Notice of Loss and Proof of Claim (Form AB-1)

This form is effective on **November 20, 2004** for accidents that occur on or after **October 1, 2004**.

Part 1: Claimant Information

Last Name	First Name	Middle Name(s)

Mailing 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
			- -	☐ Male ☐ Female

You can best be reached:

☐ at home/cell ☐ at work ☐ other (personal visit/email): _____

When is the best time to reach you (include days of the week)?	Will this be an Alberta Worker's Compensation Board Claim?
	☐ Yes ☐ No

Are Extended Health Care Benefits Available? (e.g. Blue Cross or similar Employee benefit plans)

☐ Yes ☐ No

Provide details (including plan name):

Are you currently employed or engaged in training activities?

☐ Full Time ☐ Part Time ☐ Seasonal *(provide job and title)*: _____

☐ Self-employed ☐ Retired ☐ Student ☐ 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

☐ Parent ☐ Guardian ☐ other: _____

Relevant Documentation Attached? ***If no, please authorize your Authorized Representative by completing Part 5 of this form.***

☐ Yes ☐ No

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

You were a

☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other: _____

Location of Accident

City or Town	Province	Country

Date of Accident *(dd-mm-yyyy)*	Time of Accident	Was the accident reported to the police?
	_____ : _____ ☐ a.m. ☐ p.m.	☐ Yes ☐ 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? ☐ Yes ☐ No Appointment was/is booked for: _____

Have you started treatment?

☐ Yes ☐ No Appointment was/is booked for: _____

Are you currently receiving medical or rehabilitation benefits related to another motor vehicle accident? ☐ Yes ☐ 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

Full Name of Primary Health Care Practitioner or Dentist	Profession
Dr. Moe Gebara	Chiropractor

Mailing Address

11704 Jasper Avenue NW T5K0N3

City or Town	Province	Country
Edmonton	Alberta	Canada

Telephone Number	Fax Number
780-482-7617	780-482-3795

Part 5: Authority to Act on Claimant's Behalf

This section should be completed only when the claimant chooses not to act on his/her own behalf.

I, _____ hereby 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 the 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 *(dd-mm-yyyy)*	Signature of Claimant
Date *(dd-mm-yyyy)*	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 Practitioners, dentist(s) or other health service providers to disclose my personal information to the 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 the 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 of the claimant.

Name	Date *(dd-mm-yyyy)*	Signature

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.

Part 7: Choice in Following Diagnostic and Treatment Protocols Regulation

Please state whether you choose to be treated within the Diagnostic and Treatment Protocols Regulation.

☐ I choose to be treated within the Diagnostic and Treatment Protocols Regulation as indicated on Form AB-1 (Notice of Loss and Proof of Claim).

☐ I choose **not to** be treated within the Diagnostic and Treatment Protocols Regulation.

I certify that the information provided is true and correct to the best of my knowledge. I confirm that I have consented to the collection, use and disclosure of my personal information for my treatment and care and determination of my eligibility for accident and/or disability income benefits as outline on Form **AB-1** (Notice of Loss and Proof of Claim).

☐ I am the claimant, OR ☐ I am the Authorized Representative of the claimant.

Name	Date *(dd-mm-yyyy)*	Signature

This Section to be Completed by Claimant / Authorized Representative or a Primary Health Care Practitioner

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.