Alberta Government

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 ____ : ____ ☐ a.m. ☐ p.m.	Was the accident reported to the police? ☐ 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	
Mailing Address		
City or Town	Province	Country
Telephone Number	Fax Number	

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.

AUTOMOBILE ACCIDENT HISTORY INTAKE FORM

, Date: _______________
Name: _______________________ Hm # ___________ Cell #________________
Address: _____________________________________ Postal Code: ___________
Birth Date: m ___d ___y_____ Sex: M / F
Date of Accident: _________________ Time of Accident: _______________
City of Accident: ___________________ Street of Accident: ________________

Injury History:

1. What symptoms have you noticed since the accident: _______________
____
____
____

2. How long has this been going on? _______________________________________

3. What specific life activities does it interfere with (work, sleep, etc)? ___________
____

4. How frequent is the condition (constant, daily, etc)? ________________________

5. Is there anything you can do to relieve the problem? _______________________

6. What makes the problem worse? ____

7. Describe the pain: ____
Does it travel or radiate to other areas? _________________________________

8. Are there other unrelated health problems? ______________________________

9. Have you had any broken bones? ______________________________________

10. To your knowledge, have you had any diseases, major illnesses, or other injuries not indicated on this form either past or present? _______________________
____

11. To your knowledge, is there a family history of cancer, stroke, diabetes, heart disease or a spinal condition? ____

12. List any medications you are taking: ____________________________________

Please place an "X" on the line below to indicate the level of the problem:

NO SYMPTOMS 0 --10 EXTREME SYMPTOMS

AUTOMOBILE ACCIDENT HISTORY INTAKE FORM

Your Accident Information:

Road conditions at the time of the accident: WET DRY ICY OTHER_________

Did the police come to the accident scene? YES NO: Is there a report? YES NO

Did you go to the hospital? YES NO

If yes, what is the name and city of the hospital? ______________________

How did you get to the hospital? ___________________________________

What parts of your body were x-rayed at the hospital? ___________________

What did the hospital do for your injuries? ____________________________

How long did you stay at the hospital? _______________________________

What bleeding cuts did you sustain during this accident? ________________________

What bruises did you sustain during this accident? _____________________________

Where were you seated in the vehicle? ______________________________________

Were you aware of the approaching collision prior to impact, or did impact catch you by surprise?? AWARE SURPRISE

Did you lose consciousness (black out) upon impact? YES NO: How long? _______

Did you experience a flash of light or explosion in you head? YES NO

Did you become: CONFUSED DISORIENTED LIGHT HEADED DIZZY NAUSEATED BLURRED VISION RING/BUZZ IN EARS
From the accident? (Please circle)

If you still have any of those symptoms, which ones? ________________________

Are you currently suffering for any of the following? (Please circle):

RESTLESSNESS IRRITABLE
DIFFICULTLY CONCENTRATING DIFFICULTY WITH MEMORY
SLEEPLESSNESS FORGETFULNESS
REDUCED TOLERANCE TO HEAT REDUCED TOLERANCE TO ALCOHOL

How far is the top of the headrest or seatback from the top of your head (approximately): _______ inches above or below?

Were you wearing a seatbelt? YES NO

If yes, was it a lap seatbelt___________ shoulder-lap seatbelt ________

List the year, make and model of the vehicle you were in:

Year _______ Make _____________ Model _____________

AUTOMOBILE ACCIDENT HISTORY INTAKE FORM

Was your car stopped at the time of impact? YES NO
If yes, was the driver's foot also on the brake? YES NO
If no, then estimate the speed of the vehicle you were in: _______km/hr

If your vehicle was moving at the time of impact, was it:
Slowing down? YES NO
Gaining speed? YES NO
Traveling at a steady rate of speed? YES NO

On what part of the automobile did your following body parts hit?
Head hit _________________ Chest hit ___________________
Right/left shoulder hit_______ Right/left arm hit ____________
Right/left hip hit ___________ Right/left leg hit ____________
Right/left knee hit __________ Other: _____________________

Did you receive any injury or bruise for the seat belt? YES NO
If YES, then describe: ____

What is the estimated cost damage to the vehicle you were in? $ ______

Which of the following car parts broke during the accident? (Please circle)
Windshield Front seat back
Right/left side window Other: __________________
Steering wheel Other: __________________

Was the trunk of your body pointed straight forward at the time of the collision?
YES NO (If No) How was it turned? _________________________

What is the year, make and model of the **other** vehicle?
Year _________ Make ______________ Model ____________

Was the other vehicle moving at the time of the collision? YES NO
If yes, what was its approximate speed? __________ km/hr

If the other vehicle was moving at the time of the collision, was it (please circle):
Slowing down Gaining speed traveling at a steady speed

Please describe, to the best of your knowledge, what happened during this accident:
____

____