Alberta Accident Benefits
Initial Claims Process

Overview

If you have been injured in an automobile accident in Alberta, you are entitled to accident benefits coverage regardless of whether you were at fault for the accident. The benefits you receive depend on the type of injury you have:

- If your injury is a sprain, strain or a whiplash associated disorder I or II, your primary health care practitioner (chiropractor, medical doctor or physical therapist) does not have to seek approval of the insurer for payment for treatment of these injuries **if you provide notice of your claim**. Your primary health care practitioner will be able to bill the automobile insurer for all treatment services outlined in the "Diagnostic and Treatment Protocols" that are not covered by Alberta Health Care Insurance. These protocols have been developed in consultation with primary health care practitioners and are based on the best research and evidence currently available.

- For all other injuries, or if you choose not to follow the diagnostic and treatment protocols, you will need to pay the health service provider for any services not covered by Alberta Health Care Insurance. You will be reimbursed for eligible expenses from your extended health care benefits (e.g., Blue Cross or similar employee benefits plan) and then by your automobile insurer.

What to do if you are injured in a Automobile Accident:

1. **See a primary health care practitioner** (chiropractor, medical doctor, physical therapist) as soon as possible for an assessment of your injury and, if needed, treatment advice.

2. **File an injury accident report with the police.**

3. **Complete the attached Notice of Loss and Proof of Claim Form (AB-1),** retain a copy for your records and send the original signed form(s) to the insurance company. If you are unable to send the form within the following timeframes, submit it to your insurance company as soon as practicable and explain the reason for the delay.

    - If your injury is diagnosed as a sprain, strain or a whiplash associated disorder I or II, submit this form within 10 days of the accident so that you can access accident benefits described as the "Diagnostic and Treatment Protocols."
    - If you have other types of injuries, or you choose not to access the accident benefits described as the "Diagnostic and Treatment Protocols", submit the form within 30 days of the accident.
    - If a family member is fatally injured in the collision, you can access funeral, grief counseling and death benefits. This form should be submitted within 30 days of the accident.

4. **You will be contacted** about the benefits you are entitled to receive after the insurance company reviews your completed form. If your insurance company needs any additional information in order to process your application, they will contact you.

If you have further questions about this form, the process or your benefits, please contact your claims adjuster. If you do not know who your claims adjuster is, contact your insurer or the Insurance Bureau of Canada, at 1-800-377-6378.

Important Notice Concerning Your Personal Information

The personal information you provide in forms AB-1, AB-1a (Claim for Disability Benefits) or AB-2 (Treatment Plan) is collected under the authority of the Insurance Act, Alberta's Automobile Insurance Accident Benefits Regulation, Diagnostic and Treatment Protocols Regulation and all applicable privacy legislation.

- Your primary health care practitioner or dentist will need to collect personal information from you and from other health service providers and will need to use and disclose your personal information to provide you with appropriate diagnosis, treatment and care.
- Your insurance company and its agents will need to collect, use and disclose personal information from you, your primary health care practitioner, and other health service providers concerning the accident, your injuries, any pre-existing conditions that may impede your recovery progress, the amount of treatment and care provided to you, and any assessments of your injuries and indications as to your treatment progress in order to facilitate contact with you, to determine your eligibility for accident and/or disability income benefits, and to administer your claim.

Under applicable privacy legislation, it is necessary to obtain your consent to authorize the sharing of your personal information as specified above. The legislation also regulates how primary health care practitioners, dentists, other health service providers, and insurance companies can use and disclose your information once they have it. Section 2 of form AB-1 will ask for your consent or that of your agent. Refusal to provide your authorization and consent could result in an inability to provide you with the treatment and care you require (if not covered by Alberta Health Care Insurance) and may result in an inability for your insurance company to process your claim, in whole or in part.

Your primary health care practitioner, dentist or other health service provider and insurance company will retain and rely on a copy of your consent for the period of time that your treatment and care is ongoing and your claim is active. You may revoke your consent at any time in writing to your primary health care practitioner or dentist and your insurer or any other person to whom you give consent, subject to continuing legal obligations. If you have any questions concerning the collection, use or disclosure of your personal information, please ask your primary health care practitioner, dentist, or your insurance claims representative or adjuster.

Send this form to the appropriate insurer:

Fax # (____)_____-_____

Notice of Loss & Proof of Claim Form

(Form AB-1)

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

This part is to be completed by your Insurer	
Claim Number:	
Insurance Company	
Claim Representative	
Policy Number:	
Date of Accident:	

Section 1: Claimant Information

Part 1
Claimant Information

Last Name	First Name	Middle Name(s)	
Address			
City, Town or County	Province	Postal Code	
Telephone Number (Home) (Include area code)	Telephone Number (Work) (Include area code)	Fax Number (Include area code)	
Date Of Birth (DDMMYYYY)	Gender ☐ Male ☐ Female	You can best be reached: ☐ By telephone ☐ By personal visit ☐ At home ☐ At work ☐ Other	
When is the best time to reach you?	Day(s) of the week		
Insurance Company	Policy Number		
Will this be an Alberta Workers' Compensation Board Claim? ☐ Yes ☐ No	Are Extended Health Care Benefits Available? (e.g., Blue Cross or similar Employee benefits plans) ☐ Yes ☐ No Details:		
Are you currently employed or engaged in training activities? ☐ Full Time ☐ Part Time ☐ Self-employed ☐ Retired ☐ Student ☐ Not employed	If you are making a claim for disability benefits, please also complete Form AB- 1a.		

Part 2
Claimant's Authorized Representative Information, if applicable

Last Name	First Name	Middle Name(s)
Address		
City, Town or County	Province	Postal Code
Relationship with Claimant ☐ Parent ☐ Guardian ☐ Other	Relevant Documentation Attached? If no, please authorize your representative by completing part 5 of this form. ☐ Yes ☐ No ☐ Not Applicable	
Home Telephone Number (Include area code)	Work Telephone Number (Include area code)	Fax Number (Include area code)

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, town or county	Province	
Time of Accident: ___:___ ☐ A.M. ☐ P.M.	Date of Accident (DDMMYYYY)	Was the Accident Reported to the Police? ☐ Yes ☐ No	Date Reported: (DDMMYYYY)
Please provide a brief description of how the accident occurred and how you were injured.			
Have you seen a Medical Doctor, Physical Therapist, Chiropractor, Dentist or other health service provider for diagnosis, treatment and care for an injury related to this accident? ☐ Yes ☐ No ☐ Appointment booked for:			
Have you started treatment? ☐ Yes ☐ No ☐ Appointment booked for:			
Are you currently receiving medical or rehabilitation benefits related to another motor vehicle accident? ☐ Yes ☐ No			

(If more space is required please continue on back side of this page)

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	
Address			
City, Town or County		Province	Postal Code
Telephone Number (include area code)	Fax Number (include area code)		

Section 2: Certification and Consent to Share Information

Part 5

Authority to act on claimant's behalf

(This section should be completed only when the claimant chooses not to act on his or her own behalf)

I, _____, hereby authorize _____ to act as my 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 Section 1 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 representative as required. I further authorize primary health care practitioner(s), dentist(s), other health service provider(s) and my 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 representative.

Signature of Claimant _____ Date_____

Signature of Authorized Representative _____ Date_____

Part 6

Certification and consent to share information

(To be completed by the 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 Section 1 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 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 Section 1 herein, including a treatment plan and services provided, for the purpose of determining my eligibility for accident and disability benefits as outline on Form AB-1 and administering my claim.

□ I am the claimant or □ I am the authorized representative of the claimant

Signature _____ Date_____

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 o 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 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-yyy Signature

This Section to be Completed by Claimant/Authorized Representative a Primary Health Care Practitioner		
Insurance Company		Policy Number
Mailing Address	Full Name of Claims Representative	Claim Number

Please forward this form to the Insurance Company.