Alberta Government

Claim for Disability Benefits (Form AB-1A)

For accidents that occur on or after **October 1, 2004**

The personal information you provide in your Accident Claims Benefit Package (i.e. AB-1, AB-1A, AB-2, AB-4) is collected under the authority of the *Insurance Act*, Alberta's Automobile Insurance Accident Benefits Regulations, 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 process, 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. Parts 5 and 6 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.

This section to be completed by Claimant / Authorized Representative or Physician

Insurance Company Name

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): ____________________

Authorized Representative's Last Name	Authorized Representative's First Name	Authorized Representative's Middle Name(s)

Part 2: Claim for Disability Benefits *(To be completed by Claimant or Authorized Representative)*

Are you claiming disability income benefits under the Automobile Accident Insurance Benefits Regulations? ☐ Yes ☐ No

If No, then please do not complete or submit this form at this time.

If Yes, please complete the remainder of this part of the form.

Your insurance claims adjuster may request additional information from you or your physician at a later date to assist with the claims process.

Were you employed on the date of the accident?	Date first unable to work *(dd-mm-yyyy)*	Between what dates are you claiming a Loss of Income?
☐ Yes ☐ No		From ____________ To ____________

History of Employment During the 12 Months Preceding the Accident

Name of Employer			
Mailing Address			
City or Town	Province	Country	Postal Code
Employment Term From ______ To ______	Occupation		
If you were unemployed at the date of the accident, for how much of the 12 months preceding the accident were you employed and working?		Average gross weekly income	
Are you entitled to disability or other income benefits from your employer or any other source as a result of this accident? ☐ Yes ☐ No			
Name of Source	Amount	Amount Per Week/Month	

☐ I am the claimant.

☐ I am the Authorized Representative of the claimant.

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 the determination of my eligibility for accident and/or disability income benefits as outlined on form **AB-1**.

______________________ Name (Please Print) ______________ Date *(dd-mm-yyyy)* ______________________ Signature

Part 3: Information of Physician *(To be completed by Physician)*

Date of examination *(dd-mm-yyyy)* ______________

Full Name of Physician		Mailing Address	
City or Town	Province	Country	Postal Code
Administrative Contact's Full Name	Facility Name	Telephone Number	Fax Number

Part 4: Signature of Physician for Disability Benefits Claim

To the best of my knowledge, the claimant is totally disabled (unable to work) from ______________ Date *(dd-mm-yyyy)* to ______________ Date *(dd-mm-yyyy)* inclusive.

If still disabled, give approximate date patient should be able to return to work, ______________ Date *(dd-mm-yyyy)* .

______________________ Name (Please Print) ______________ Date *(dd-mm-yyyy)* ______________________ Signature

Please forward this form to the Insurance Company.