Return this form to:

Expenses Claim Form (OCF-6)

Use this form for accidents that occur on or after January 1, 1994

Claim Number:	
Policy Number:	
Date of Accident: (YYYY/MM/DD)	

Only use this form to claim expenses not submitted on your behalf by your health care provider.

You can apply for reasonable and necessary expenses incurred as a result of the accident and not covered under another plan. Such expenses may include the costs of medical and rehabilitation treatment, lost educational expenses, caregivers, attendant care and housekeeping services, transportation expenses, expenses of visitors, and the cost to repair or replace lost or damaged clothing, dentures, glasses, prostheses, hearing aids, etc. Please attach all bills and receipts.

Part 1 Applicant Information

Last Name		First Name and Initial	Gender ☐ Male ☐ Female
Address			
City	Province	Postal Code	
Birth date (yyyy/mm/dd)	Home Telephone	Work Telephone	Ext

Part 2 Expenses

☐ additional sheets attached

Attach all bills and receipts. If a bill or receipt is not available, please explain. If you need more space, please attach additional sheets.

Item	Date	Description of Goods and Services and Name of Service Provider	Amount
		Total Amount	

Part 3 Signature

I certify that the information provided is true and correct. I understand that it is an offence under the *Insurance Act* to knowingly make a false or misleading statement or representation to my insurer under a contract of insurance. I further understand that it is an offence under the federal *Criminal Code* for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company. I further understand that the use and disclosure of information contained on this form is subject to the terms described on my Application for Accident Benefits.

Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (yyyy/mm/dd)
	✓	