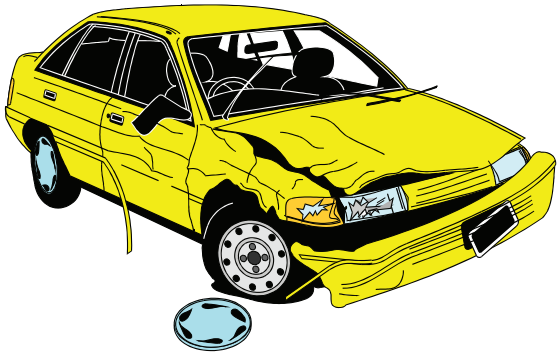
INSURANCE BUREAU OF CANADA

BUREAU D'ASSURANCE DU CANADA

Accident Benefits Coverage in Ontario



September 2010

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There is not enough space in this brochure to deal with every detail of the laws covering statutory accident benefits. It does not contain all aspects of the auto insurance legislation. For the precise wordings of the law, you should consult the Ontario Insurance Act and the Statutory Accident Benefits Schedule made under that Act. Contact your claims representative if you would like a copy of the Statutory Accident Benefits Schedule.

If you have any questions about the legislation or how to make a claim, contact your claims representative or call the Insurance Bureau of Canada Consumer Information Centre at 1-800-387-2880 or (416) 362-9528 in the Toronto area.

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If You Are In A Car Accident

THERE ARE IMPORTANT FACTS YOU NEED TO KNOW ABOUT ONTARIO'S LAWS THAT WILL AFFECT THE ACCIDENT BENEFITS YOU COULD RECEIVE.

Accident benefits are available to people who suffer a disabling physical or psychological injury as a direct result of a motor vehicle accident that occurs in Canada or in the United States of America. If the accident occurs outside of Ontario, you may have to choose whether to receive benefits in accordance with the laws of Ontario or in accordance with the province or state in which the accident occurred.

How Do I Apply For Benefits?

If you suffer a disabling injury in a motor vehicle accident, you must tell your insurer within 7 days of the accident, or as soon after that as possible, that you wish to apply for benefit payments. You must send your application for benefits within 30 days of receiving the application forms. Your insurer will supply the forms. **Failing to notify your insurer within 7 days or failing to return the forms within 30 days could mean that you will lose your right to receive any benefits.**

Where Does My Application Go?

If you have your own motor vehicle insurance, have regular use of a company vehicle or are covered under someone else's policy, such as your spouse or parent, return the completed application to that insurance company. If you don't have insurance, return the completed application to the insurer of the vehicle in which you were an occupant or which hit you if you were a pedestrian. If there is no insurance on that vehicle, return the application to the insurer of any other vehicle involved in the accident. If no automobile insurance exists to respond to your claim, you may be entitled to receive benefits from the Motor Vehicle Accident Claims Fund (MVACF). Your claims representative or the MVACF can explain how the Fund works in these situations.

If you are insured under more than one policy, there are special rules that determine from which policy you are eligible to receive benefits. Your claims representative can also explain these rules.

Who Is Eligible For Benefits?

Any person who is injured as a direct result of a motor vehicle accident and certain persons who suffer psychological or mental injury because of an accident that injures certain relatives or dependants.

You are not entitled to receive accident benefits if, as a result of the accident, you qualify to receive benefits under any worker's compensation law or plan. There are certain exceptions. Your claims representative can discuss these with you.

What Are The Benefits?

The following are brief descriptions of the types of benefits for which you may be eligible. **Some of these benefits will only be available if you have suffered a catastrophic impairment or if you purchased them as optional benefits.** For more complete descriptions and to determine if you are in fact eligible for any of the following benefits, you should refer to the specific sections of this booklet that deal with that benefit and to the *Statutory Accident Benefits Schedule*.

INCOME REPLACEMENT BENEFIT

This weekly benefit will partially compensate you for the loss of your income if you are unable to return to work because of your injuries.

NON-EARNER BENEFIT

This weekly benefit is payable if you suffer a complete inability to carry on your normal activities because of your injuries.

CAREGIVER BENEFIT

This weekly benefit will reimburse you for expenses you incur if you are unable to continue as the main caregiver for a member of your household who is under 16, or who is over 16 and suffers from a disability.

MEDICAL AND REHABILITATION BENEFITS

This benefit will pay for reasonable and necessary medical and rehabilitation expenses not covered by a government health plan or by any supplementary health plan you may have.

ATTENDANT CARE BENEFIT

This benefit will pay reasonable and necessary expenses you incur to have an aide, attendant or long term care facility help with your personal care.

OTHER EXPENSES

This benefit will pay for other expenses such as the cost of examinations or assessments, lost educational expenses, expenses of visitors, and the reasonable cost of housekeeping and home maintenance necessary due to injuries sustained in the accident. Repairing or replacing certain items lost or damaged in the accident may also be covered.

DEATH AND FUNERAL BENEFITS

There are lump sum payments available for certain survivors of a person killed in an accident and to help pay for the expense of a funeral.

Payment Restrictions For Certain Benefits

You are not eligible to receive **income replacement benefits, non-earner benefits, lost educational expenses, expenses of visitors and housekeeping and home maintenance expenses** if you were:

- driving an automobile that you knew or should reasonably have known was not insured;
- driving without a valid licence;
- driving an automobile under which you were an excluded driver;
- driving a vehicle you knew or should have known you were driving without the owner's consent;
- an occupant who knew or should have known that the driver did not have the owner's consent to drive the vehicle; (Note: Excluded drivers and occupants of vehicles driven by excluded drivers may be able to collect under a policy where they are a named insured.)
- convicted of impaired driving, exceeding the blood alcohol limit or refusing to provide a breath sample;
- an occupant of a vehicle and convicted of a criminal offence arising out of the use of an automobile in connection with criminal activity;
- at the time of the accident, engaged in an act for which you are convicted of a criminal offence; or
- a person who knowingly misrepresented any important information when applying for auto insurance or who intentionally failed to notify the insurer of any change in the risk material to the contract of insurance.

Your insurance company can terminate the payment of any benefit if you wilfully misrepresent material facts regarding your application for the benefit.

Requests For Additional Information

Your insurance company may need additional information in order to process your application for a benefit. When this happens, you will be given a written request and a deadline for giving the information to your insurer. **Penalties may apply if you do not meet the deadline.**

What Are "Incurred" Expenses?

The following benefits require that an expense be incurred before any payment can be made:
Caregiver, Medical, Rehabilitation, Attendant Care, Expenses of Visitors, Housekeeping and Home Maintenance and Cost of Examinations.

An expense is "incurred" if you can prove all of the following:

- You received a good or service;
- You paid the expense, promised to pay the expense or otherwise are

legally obligated to pay the expense; and

- The person who provided the goods or services did so in the course of the employment, occupation or profession in which s/he would ordinarily have been engaged but for the accident, or
- The person who provided the goods or services sustained an economic loss as a result of providing the goods or services.

It is your responsibility to prove that you have incurred an expense. Ask your claims representative what type of documentation you need to submit.

What Is An Insurer Examination?

Your insurer has the right to arrange to have you assessed by a regulated health professional or vocational rehabilitation expert of its choice. This examination is done to help determine whether your injuries entitle you to receive or continue to receive a benefit that you have applied for or to help your insurer determine whether you have sustained a catastrophic impairment. **Your insurer can reject or stop payment of a benefit if you refuse to attend the examination or refuse to provide relevant or necessary information and documents to the examiner upon request.** After the examination is completed, your insurance company will give you a written notice letting you know whether they agree to pay you the benefit related to the examination, or whether they agree that you have sustained a catastrophic impairment. You will receive a copy of the insurer examination report.

What If I Have A Dispute With My Insurance Company?

If your insurance company believes that you do not qualify or no longer qualify to receive a benefit, or if it reduces the amount of your benefit, it will notify you in writing. If you disagree with the decision, you have the right to apply to the Financial Services Commission of Ontario (FSCO) for dispute resolution services. The first step in the process requires that you file for mediation within two years of your insurer's refusal or reduction of a benefit. Before you can apply for mediation, you have to report the claim and submit an application to your insurance company. You must also co-operate with your insurance company's request for an insurer examination. An application for mediation can be obtained from your insurance company. Information and application forms are also available on FSCO's website www.fsco.gov.on.ca .

To find out more about the FSCO dispute resolution services, call 1-800-517-2332 or (416) 250-6714 in the Toronto area.

Additional Information And Help

If you need help understanding the benefits or your eligibility to the benefits, contact your claims representative or the Insurance Bureau of Canada Consumer Information Centre at 1-800-387-2880 or 416-362-9528 in the Toronto area.

Weekly Benefits

If, as a result of being injured in a motor vehicle accident, you are not able to work or carry on your normal activities as before, a weekly benefit may be available to you. There are three types of weekly benefits: the income replacement benefit, the non-earner benefit and the caregiver benefit. There are important facts you need to know when applying for a weekly benefit. This section will help explain the laws concerning the payment of these benefits to people injured in motor vehicle accidents. Weekly benefits are available to the following persons:

- People who have been employed.
- Those who have no income (non-earners).
- Caregivers who suffer a catastrophic impairment because of the accident or to whom the optional caregiver, housekeeping and home maintenance benefit applies.

Disability Certificate Requirement

In order to receive an income replacement, non-earner or caregiver benefit, you will be required to provide a certificate from a qualified medical person stating the cause and nature of your injuries with an estimate of how long your disability will last. Your insurer will provide you with the certificate and pay for it to be completed. **The certificate has to be sent with your application form. If you send your application without a disability certificate, your insurance company does not have to pay you a weekly benefit for any time before the completed certificate is received.**

If your application for a weekly benefit is approved, your insurance company has the right to ask that you provide updated disability certificates to determine if you are still entitled to the benefit.

Insurer Examinations & Requests For Additional Information

You should review the information on page 5 to help you understand these important requirements.

If You Refuse Treatment Or Rehabilitation

Your weekly benefit payment can be reduced to $0 if you refuse to participate in rehabilitation or treatment that is reasonable, available and necessary.

Which Weekly Benefit Is Right For Me?

If your application for benefits indicates that you may qualify for more than one of the weekly benefits, your insurance company will notify you that you must choose one of the benefits. You must advise your insurance company which weekly benefit you wish to receive by signing and returning an election form within 30

days of receiving it. Your insurance company will give you this form.

If your insurance company notifies you that you must choose which weekly benefit to receive, you should pay special attention to the fact that the weekly benefit that pays the most might not be the benefit that pays for the longest period of time.

What follows is an overview of the three weekly benefits. Contact your claims representative if you have questions after reading this information.

— Income Replacement Benefit

This benefit may be available to you if you were employed or self-employed at the time of the accident or were employed just before the accident. The benefit provides a payment to partially replace lost income if, within two years of the accident, you suffer a physical or psychological impairment that prevents you from working as a direct result of the motor vehicle accident.

Any one of the following situations must apply to you in order for you to qualify to receive an income replacement benefit:

- You were employed or self-employed at the time of the accident and your injuries substantially prevent you from completing the essential tasks of your job; or
- You were unemployed at the time of the accident, and
  - had been employed for at least 26 weeks during the 52 weeks before the accident or were receiving Employment Insurance benefits at the time of the accident, and
  - were 16 years of age or more or were excused from attending school under the *Education Act*, and
  - your injuries substantially prevent you from completing the essential tasks of the job you spent the most time in during the 52 weeks before the accident.

How Is The Benefit Calculated?

The policy allows for payment of 70% of your gross income from employment and self-employment based on your income history before the accident. Included in the gross income calculation are payments received from Employment Insurance before the accident. Gross annual income is calculated as follows:

- For persons employed at the time of the accident, the gross annual income is based on earnings in the four or 52 weeks before the accident.
- Self-employed people have their gross annual income based on earnings during the 52 weeks before the accident, or based on their last fiscal year completed before the accident.
- For persons unemployed at the time of the accident and receiving Employment Insurance Benefits, or for persons who were unemployed but employed for at least 26 weeks in the 52 weeks before the accident, gross annual income is based on earnings during the 52 weeks before the accident.

Income that you were required to report and did not report for income tax purposes will not be included in the calculation of your gross income from employment.

From 70% of your gross income will be deducted gross benefits you receive from other sources as a result of the accident, such as employment or private income continuation benefit plans or payments from the Canada Pension Plan. Also deductible are certain temporary disability benefits that are received because of a disability you had before the accident. If you are able to start back to work after the accident on a part-time basis, your insurance company can deduct 70% of those gross earnings from the benefit payable.

How Much Is Payable?

The maximum payment is $400.00 per week unless you purchased higher benefits before the accident. There is no minimum weekly benefit unless your disability lasts for more than 104 weeks. If you qualify to continue receiving the benefit after 104 weeks because you suffer a complete inability to engage in any employment or self-employment for which you are reasonably suited by education, training or experience, the minimum weekly benefit is $185. Benefits you receive from other sources or plans are deductible from the minimum amount.

If you are 65 years of age or older, benefits are payable for a maximum of four years and the amount of your benefit will be reduced on an annual basis. If you are less than 65 years of age and continue to qualify to receive the benefit when you reach age 65, your benefit will be converted to a lifetime pension at a reduced rate.

When Are Payments Made?

Benefit payments will begin within 10 business days of your insurance company approving your application. If your application is questioned or refused, your insurance company will send you a written explanation or a request for more information.

If your application is approved, a payment will be sent to you at least once every

two weeks as long as your disability continues to entitle you to receive the benefit. Updated medical documentation is required to prove your ongoing entitlement to the benefit.

Are There Any Restrictions On When Or How Long The Benefit Is Payable?

An income replacement benefit is not payable:

- For the first week of disability.
- When your injuries no longer substantially prevent you from completing the essential tasks of your job. (This applies during the first 104 weeks of your disability.)
- For longer than 104 weeks of disability unless, because of the accident, you suffer a complete inability to engage in any employment or self-employment for which you are reasonably suited by education, training or experience.

Other Restriction

Your income replacement benefit payment can be reduced to $0 if you do not make a reasonable effort to return to work or to obtain other employment or self-employment for which you are suited once you receive medical approval to do so.

What If My Injuries Stop Me From Working Again After I Go Back To Work?

Your insurer will stop paying you an income replacement benefit when you go back to work. You can re-apply for the benefit if:

- You went back to your job or started another job within 104 weeks of when you first became disabled; AND
- You have to stop working again because of the injuries you received in the accident.

You must tell your insurance company that you want to re-apply for an income replacement benefit within 7 days of stopping work or as soon after that date as possible. **Failing to notify your insurer within 7 days could mean that you will lose your right to receive any further income replacement benefits.** Before the benefit can be resumed, you will need to give your insurance company medical and other information to confirm that your injuries are the reason you can't work.

— Non-Earner Benefit

To receive a non-earner benefit, the accident must cause you to suffer a complete inability to carry on a normal life. This means that, within two years of the accident, you must be continuously prevented from engaging in substantially all of the activities in which you ordinarily engaged before the accident due to a physical or psychological impairment. In addition to suffering a complete inability to carry on a normal life, at least one of the following situations must apply to you:

- You do not qualify for an income replacement benefit.
- You are a student, meaning that you are enrolled on a full-time basis in elementary, secondary or post-secondary education.
- You are a recent graduate, meaning that you completed your education less than one year before the accident but haven't yet secured employment related to your education and training.

How Much Is Payable?

The non-earner benefit pays a weekly benefit of $185. If you are a student or recent graduate, the weekly benefit is increased to $320 if you remain disabled 104 weeks after you first qualified to receive the benefit.

From this amount will be deducted benefits you receive from other sources as a result of the accident, such as employment, self-employment or private income continuation benefit plans or payments from the Canada Pension Plan. Also deductible are certain temporary disability benefits received because of a disability you had before the accident.

If you are 65 years of age or older when you become disabled, benefits are payable for a maximum of four years and the amount of your benefit will be reduced on an annual basis. If you are less than 65 years of age and continue to qualify to receive the benefit when you reach age 65, your benefit will be converted to a lifetime pension at a reduced rate.

When Are Payments Made?

Your insurance company will let you know whether you qualify to receive this benefit within 10 business days of receiving your application. If your application is questioned or refused, your insurance company will send you a written explanation or a request for more information. If your application is approved, benefit payments will begin within 10 business days after expiry of the 26-week waiting period or after you reach age 16, so long as you still qualify to receive the benefit at that time.

If your application is approved, a payment will be sent to you at least once every two weeks as long as your disability continues to entitle you to receive the benefit. Updated medical documentation is required to prove your ongoing entitlement to the benefit.

Are There Any Restrictions On When Or How Long The Benefit Is Payable?

A non-earner benefit is not payable:

- For the first 26 weeks after the onset of your complete inability to carry on a normal life.
- Before you reach the age of 16.
- When your impairment no longer continuously prevents you from engaging in substantially all of the activities in which you ordinarily engaged before the accident.

— Caregiver Benefit

This benefit is only payable if you have suffered a catastrophic impairment or if the optional caregiver, housekeeping and home maintenance benefit applies to you.

This benefit may apply to you if you were responsible for, but were not paid for, looking after others at the time of the accident. The benefit provides reimbursement of your expenses to have someone else provide the care you can no longer provide if, within two years of the accident, you suffer a physical or psychological impairment as a direct result of a motor vehicle accident.

All of the following must apply in order for you to qualify to receive a caregiver benefit:

- You must reside with the person(s) you provided care to.
- You must be the primary caregiver to the person(s) you provided care to.
- You did not receive any compensation for providing the care.
- The person(s) receiving the care must be under the age of 16 or must require your care due to their physical or mental incapacity.
- You must suffer a substantial inability to engage in the caregiving activities you engaged in at the time of the accident.

How Much Is Payable?

The caregiver benefit will refund your incurred expenses to replace your pre-accident caregiving services. Payment is limited to up to $250 per week if you cared for one person at the time of the accident. If you cared for more than one person, expenses of up to $50 per week are payable for each additional person.

How do I Incur Expenses?

Please review the definition of "incurred" on page 4 to help you understand this important requirement.

When Are Payments Made?

Your insurance company must first receive all of the necessary completed application forms before a payment can be made. If your application or expenses are questioned or refused, your insurance company will send you a written explanation or a request for more information.

If your application is approved, benefits are payable within 10 business days of you giving your insurance company written documentation of your incurred expenses.

Are There Any Restrictions On When Or How Long The Benefit Is Payable?

A caregiver benefit is not payable:

- For expenses incurred for children after they reach the age of 16.
- For persons who previously received care due to a physical or mental incapacity once they no longer require care.
- When your injuries no longer substantially prevent you from engaging in the caregiving activities you engaged in at the time of the accident. (This applies to the first 104 weeks of your disability.)
- After 104 weeks of disability unless, because of the accident, you are continuously prevented from engaging in substantially all of the activities in which you ordinarily engaged before the accident.

Medical And Rehabilitation Benefits

There is information you should know about the medical and rehabilitation benefits if you are injured in a motor vehicle accident and require treatment for your injuries. This section will help to explain the benefits that you may be eligible to receive.

What Are Medical Benefits?

Medical benefits are payments for reasonable and necessary expenses not covered by another health plan or other extended health policy, incurred as a result of the motor vehicle accident in which you were injured.

The coverage includes reasonable and necessary incurred expenses for:

- medical, surgical, dental, optometric, hospital, nursing, ambulance, hearing and speech-therapy services;
- chiropractic, psychological, occupational therapy and physiotherapy services;
- medication;
- prescription eyewear;
- dentures and other dental devices;
- hearing aids, wheelchairs or other mobility devices, prostheses, orthotics and other assistive devices;
- transportation to and from treatment sessions, including transportation for an attendant;
- other required goods and services of a medical nature.

NOTE: Your insurance company is not obligated to pay for any goods or services that are considered experimental.

What Are Rehabilitation Benefits?

Rehabilitation benefits pay for expenses incurred by you or on your behalf, provided you have been injured in a motor vehicle accident. The coverage is for costs incurred for reasonable and necessary measures to:

- reduce or eliminate the effects of the disability resulting from your impairment; or
- help you in reintegrating into a family role, the labour market (if you had a labour force attachment) and into your community.

The coverage includes reasonable and necessary incurred expenses for:

- life skills, vocational and academic training;
- family, social rehabilitation, financial and employment counselling;
- vocational assessments;
- workplace, home and vehicle modifications;
- transportation for you and, if necessary, an attendant to and from counselling and training sessions;
- other required goods and service that are rehabilitative in nature.

NOTE: The expenses of a qualified case manager are also payable if you sustain an impairment that is defined by the Regulation to be a catastrophic impairment, or if you purchased the optional combined medical, rehabilitation and attendant care benefit before the accident. A case manager is a person who is qualified to co-ordinate medical, rehabilitation and attendant care goods and services.

How Much Is Payable In Medical And Rehabilitation Benefits?

The amount payable for medical and rehabilitation benefits depends on the severity of the injury/injuries. If your injury is predominantly a "minor injury", the maximum amount payable for medical and rehabilitation benefits is $3,500. If your injury does not result in a catastrophic impairment as defined by the Regulation, combined medical and rehabilitation benefit payments will be up to a maximum of $50,000. If your injury is catastrophic, combined benefit payments will be up to a maximum of $1,000,000. If you purchased one of the optional medical and rehabilitation benefits before the accident, maximum payment amounts will be greater. Your claims representative will provide you with more information about the optional benefit maximums **if one applies to you**.

It is important to know that whichever maximum payment amount applies, it includes all amounts paid for assessments, examinations and report preparation fees.

How Do I Incur an Expense?

Please review the definition of "incurred" on page 4 to help you understand this important requirement.

How Long Are Medical And Rehabilitation Benefits Payable?

If your injury is not catastrophic as defined by the Regulation, medical and rehabilitation benefits are payable for up to 10 years after the accident. If you are less than 15 years old at the time of the accident, benefits may be paid until you reach age 25. There is no time limit for payment of these benefits if your injury is catastrophic, or if you purchased the optional combined medical, rehabilitation and attendant care benefit before the accident.

Do I Qualify For Medical And Rehabilitation Benefits?

It is important to understand that expenses you incur must be as a result of injuries you sustained in the motor vehicle accident, as well as being reasonable and necessary. With the exception of ambulance fees, emergency goods or services provided within 5 business days after the accident, drugs prescribed by a regulated health professional, goods with a cost of $250 or less per item, and initial treatment under the *Minor Injury Guideline*, medical and rehabilitation expenses must be pre-approved by your insurance company. **Your insurance company has the right to refuse payment of all other medical or rehabilitation expenses you incur without its approval.** Therefore, you must apply for a medical or rehabilitation expense by submitting a treatment and assessment plan form prepared by a regulated health professional. A treatment and assessment plan includes a description of your impairment and of the goods and services that are recommended. It must also indicate whether your impairment is predominantly a "minor injury". "Minor injury" is a category of injury that is described in more detail below. Your insurer will respond to the treatment and assessment plan within 10 business days of receiving it. If the plan is acceptable, your insurer will pay for expenses within 30 days of receiving invoices. If any part of the plan is questioned, your insurer will advise which goods, services, assessments or examinations it takes issue with and why and may notify you that they want you to attend an insurer examination.

Any medical or rehabilitation coverage available to you through other sources, such as provincial, employment or private health plans must be accessed first before your insurance company is required to pay.

Insurer Examinations And Requests For Additional Information

You should review the information on page 5 to help you understand these important requirements.

Minor Injuries and the Minor Injury Guideline

A minor injury is defined as one or more of a "sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury". If your health practitioner determines that your injury is predominantly a minor injury, treatment to facilitate recovery and restore function can begin immediately in accordance with the *Minor Injury Guideline* which sets out the goods and services that will be paid for by your insurer without prior approval. However, a treatment confirmation form must first be submitted to the insurer unless your insurer has waived the requirement to do so. The insurance company will be billed according to a pre-determined fee schedule.

Ask your claims representative if you would like to receive a copy of the *Minor Injury Guideline*.

Maximum Fees For Professional Services

Expenses for health care services are subject to maximum fees. Motor vehicle insurers do not have to pay more than these fees. Contact your claims representative if you would like a copy of the *Professional Services Guideline* or for information about maximum rates payable according to the Ontario Medical Association.

Transportation Expenses

Medical and rehabilitation transportation expenses are payable according to a *Guideline* issued by the Superintendent of Insurance. There is a set compensation rate for travel in a vehicle you own, lease or have access to. There is also a 50 km round trip deductible (i.e. no compensation for the first 50 km of any trip) unless the impairment you receive in the accident is a catastrophic impairment as defined in the Regulation. Contact your claims representative if you would like a copy of the *Transportation Expense Guideline*.

Attendant Care Benefit

What Are Attendant Care Benefits?

Attendant care benefits pay for reasonable and necessary expenses you incur because your injuries require you to have someone help you with your personal care activities. This benefit pays for the following:

- services provided by an aide or attendant; or
- services provided by a long-term care facility, including a long-term care home or chronic care hospital.

How Much Is Payable?

If your injury does not result in a catastrophic impairment as defined by the Regulation, benefit payments will be up to $3,000 per month and $36,000 in total for expenses incurred within two years of the accident. If your injury is catastrophic, benefit payments will be up to $6,000 per month and $1,000,000 in total with no time limit. If you purchased one of the optional attendant care benefits before the accident, the maximum amounts payable will be greater and there is no time limit for payment. Your claims representative will provide you with more information about the optional benefit maximums **if one applies to you**.

How Do I Incur an Expense?

Please review the definition of "incurred" on page 4 to help you understand this important requirement.

How Long Is The Benefit Payable?

If your injury is not catastrophic as defined by the Regulation, an attendant care benefit is payable for up to two years after the accident. There is no time limit for payment of these benefits if your injury is catastrophic or if you purchased the optional combined medical, rehabilitation and attendant care benefit before the accident.

Do I Qualify For Attendant Care Benefits?

The expenses you incur must be required as a result of the injuries you sustained in the motor vehicle accident, as well as being reasonable and necessary. To apply for this benefit, you must give your insurance company an Assessment of Attendant Care Needs (Form 1) completed by an occupational therapist or a registered nurse. Information in the form will calculate the amount of the benefit. Your insurance company can provide you with the form and will pay for it to be completed.

It is important for you to know that your insurance company has the right to refuse to pay for any attendant care expenses you incur before you send in a completed Assessment of Attendant Care Needs (Form 1).

Once it receives your completed form, your insurer will let you know if it accepts your application or if it needs you to attend an insurer examination. It will begin paying the benefit within 10 business days even if it questions your application.

If your application for attendant care benefits is accepted, your insurer may ask you to submit a new Assessment of Attendant Care Needs (Form 1) from time to time. You can also submit a new form if your monthly needs change. Your insurer can ask you to attend an insurer examination if they question your need for the benefit, the amount of the benefit or if you apply to increase the benefit. Some restrictions on submission of new forms and insurer examinations apply if you qualify to receive an attendant care benefit more than 2 years after the motor vehicle accident.

Any attendant care coverage available to you through other sources, such as provincial, employment or private health plans must be accessed first before your insurance company is required to pay.

Insurer Examinations And Requests For Additional Information

You should review the information on page 5 to help you understand these important requirements.

Payment Restriction Regarding Minor Injuries

Your insurer is not required to pay an attendant care benefit if you sustain an impairment that comes within the *Minor Injury Guideline*. Ask your claims representative if you would like to receive a copy of the *Minor Injury Guideline*.

Other Expenses

Certain other expenses may be payable to you or on your behalf as a result of a motor vehicle accident. What follows is an outline of the process for claiming these expenses and a description of the expenses.

Insurer Examinations And Requests For Additional Information

You should review the information on page 5 to help you understand these important requirements.

— Lost Educational Expenses

This benefit is for people who, at the time of the accident, were enrolled in an elementary, secondary, post-secondary or continuing education program and, as a result of an impairment sustained in an accident, are unable to continue the program.

The benefit covers expenses incurred before the accident for tuition, books, equipment or room and board to a maximum of $15,000. The expenses must be related to the program that you can no longer continue and for the school term in which you were enrolled at the time of the accident.

In order to receive a lost educational expense, you will be required to supply proof of your incurred expenses and provide a disability certificate from a qualified medical person stating the cause and nature of your injuries with an estimate of how long your disability will last. Your insurer will provide you with the certificate and pay for it to be completed.

— Expenses of Visitors

If you sustain an impairment as a result of an accident, your insurance company will pay for reasonable and necessary expenses incurred by the following people when they visit you during your treatment or recovery:

- your spouse, children, grandchildren, parents, grandparents, brothers and sisters;
- an individual who was living with you at the time of the accident;
- an individual who you were clearly treating as a child of your family;
- in the case of an injured child, an individual who is clearly treating that child as part of the individual's family.

There is a maximum of 104 weeks after the accident during which these expenses can be claimed, unless your impairment is catastrophic as defined by the Regulation.

How Do I Incur an Expense?

Please review the definition of "incurred" on page 4 to help you understand this important requirement.

— Housekeeping and Home Maintenance Expenses

This benefit is only payable if you have suffered a catastrophic impairment or if the optional caregiver, housekeeping and home maintenance benefit applies to you.

If your injuries result in a substantial inability to take care of your home as you did before the accident, your insurance company will pay for reasonable and necessary additional expenses actually incurred by you to replace your housekeeping and home maintenance services.

The maximum payable is up to $100 per week. Incurred expenses can be claimed for a maximum of 104 weeks after the start of your disability unless your impairment is catastrophic as defined by the Regulation. You will have to supply documentation to confirm that you have incurred expenses. Your claims representative will explain what is needed.

How Do I Incur an Expense?

Please review the definition of "incurred" on page 4 to help you understand this important requirement.

Disability Certificate Requirement

In order to receive payment of housekeeping and home maintenance expenses, you will be required to provide a certificate from a qualified medical person stating the cause and nature of your injuries with an estimate of how long your disability will last. Your insurer will provide you with the certificate and pay for it to be completed. **The certificate has to be sent with your application for expenses. If you send your application without a disability certificate, your insurance company does not have to pay your housekeeping and home maintenance expenses for any time before the completed certificate is received.**

If your application for housekeeping and home maintenance expenses is approved, your insurance company has the right to ask that you provide updated disability certificates to determine if you are still entitled.

If your application is accepted, your insurer will pay for expenses within 30 days of receiving invoices. If any of your expenses are questioned, your insurer may require that you be assessed at an insurer examination.

— Damage to Clothing, Glasses, Hearing Aids, Etc.

Your insurance company will pay for reasonable expenses incurred by you to repair or replace clothing you were wearing at the time of the accident, and prescription eyewear, dentures, hearing aids, prostheses and other medical or dental devices that were lost or damaged as a result of the accident.

— Cost of Examinations

Your insurer will pay for reasonable expenses incurred by you to have an authorized person complete an examination, assessment or report or to complete certain claim forms. Your insurer will also pay for transportation expenses incurred by you and, if required, an aide or attendant, in travelling to and from an examination or assessment.

There is a $2,000 maximum limit per assessment or examination. All assessment, examination and report expenses are deductible from the maximum amount payable to you for medical and rehabilitation benefits.

If your injury is classified as a "minor injury", no assessments or examinations can be conducted in your home.

Any coverage available to you through other sources, such as provincial, employment or private health plans must be accessed first before your insurance company is required to pay.

How Do I Incur an Expense?

Please review the definition of "incurred" on page 4 to help you understand this important requirement.

Maximum Fees For Professional Services

Expenses are subject to maximum fees. Motor vehicle insurers do not have to pay more than these fees. Contact your claims representative if you would like a copy of the *Professional Services Guideline* or for information regarding maximum rates payable according to the Ontario Medical Association.

Transportation Expenses

Transportation expenses for you to attend assessment and examinations are

payable according to a *Guideline* issued by the Superintendent of Insurance. There is a set compensation rate for travel in a vehicle you own, lease or have access to. There is also a 50 km round trip deductible (i.e. no compensation for the first 50 km of any trip) unless the impairment you receive in the accident is a catastrophic impairment as defined in the Regulation. Contact your claims representative if you would like a copy of the *Transportation Expense Guideline*.

Catastrophic Impairments

A catastrophic impairment is a serious injury that meets certain criteria outlined in the accident benefit Regulation. When it is determined that a person has a catastrophic impairment due to the injuries received in a motor vehicle accident, they are entitled to receive extended medical, rehabilitation, attendant care, visitor and/or housekeeping and home maintenance benefits.

What Is A Catastrophic Impairment?

According to the accident benefit Regulation, you will have sustained a catastrophic impairment if <u>any</u> of the following criteria apply to you because of the accident:

(a) Paraplegia or quadriplegia;

(b) The amputation of or other impairment causing the total and permanent loss of use of an arm or a leg;

(c) The total loss of vision in both eyes;

(d) Brain impairment that, in respect of the accident, results in,

  (i) A score of 9 or less on the Glasgow Coma Scale, as published in Jennett, B. and Teasdale, G., *Management of Head Injuries*, Contemporary Neurology Series, Volume 20, F.A. Davis Company, Philadelphia, 1981, according to a test administered within a reasonable period of time after the accident by a person trained for that purpose, or

  (ii) A score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale, as published in Jennett, B. and Bond, M., *Assessment of Outcome After Severe Brain Damage*, Lancet i:480, 1975, according to a test administered more than six months after the accident by a person trained for that purpose;

(e) An impairment or combination of impairments that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent*

Impairment, 4th edition, 1993, results in 55 per cent or more impairment of the whole person; or

(f) An impairment that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder.

NOTES

- Clauses (e) and (f) do not apply unless,

  - A physician states in writing that the person's condition is unlikely to cease to be a catastrophic impairment;
  (Note: a physician or neuropsychologist can give this opinion if the only impairment is a brain impairment); or

- - Two years have passed since the accident.

  There are special rules for determining how clauses (d), (e) and (f) apply to a person who was less than 16 years old at the time of the accident.

How Do I Apply If I Think I Have A Catastrophic Impairment?

If, after reading this information, you think that you may have sustained a catastrophic impairment, you should discuss this with your health practitioner. You can apply to your insurance company for a determination of whether or not the injuries you received in the accident meet the definition of a catastrophic impairment under the accident benefit Regulation. Ask your claims representative for an application form. Your insurance company will pay for it to be completed.

Your insurance company will respond to your application for designation of a catastrophic impairment within 10 business days. It will advise you in writing if it agrees that your impairment is catastrophic. If it disagrees or questions whether your impairment is catastrophic, it will give you an explanation in writing and may require you to attend for an insurer examination.

Insurer Examinations And Requests For Additional Information

You should review the information on page 5 to help you understand these important requirements.

Death And Funeral Benefits

If, as the result of a motor vehicle accident, you have lost your spouse, your dependant or someone on whom you have been dependent, there are important facts you need to know when applying for survivor benefits through an automobile insurance policy.

You must notify the insurance company of the deceased person within 7 days of the person's death, or as soon after that as possible, that you wish to apply for payments. The insurer will supply you with the necessary forms and any other information you need. You must file your application for payment of death and funeral benefits within 30 days of receiving the application forms. **Failing to notify the insurer within 7 days or failing to return the forms within 30 days could mean that you will lose your right to receive any payments**.

The insurance company that you apply to may ask you to provide a copy of the autopsy report.

Where Does the Application Go?

If the deceased had his or her own motor vehicle insurance or was covered under someone else's policy, return the completed application to that insurance company. If they did not have insurance, return the completed application to the insurer of the vehicle in which the person was an occupant or which hit the person if s/he was a pedestrian. If there is no insurance on that vehicle, return the application to the insurer of any other vehicle involved in the accident. If no automobile insurance exists to respond to the claim, there may be entitlement to benefits from the Motor Vehicle Accident Claims Fund (MVACF). Your claims representative or the MVACF can explain how the Fund works in these situations.

What Are Death Benefits and Funeral Benefits?

Death Benefits are lump sum payments to you if you have lost a spouse, dependant or someone on whom you were dependent.

Funeral benefits provide reimbursement of funeral expenses up to a maximum amount.

Do I Qualify For Payments?

Before you can receive death benefits or reimbursement of funeral expenses under an automobile insurance policy, your situation must qualify under the accident benefit Regulation.

You may qualify for payment of a death benefit if, as a result of the accident:

- your spouse (or former spouse from whom you were receiving support under a domestic contract or court order), or
- the person on whom you were dependent or a person from whom you were receiving support under a domestic contract or court order, or
- a person dependent on you,

  dies within 180 days of the accident, or within 156 weeks of the accident if the injury sustained was continuously disabling during that period.

The Regulation defines "spouse" and "dependant". Your claims representative can give you more information about the definitions.

Death benefits are not payable to a person who dies before the person that is killed in the motor vehicle accident, or who dies within 30 days of the person that is killed in the motor vehicle accident.

A funeral benefit is payable when an insured person dies as a result of a motor vehicle accident. This benefit pays the person who incurs these expenses up to the policy maximum.

How Much Is Payable?

The amount of the death benefit payable depends on your particular situation:

1. If you are the spouse of a person killed in the accident, you will be entitled to a payment of $25,000 ($50,000 if the optional death and funeral benefit had been purchased). If the deceased person had more than one spouse at the time of the accident, this payment will be divided equally among them.

   If the deceased person had no spouse, the dependants of the deceased person and persons who were entitled to receive support from the deceased under a domestic contract or court order will be entitled to share this payment equally. However, you are not entitled to share in this payment if you were a former spouse that was receiving support from the deceased under a domestic contract or court order.
2. In addition to the amount identified in #1, if you were a dependant of the person who died, or if the person who died was obligated under a domestic contract or court order to provide support to you, you will be entitled to a payment of $10,000 ($20,000 if the optional death and funeral benefit had been purchased). This payment does not apply to you if you were a former spouse that was receiving support from the deceased under a domestic contract or court order.
3. If you were a former spouse and were receiving support from the person

who died under a domestic contract or court order, you will be entitled to a payment of $10,000.

4. If a person who is a dependant is killed as a result of a motor vehicle accident, a $10,000 payment will be made to the dependant's main provider of financial support or care. If the main provider dies before or within 30 days of the dependant, the $10,000 payment will be made to the spouse of the main provider if the spouse was the deceased person's primary caregiver. If that person also dies before or within 30 days of the dependant, the dependants of the main provider will share the $10,000 payment equally.

(NOTE: A maximum of $10,000 is payable when a person who is a dependant dies. This amount will be shared equally if more than one person is entitled to the payment.)

Funeral expenses are reimbursed up to a maximum of $6,000 or, $8,000 if the optional death and funeral benefits had been purchased.

If after reading this you still have questions, please contact your claims representative.

More Information

If you would like more information, we encourage you to call the following organizations or visit their websites:

Insurance Bureau of Canada:
(416) 362-9528 | Toll-free: 1-800-387-2880 | www.ibc.ca

Financial Services Commission of Ontario
(416) 250-7250 | Toll-free: 1-800-668-0128 | www.fsco.gov.on.ca

Motor Vehicle Accident Claims Fund
(416) 250-1422 | Toll-free: 1-800-268-7188

For more information on making a claim through MVACF, visit FSCO's Automobile Insurance website at: www.autoinsurance.gov.on.ca.

Information provided courtesy of the Insurance Bureau of Canada.

If you have any questions about the legislation or how to make a claim, please contact your claims representative.

September 2010