related to this accident?
☐ Yes ☐ No ☐ Appointment booked for:

Have you started treatment?
☐ Yes ☐ No ☐ Appointment booked for:

Are you currently receiving medical or rehabilitation benefits related to another motor vehicle accident?
☐ Yes ☐ No

Please provide a brief description of your injuries and the symptoms that you are currently experiencing:

Part 4 – Information of Health Provider Providing Ongoing Treatment and Care

Name of Primary Health Care Practitioner or Dentist	Profession

Address		

City, Town or County	Province	Postal Code

Telephone Number *(Include area code)*	Fax Number *(Include area code)*

Section 2: Certification and Consent to Share Information

Part 5 – Authority to Act on Claimants Behalf
(this section should be completed only when the claimant chooses not to act on his/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 6 – Certification and Consent to Share Information
(to be completed by 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, _____ 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_____