Return this form to:

Explanation of Benefits (OCF-9)

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

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

We have reviewed your application for accident benefits or your ongoing entitlement to benefits. This review has included any information that you or your health care provider has submitted as well as the findings of an examination by a health care provider or providers if one was required by the insurer. This form tells which benefits are approved, the amount payable and any benefits that have not been approved or are ending. If an examination was performed, a copy of the report of examination has been enclosed or has been sent to you separately. **If you disagree with this determination, you have the right to dispute it according to the procedure described in Part 6 on page 3 of this form.**

Part 1 Applicant Information

Last Name	First Name and Initial	
Address		
City	Province	Postal Code

Birth Date	(YYYYMMDD)	Home Telephone	Work Telephone	Extension

Part 2 Income Replacement Non Earner or Caregiver Benefits Payable

Report of Examination:
- ☐ Attached
- ☐ Sent Separately

We have reviewed your application for income replacement benefits and have determined you are:

☐ **A. Eligible**

Calculation

Gross Weekly Income	
Net Income	
80% of Net Weekly Income	
Minus Post-Accident Net Weekly Income/Payments from Other Sources	
Income Replacement Benefit Payable	
Non Earner or Caregiver Benefit Payable	

Details of how we calculated your income replacement benefit, including adjustments for income or payments from other sources.

☐ additional sheets attached

☐ **B. Not Eligible/Stoppage of Benefit**

☐ additional sheets attached

Part 3 Catastrophic Impairment Determination

Report of Examination:
- ☐ Attached
- ☐ Sent Separately

We have reviewed your application for determination of catastrophic impairment and have determined:

☐ You have sustained a catastrophic impairment as a result of the accident

☐ You have not sustained a catastrophic impairment as a result of the accident for the following reasons:

Part 4 Medical and Rehabilitation and Other Benefits

Report of Examination:
- ☐ Attached
- ☐ Sent Separately

Benefit Identification	Benefit Description
MR	Medical and Rehabilitation
AC	Attendant Care Expenses
CM	Case Manager Expenses
LE	Lost Educational Expenses
HH	Housekeeping and Home Maintenance Expenses
RR	Expenses to Repair or Replace Lost or Damaged Clothing, Hearing Aids, etc.
FE	Funeral Expenses
DB	Death Benefits
AE	Assessment or Examination

Item	Details	Amount Claimed	Amount Payable	Interest Payable	Item Not Payable
		$	$	$	☐
		$	$	$	☐
		$	$	$	☐
		$	$	$	☐
		$	$	$	☐
		$	$	$	☐
		$	$	$	☐
		$	$	$	☐
		$	$	$	☐
		$	$	$	☐
		$	$	$	☐
		$	$	$	☐

Reasons why expenses are not payable or being stopped:

☐ additional sheets attached

Part 5 Insurance Company Information

Name of Insurance Company Representative	
Name of Insurance Company	
Telephone Number	FAX Number

Signature of Insurance Company Representative	Date (YYYYMMDD)

Part 6 Applicant's Rights to Dispute

YOUR RIGHT TO DISPUTE THE INSURER'S DETERMINATION OF YOUR CLAIM FOR STATUTORY ACCIDENT BENEFITS

Under the Insurance Act, if your claim for statutory accident benefits has been reduced or denied by your insurer, you have a right to dispute your insurer's determination. There are a numbers of steps you can take to try and resolve the dispute.

STEP 1: NOTIFY YOUR INSURER/FURTHER EXAMINATION

Notify your insurer that you dispute the insurer's decision. You may have the right to a further examination or assessment in respect of the insurer's decision by your health professional or, in certain circumstances, another health professional, paid for by your insurer. Please contact your insurance adjuster, health professional or legal representative for further information about this additional examination.

STEP 2: MEDIATION

If you are unable to resolve your dispute by speaking to your adjuster, you may apply to mediate your dispute through the Financial Services Commission of Ontario (FSCO) within two years of your insurer's refusal to pay, or reduction of a benefit.*

To begin the mediation process, you must complete an application for mediation. The application for mediation can be provided to you by your insurance company, or can be obtained from FSCO's web site at www.fsco.gov.on.ca or by contacting FSCO at:

Dispute Resolution Services
Mediation – Financial Services Commission of Ontario
Box 85, 14th Floor
Toronto, Ontario
M2N 6L9

Toll Free: 1-800-517-2332 ext. 7210
Fax: (416) 590-7077
Mediation Hotline: (416) 590-7210

Once you submit a completed application for mediation, FSCO will appoint a mediator to conduct the mediation. At the end of the mediation, the mediator will issue a written report of mediation indicating whether or not the mediation resolved the issues between you and your insurer.

STEP 3: ARBITRATION, LAWSUIT OR EVALUATION

If mediation does not resolve the dispute, you have the right to:

(i) apply for the appointment of an arbitrator at FSCO, or

(ii) commence a lawsuit in court, or

(iii) if you and your insurer both agree, you may request a neutral evaluation at FSCO before proceeding to arbitrate or commence a lawsuit in court. If you and your insurer proceed to a neutral evaluation, the neutral evaluator will provide an oral opinion on the likely outcome of a proceeding in court or an arbitration and a written report identifying issues evaluated and still in dispute.

However, you CANNOT arbitrate, commence a lawsuit or request a neutral evaluation UNLESS:

(i) you proceeded with mediation, AND

(ii) the mediation failed.

***WARNING: TWO YEAR TIME LIMIT**

You have TWO YEARS from the date of your insurer's refusal to pay, or reduction of a benefit, to arbitrate or commence a lawsuit in court. You may have longer than two years if the arbitration or lawsuit is commenced 90 days from the date the mediator provides his or her mediation report, or within 30 days from the date the neutral evaluator provides his or her report.