

Return this form to:

Voluntary Consent for Pre-Claim Examination (OCF-26)

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

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

To assist you following your accident, we are seeking your consent to be examined by one or more health care professionals. This examination is voluntary and will only apply if you have not completed an application for accident benefits and are in hospital or have been discharged recently.

The examination is to assist in determining your entitlement to attendant care, assistive devices, or home modifications and devices that you may need as a result of the accident.

Part 1 Claimant Information

| | | | | |
|--|-----------|---|------------------|-----------|
| Date of Birth (YYYYMMDD) | Age | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | Telephone Number | Extension |
| Last Name | | First Name | Middle Name | |
| Address | | | | |
| City | | Province | Postal Code | |
| Special Needs (if applicable) <input type="checkbox"/> Mobility <input type="checkbox"/> Interpreter (Type: _____) <input type="checkbox"/> Other (specify) | | | | |
| Representative (if applicable) | | | Address | |
| City | | Province | Postal Code | |
| Telephone Number | Extension | Fax Number | Email | |

Part 2 Health Care Professionals Conducting the Examination

| | | |
|---------------------|---------------------------|----------------------|
| 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 | | |

Part 3 Date and Location of Examination

| |
|--|
| Date and time of examination: |
| Location of examination <input type="checkbox"/> applicant's home |
| <input type="checkbox"/> hospital: |
| <input type="checkbox"/> other: |

**Part 4
Consent**

I authorize my insurer or health professional appointed by my insurer to conduct this pre-claim examination, to collect and use personal information and health information related to accessing accident benefits for attendant care, assistive devices or home modifications.

I understand that my consent to this examination is voluntary. Refusing to consent to this pre-claim examination will not affect my right to apply for or receive accident benefits. This examination can only be used to assist me in accessing benefits and cannot be relied upon to determine that I am not entitled to an accident benefit.

I consent to this pre-claim examination in the manner described above.

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

The health care professional(s) that conduct the examination will provide you with a copy of the examination report within 5 business days after conducting the examination.

If you have questions or concerns about the examination please contact the adjuster listed below.

**Part 5
Insurance
Company
Information**

| | | | |
|------------------|-----------|------------|-------|
| Adjuster's Name | | | |
| Telephone Number | Extension | Fax Number | Email |