

Part 1 – Claimant Information

Last Name		First Name		Middle Name(s)	
Address			City or Town		
Province	Country	Postal Code	Email Address		
Telephone Number (Home)	Telephone Number (Work)	Telephone Number (Cell)	Date of Birth (DD/MM/YYYY)	Gender	
You can best be reached:					
<input type="checkbox"/> at home/cell <input type="checkbox"/> at work <input type="checkbox"/> other (personal visit/email): _____					
When is the best time to reach you? (include days of the week)?			Will this be an Alberta Compensation Board Claim?		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Are Extended Health Care Benefits Available? (e.g., Blue Cross or similar Employee benefits plans)		Provide details (including plan name)			
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Are you currently employed or engaged in training activities?					
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal (provide job and title): _____					
<input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Not Employed					

If you are making a claim for disability benefits, please also complete Form AB0001a.

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

Last Name		First Name		Middle Name(s)	
Mailing Address					
City or Town		Province	Country	Postal Code	
Telephone Number (Home)	Telephone Number (Work)	Telephone Number (Cell)	Fax Number		
Relationship with Claimant					
<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> other: _____					
Relevant Documentation Attached? <i>If no, please authorize your Authorized Representative by completing Part 5 of this form.</i>					
<input type="checkbox"/> Yes <input type="checkbox"/> No					

Part 3 – Claimant's Accident Details (If more space is required please continue on back side of this page)

You were a:		
<input type="checkbox"/> Driver	<input type="checkbox"/> Passenger	<input type="checkbox"/> Pedestrian <input type="checkbox"/> Other : _____
Location of Accident		
City or Town	Province	Country
Date of Accident (DD/MM/YYYY)	Time of Accident : <input type="checkbox"/> a.m <input type="checkbox"/> p.m.	Was the Accident reported to the police? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide a brief description of how the accident occurred and how you were injured:		
Have you seen a Physician, Physical Therapist, Chiropractor, Dentist or other health service provider for diagnosis, treatment and/or care for an injury related to this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Appointment booked for:		
Have you started treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Appointment booked for:		
Are you currently receiving medical or rehabilitation benefits related to another motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> 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	
Mailing Address		
City or Town	Province	Country
Telephone Number	Fax Number	

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, _____, here by authorize _____ to act as my Authorized 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 Parts 1 through 4 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 Authorized Representative as required. I further authorize Primary Health Care Practitioner(s), dentist(s), other health service provider(s) and the 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 Authorized Representative.

Date _____ Signature of Claimant _____

Date _____ Signature of Authorized Representative _____

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 Parts 1 through 4 herein, for the purpose of providing ongoing treatment and care.

I further authorize all assessing or treating Primary Health Care Practitioner(s), dentist(s) or health service provider(s) 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 Parts 1 through 4 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 for the claimant

Signature _____ Date _____

This Section to be Completed by Insurer

Insurance Company		Policy Number
Date of Accident (dd-mm-yyyy) _____	Full Name of Claims Representative	Claim Number

Please forward this form to the Insurance Company.