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 with disorder I or II, your Primary Health Care Practitioner (chiropractor, physician 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 Regulation (DTPR) 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, if you choose not to follow the DTPR, you will need to pay health service providers 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 an Automobile Accident:

1. **See a Primary Health Care Practitioner** 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 Form),** retain a copy for your records and send the original signed form(s) to the insurer of the vehicle you were in at the time of the accident (insurance company). If you are unable to send the form within the following timeframes, submit it to the insurance company as soon as practicable and explain the reason for the delay.
   - If your injury is diagnosed as a sprain, strain or whiplash associated disorder I or II, submit this form within 10 business days of the accident so that you can access accident benefits described in the DTPR.
   - If you have other types of injuries, or you choose not to access the accident benefits described in the DTPR, submit the form within 30 days of the accident.
   - If you have other types of injuries, or you choose not to access the accident benefits described in the DTPR, submit the form 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 the 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 the insurance company 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 Alberta's *Insurance Act,* 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.

- The 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. Parts 5 and 6 of form AB-1 will ask for your consent or that of your Authorized Representative. 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 the insurance company to process your claim, in whole or in part.

Your Primary Health Care Practitioner, dentist or other health service provider and the 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 the insurance company 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.

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? Provide details (including plan name):
(e.g. Blue Cross or similar Employee benefit plans)

◯ Yes ◯ No

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	Was the accident reported to the police?
	_____ : _____ ◯ a.m. ◯ p.m.	◯ 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
Dr. Candice Hueppelsheuser	Chiropractor

Mailing Address		
5007 Broadway Ave. P.O. Box 1510		
City or Town	**Province**	**Country**
Blackfalds	Alberta	Canada
Telephone Number	**Fax Number**	
403-885-5808	403-885-5881	

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.

Part 7 – Choice in Following Diagnostic and Treatment Protocols

Please state your preference of treatment within or not within the Diagnostic and Treatment Protocols:

- ◯ I choose to be treated within the Diagnostic and Treatment Protocols as indicated on Form AB-1
- ◯ I choose **not to** be treated within the Diagnostic and Treatment Protocols

- ◯ 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 my treatment and care and determination of my eligibility for accident and/or disability income benefits as outline on Form **AB-1** .

Name (Please Print) _____

Signature _____ Date_____