Return this form to:

Notice of Examination (OCF-25)

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

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

In response to your recent application for accident benefits or catastrophic impairment determination or as part of our review of entitlement to benefits that are currently being paid to you, we will be conducting an examination of you by one or more health professionals or a social worker or a person who has vocational rehabilitation expertise. The information listed below outlines the:

- type of examination that will be conducted;
- reasons for the examination;
- the name, professions and designations of the persons conducting the examination;
- whether your personal attendance is required; and
- the date time and location of the examination.

Within 5 business days of receiving this notice, you are required to provide all reasonably available information and documents that are relevant or necessary for the review of your medical condition prior to your examination to the person or persons conducting the examination identified in Part 4 of this form.

Not participating in an examination may result in the application being rejected or benefits being suspended. A copy of the examination report and determination with respect to the application for accident benefits or your entitlement to ongoing benefits will be sent to you.

Part 1 Claimant Information

Date of Birth (YYYYMMDD)	Age	Gender ☐ Male ☐ Female	Telephone Number	Extension
Last Name	First Name	Middle Name		
Address				
City	Province	Postal Code		
Special Needs (if applicable) ☐ Mobility ☐ Interpreter (Type:) ☐ Other (specify)				
Representative (if applicable)	Address			
City	Province	Postal Code		
Telephone Number	Extension	Fax Number	Email	

Part 2 Type(s) and Reasons for the Examination

Type(s) of Examination

☐ Income Replacement Benefits ☐ Employed ☐ Unemployed ☐ Post-104 Weeks Disability	☐ Non-Earner Benefits ☐ Caregiver Benefits ☐ Medical and Rehabilitation Benefits ☐ Application for Approval of an Assessment	☐ Applicability of Pre-Approved Framework Guideline ☐ Attendant Care ☐ Catastrophic Impairment ☐ Housekeeping and Home Maintenance ☐ Other Benefits

Reasons and Description of the Examination

Part 3
Arrangements for Examination

Arrangements for Examination are: ☐ Listed Below ☐ Will Follow

Part 4
Health Professional(s) Conducting the Examination / Date /Location

Name		Profession or Designation	Speciality
Facility Name			
Address			
City		Province	Postal Code
Contact's Last Name			Contact's First Name
Telephone Number	Extension	Fax Number	Email
Are You Required to Attend the Examination; ☐ Yes		☐ Not Required to Attend – File Review	
If yes, date and time of Examination;			
Location of Examination		☐ At Address Listed Above or at:	

Part 5
Insurance Information

Insurance Company Name		City or Town of Branch Office (if applicable)
Address		
City	Province	Postal Code
Adjuster's Name		
Telephone Number	Fax Number	Email

Part 6
Insurer Signature

If you have any questions or concerns about the examination or conflicts with the examination date or time, please contact your adjuster listed in Part 5.

Name of Insurance Company Representative (please print)	Signature of Insurance Company Representative	Date (YYYYMMDD)