Return this fo	rm to:		Use this for Collection	Health orm for accidents to, use and disclosu	Informa hat occur on or a	n to Disclose ation (OCF-5) fter January 1, 1994. tion is subject to all applicable
			privacy le	gislation. im Number:		
			Poli	Policy Number:		
L			Date o	of Accident: (YYYYMMDD)		
Part 1 Applicant Information	Last Name	First Name	First Name and Initial		Date of Accident	year month day
	Address					
	City	ry Province			Postal Code	
	Birth year month day Home Telepho	one	Work Telep		one Extension	
Part 2 Insurance Company Information	Name of Insurance Company Name of Insurance Company Representative Address City					
	Province Postal Code To	elephone Number			FAX Numbe	er
Part 3 Treating Health Professional	Name of Health Professional		Health Profe	ealth Profession		
	Address					
	City		Pro	ovince		Postal Code
	Telephone Number		X Number			
Part 4 Signature	I authorize my treating health professional t social worker, or vocational rehabilitation exonly such information relating to my health accident and any pre-existing or subsequer as a result of the automobile accident, as is determining my eligibility for benefits. This has been concluded or until I withdraw this benefit entitlement). This authorization does not apply to a consprofessional conducting an examination. Seconsent should be in writing.	xpert properly a condition and t ntly occurring h reasonably re authorization is consent. (Plea ultation betwee	appointed reatment is ealth cond quired for sivalid unties note with the many hear my hear reatments.	by my insure received as a ditions that m the purpose il my claim fo ithdrawal of the lth care prov	er to conduct a result of the nay be a bar of providing or Statutory this consent ider and the	et an examination, the automobile trier to my recovery getreatment and Accident Benefits the may impact your the insurer's health

Name of Applicant or Substitute Decision Maker (please print)

Date (YYYYMMDD)

Signature of Applicant or Substitute Decision Maker