Return this form to:

Declaration of Post-Accident Income and Benefits (OCF-13)

Use this form for accidents that occur on or after January 1, 1994.

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

The information collected in this form will help your insurance company determine the correct amount of accident benefits that you are entitled to receive.

Part 1 Applicant Information

Last Name			First Name and Initial		
Address				City	
Province	Postal Code	Home Telephone	Area Code	Date of Accident	year month day

Part 2 Employment Income

Since the date of the accident, have you received any income from:

Employment	☐ Yes (Give details below)	☐ No (Continue to part 3)
Self-employment	☐ Yes (Give details below)	☐ No (Continue to part 3)

Name of Employer/Business		Employer Contact Name	
Job Title		Telephone Number	Area Code
Employed From: year month day	To: year month day	Total Hours	Total Income Received $

Name of Employer/Business		Employer Contact Name	
Job Title		Telephone Number	Area Code
Employed From : year month day	To: year month day	Total Hours	Total Income Received $

Name of Employer/Business		Employer Contact Name	
Job Title		Telephone Number	Area Code
Employed From: year month day	To: year month day	Total Hours	Total Income Received $

Name of Employer/Business		Employer Contact Name	
Job Title		Telephone Number	Area Code
Employed From: year month day	To: year month day	Total Hours	Total Income Received $

Name of Employer/Business		Employer Contact Name	
Job Title		Telephone Number	Area Code
Employed From: Year month day	To: year month day	Total Hours	Total Income Received $

Part 3 Private Disability Benefits

Have you received any private disability/income replacement benefits since the accident?

Group Benefits	Short Term ☐ Yes ☐ No	Long Term ☐ Yes ☐ No
Private Benefits	Short Term ☐ Yes ☐ No	Long Term ☐ Yes ☐ No
Other	☐ Yes (Specify type of benefit) ____________	☐ No

If you have checked yes to any box above, give details below

Name of Insurance Company	Name of Policyholder	Policy/Group Certificate Number	How many weeks are you eligible to receive benefits?	Benefits Start Date	Total Amount Received
				year month day	$
				year month day	$

Part 4 Public Benefit Plans

Have you received any public benefits since the accident?

CPP Disability Pension	☐ Yes	☐ No
Workplace Safety and Insurance Board (other than permanent pensions)	☐ Yes	☐ No
Employment Insurance (EI) Sick Benefits under the Employment Insurance Act	☐ Yes	☐ No
Other ☐ Yes (specify type of benefit) ____________		☐ No

If you have checked yes to any box above, give details below.

Claim Number	Benefits	Total Amount Received
	Received From: year month day To: year month day	$
	Received From: year month day To: year month day	$

Part 5 Medical/ Dental Benefits

Have you submitted any medical/dental receipts covering expenses incurred as a result of the accident to any of the following?

Group Benefit Plan	☐ Yes	☐ No
Private Benefit Plan	☐ Yes	☐ No
Other ☐ Yes (specify type of benefit) ____________		☐ No

If you have checked yes to any box above, give details below.

Name of Insurance Company	Name of Policyholder	Policy Number	Type of Expense

Part 6 Signature

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. I further understand that the information contained on this form may be used and disclosed in the manner described in my Application for Accident Benefits.

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