



FORM 3

THE MOTOR VEHICLE ACCIDENT CLAIMS FUND APPLICATION FOR STATUTORY ACCIDENT BENEFITS (Under section 6 of the Motor Vehicle Accident Claims Act)

This application form must be completed, signed and delivered to the Motor Vehicle Accident Claims Fund (the "Fund") together with your Application for Accident Benefits Package (including OCF 1). Failure to complete this form will delay or jeopardize your right to apply to the Minister of Finance for payment out of the Fund.

The claimant \_\_\_\_\_, and his/her solicitor/agent/SABS representative \_\_\_\_\_, hereby certify:

- 1. the date of the accident is \_\_\_\_\_;
2. the claimant was: [ ] a pedestrian OR [ ] occupant of an insured vehicle OR [ ] occupant of an uninsured vehicle OR [ ] a cyclist;
3. the claimant has investigated and determined that the following vehicles were involved in the accident:
a) vehicle which struck me
plate number \_\_\_\_\_ make \_\_\_\_\_
owner name \_\_\_\_\_ insurer name \_\_\_\_\_
driver name \_\_\_\_\_ policy no. \_\_\_\_\_
expiry/cancellation \_\_\_\_\_
b) vehicle in which I was an occupant
plate number \_\_\_\_\_ make \_\_\_\_\_
owner name \_\_\_\_\_ insurer name \_\_\_\_\_
driver name \_\_\_\_\_ policy no. \_\_\_\_\_
expiry/cancellation \_\_\_\_\_
c) vehicle(s) involved in accident other than above (attach a separate sheet if required);
plate number \_\_\_\_\_ make \_\_\_\_\_
owner name \_\_\_\_\_ insurer name \_\_\_\_\_
driver name \_\_\_\_\_ policy no. \_\_\_\_\_
expiry/cancellation \_\_\_\_\_
4. a copy of the police report is attached;
5. on the date of the accident the claimant [ ] did reside in Ontario OR [ ] did reside outside Ontario in \_\_\_\_\_ (jurisdiction);
6. the claimant has investigated and determined that he/she does NOT have access to a motor vehicle liability policy [ ] in his/her name OR [ ] as a listed driver OR [ ] as a spouse or former spouse OR [ ] as a dependant OR [ ] as someone who had access to a business or employer's vehicle;
7. the claimant has investigated and determined that the vehicle which he/she occupied or which struck him/her was leased from \_\_\_\_\_, and was insured by \_\_\_\_\_ under policy number \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_.
8. a claim has been made against \_\_\_\_\_ (name of insurance company), under policy number \_\_\_\_\_, BUT the claim has been denied for these reasons: \_\_\_\_\_
(Attach a copy of Insurer's Assessment Form)
9. the first application for accident benefits was submitted to \_\_\_\_\_ (Name of Insurer), on \_\_\_\_\_ (date);
10. subsequent applications were submitted to \_\_\_\_\_ (Name of Insurer), on \_\_\_\_\_ (date);
11. a completed\* Application for Accident Benefits Package is attached;
12. the Notice of Collection of Personal Information - Applicants for Statutory Accident Benefits form is signed and attached;
13. my SABS Representative (if applicable) has completed the necessary filing requirements of the Financial Services Commission of Ontario;
14. that I/we acknowledge it as an offence to make a false or misleading statement or representation.

Claimant's Signature \_\_\_\_\_

Solicitor / Agent / SABS Representative \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

\* COMPLETED MEANS ALL FORM PARTS FILLED OUT AND SIGNED BY CLAIMANT, EMPLOYERS AND HEALTH PRACTITIONERS.