Return this form to:

# Disability Certificate (OCF-3)

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

| | |
|---|---|
| **Claim Number:** | |
| **Policy Number:** | |
| **Date of Accident:** (YYYYMMDD) | |

**For this applicant, this is Disability Certificate number _____ from this health professional/facility**

Use this form for accidents that occur on or after November 1, 1996. If your insurance company asks you to complete this form, fill out Parts 1 to 3 and give the form to your **health practitioner (chiropractor, dentist, nurse practitioner, occupational therapist, optometrist, physician, physiotherapist, psychologist, speech language pathologist).** After your health practitioner has explained your accident-related injury to you, sign Part 4. Your health practitioner will complete the rest of the form, based on his/her most recent assessment, and return it to the insurance company. Your health practitioner must forward the form to the insurance company within **21** days of your company sending this form to you or within 14 days of your insurance company notifying you that they intend to discontinue your benefits. **Only an authorized health practitioner can complete this form. The health practitioner's opinion will be relied upon by people who review the certificate to make important decisions. Accordingly, it is necessary to be accurate and complete. Please print clearly and provide all information requested. This form may not be materially altered.**

Confidentiality: Collection, use and disclosure of this information is subject to all applicable privacy legislation.

## Part 1 Applicant Information

To be completed by the applicant

| | | |
|---|---|---|
| Date Of Birth (YYYYMMDD) | Gender ❑ Male ❑ Female | Telephone Number Extension |
| Last Name | | |
| First Name | Middle Name | |
| Address | | |
| City | Province | Postal Code |

## Part 2 Insurance Company Information

To be completed by the applicant

| | | |
|---|---|---|
| Name of Insurance Company | | City or Town of Branch Office (if applicable) |
| Name of Insurance Company Representative: | | |
| Adjuster Telephone | | Adjuster Fax |
| Name of policy holder same as: ❑ Applicant OR | Policy Holder Last Name | Policy Holder First Name |

## Part 3 Accident Description

To be completed by the applicant

Give a brief description of the accident and what happened to you. Please describe any injuries you sustained as a direct result of the accident.

❑ additional sheets attached

## Part 4 Applicant Signature

I authorize my treating health professional to collect, use and disclose to my insurer, any information relating to my health condition and treatment received as a result of the automobile accident and any pre-existing or subsequently occurring health conditions that may be barriers to my recovery as a result of the automobile accident, for the purpose of providing treatment and determining my eligibility for benefits. This authorization is valid until my claim for Statutory Accident Benefits has been concluded.
I authorize the health practitioner who completes this form to contact my employer, if this is necessary, to confirm the essential tasks of my employment and the nature and extent of any available work with modified hours or duties.

**TO THE INSURER**:

**I UNDERSTAND** that you, and persons acting for you, will collect and use personal information and personal health information about me that is related to my claims for accident benefits arising out of the accident described in my application.

**I ALSO UNDERSTAND** that this information will be collected, used and disclosed for the purposes of:

- Investigating and processing my claims as required by law, including the Ontario Automobile Policy;
- Obtaining or verifying information relating to my claims in order to determine entitlement and the proper amount of payment;
- Identifying and analyzing the nature, effects and costs of goods and services that are provided to automobile accident victims by health care providers;
- Preventing and detecting fraud;
- Compiling anonymized statistics for government agencies;
- Assessing underwriting risks and claims experience; and
- Allowing you to comply with your legal obligations to others, such as government regulators, auditors and reinsurers.

**I ALSO UNDERSTAND** that you, and persons acting for you, may disclose this information to the following persons, who may collect and use this information for the purposes described above:

- Insurers; reinsurers; insurance adjusters, agents and brokers; employers; health care professionals; hospitals; accountants; financial advisors; solicitors; federal, provincial or municipal governments and agencies where required or authorized by law; police forces or law enforcement agencies; and my agents or representatives;
- Organizations designated as investigative bodies under privacy laws;
- Claims processing agencies and statistical analysis organizations to whom you are directed by law to disclose claims, payment requests and other claims information; and
- Organizations that consolidate claims and underwriting information for the insurance industry.

**I CONSENT** to you collecting, using and disclosing this information in the manner described above.

I certify that the information provided is true and correct. I understand that it is an offence under the *Insurance Act* to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal *Criminal Code* for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.

| Name of Applicant or Substitute Decision Maker (please print) | Signature of Applicant or Substitute Decision Maker | Date (YYYYMMDD) |
|---|---|---|
| | | |

**To the Health Practitioner:**
Please complete the following information based on your most recent examination of the applicant named in Part 1 and return the form to the insurance company listed in Part 2. **Please print clearly.**

## Part 5 Injury and Sequelae Information

This part and the rest of this form must be completed by your Health Practitioner

Provide a description (list most significant first) and associated ICD-10-CA[+] code for any injuries and sequelae that are the direct result of the automobile accident.

| Description | Code |
|---|---|
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| | |

Note[+]:Refer to the User manual at www.autoinsurancereforms.on.ca for ICD-10-CA coding information.

| Part 6 Relevant Dates | Date symptoms first appeared: (YYYYMMDD) | Date of most recent examination: (YYYYMMDD) |
|---|---|---|
| | Date of first post-accident examination: (YYYYMMDD) | (a) Applicant was seen by me prior to the accident. Yes ☐ No ☐<br>(b) If answer to (a) is yes, enter date on which applicant was first seen:<br>_____ |

## Part 7 Disability Tests and Information

a) Based on your current knowledge and information provided by the applicant, please provide a response to each Benefit/Applicant Category

| Benefit/Applicant Category | Disability Test | Onset of Disability (YYYYMMDD) | Task/Activity Limitations | Anticipated Duration |
|---|---|---|---|---|
| **Income Replacement Benefits**<br><br>**Employed:** working at the time of the accident | Is the applicant substantially unable to perform the essential tasks of his/her employment at the time of the accident as a result of and within 104 weeks of the accident?<br><br>❑ Yes ❑ No ❑ N/A | | Please explain: | ❑ 1-4 weeks<br>❑ 5-8 weeks<br>❑ 9-12 weeks<br>❑ more than 12 weeks |
| | Can the applicant return to work on modified hours and/or duties?<br><br>❑ Yes ❑ No ❑ N/A | | Please explain: | ❑ 1-4 weeks<br>❑ 5-8 weeks<br>❑ 9-12 weeks<br>❑ more than 12 weeks |
| **Unemployed:** but worked 26 weeks during the 52 weeks before the accident | Is the applicant substantially unable to perform the essential tasks of the employment held for most of the time during the 52 weeks before the accident?<br><br>❑ Yes ❑ No ❑ N/A | | Please explain: | ❑ 1-4 weeks<br>❑ 5-8 weeks<br>❑ 9-12 weeks<br>❑ more than 12 weeks |
| **Future employment:** had accepted a job offer to start work within one year of the accident | Is the applicant substantially unable to perform the essential tasks of the employment he/she would have begun?<br><br>❑ Yes ❑ No ❑ N/A | | Please explain: | ❑ 1-4 weeks<br>❑ 5-8 weeks<br>❑ 9-12 weeks<br>❑ more than 12 weeks |
| **Non-Earner Benefits** | Does the applicant suffer a complete inability to carry on a normal life? (i.e., Has the applicant sustained an impairment that continuously prevents the person from engaging in substantially all of the activities in which the person ordinarily engaged before the accident?)<br>❑ Yes ❑ No ❑ N/A | | Please explain: | ❑ 1-4 weeks<br>❑ 5-8 weeks<br>❑ 9-12 weeks<br>❑ more than 12 weeks |

| Benefit/Applicant Category | Disability Test | Onset of Disability (YYYYMMDD) | Task/Activity Limitations | Anticipated Duration |
|---|---|---|---|---|
| **Caregiver Benefits** | As the Primary Caregiver, does the applicant suffer a substantial inability to engage in the caregiving activities in which he/she engaged at the time of the accident? (Primary Caregiver means that, at the time of the accident, the applicant was residing with a person in need of care and the applicant was the primary caregiver for the person in need of care and did not receive any remuneration for engaging in caregiver activities.)<br>❑ Yes ❑ No ❑ N/A | | Please explain: | ❑ 1-4 weeks<br>❑ 5-8 weeks<br>❑ 9-12 weeks<br>❑ more than 12 weeks |
| **Lost Educational Expenses** | Is the applicant, as a result of the accident, unable to continue in an elementary, secondary, post-secondary or continuing education program that the applicant was enrolled in at the time of the accident ?<br>❑ Yes ❑ No ❑ N/A | | Please explain:. | ❑ 1-4 weeks<br>❑ 5-8 weeks<br>❑ 9-12 weeks<br>❑ more than 12 weeks |
| **Housekeeping and Home Maintenance Expenses** | Does the applicant suffer a substantial inability to perform the housekeeping and home maintenance services that he/she normally performed before the accident?<br>❑ Yes ❑ No ❑ N/A | | Please explain: | ❑ 1-4 weeks<br>❑ 5-8 weeks<br>❑ 9-12 weeks<br>❑ more than 12 weeks |

b) If you responded Anticipated Duration 'more than 12 weeks' to any disability test above, please explain why the task/activity limitations are likely to persist beyond 12 weeks.

## Part 8 Further Investigations or Consultations

a) Have there been any examinations, investigations, or consultations not previously reported by you?
❑ No ❑ Yes (please specify findings and results)

b) Are further examinations, investigations or consultations contemplated or required?
❑ No ❑ Yes (please specify)

## Part 9 Prior and Concurrent Conditions

a) Prior to the accident, did the applicant have any disease, condition or injury that affected his/her ability to perform the activities listed in Part 7?

❑ No ❑ Unknown ❑ Yes (please explain)

If yes, is the applicant currently receiving any disability benefits for the pre-existing disease, condition or injury?

❑ No ❑ Unknown ❑ Yes (please explain)

If you treated the applicant for similar conditions prior to the accident, please describe (include date of onset, any subsequent interventions, and status at the time of the accident).

b) Since the automobile accident, has the applicant developed any disease, condition or injury, not related to the accident, that could affect his/her disability?

❑ No ❑ Unknown ❑ Yes (please explain)

## Part 10 Medications

a) Please list any medications (including dosage and frequency) that the applicant is currently taking for injuries related to the automobile accident.

Were these medications prescribed by you? ❑ No ❑ Yes

b) Please list any medications (including dosage and frequency) that the applicant is currently taking as a result of prior or concurrent conditions identified in Part 9.

Were these medications prescribed by you? ❑ No ❑ Yes

## Part 11 Health Practitioner Signature

| Name of Health Practitioner | | College Registration Number | |
|---|---|---|---|
| Facility Name (if applicable) | | AISI Facility Number (if applicable) | |
| Address | | | |
| City | | Province | Postal Code |
| Telephone Number | Extension | Fax Number | |
| Email Address | | | |

**You are a:**

❑ Chiropractor
❑ Dentist
❑ Nurse Practitioner
❑ Occupational Therapist
❑ Optometrist
❑ Physician
❑ Physiotherapist
❑ Psychologist
❑ Speech-Language Pathologist

I confirm that the information provided is true and correct. I understand that it is an offence under the *Insurance Act* to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal *Criminal Code* for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.

| Name of Health Practitioner (please print) | Signature of Health Practitioner | Date (YYYYMMDD) |
|---|---|---|
| | | |

Note: The fee for completing this certificate is not a health care benefit of the Ontario Ministry of Health and Long-Term Care. This fee should be billed to the insurer directly.