

Return this form to:



GENERAL INSURANCE COMPANY  
1550 Enterprise Road, Suite 310  
Mississauga, ON L4W 4P4

# Declaration of Post-Accident Income and Benefits (OCF-13)

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

<b>Claim Number:</b>	
<b>Policy Number:</b>	
<b>Date of Accident:</b> (YYYYMMDD)	

The information collected in this form will help your insurance company determine the correct amount of accident benefits that you are entitled to receive.

## Part 1 Applicant Information

Last Name				First Name and Initial				
Address						City		
Province	Postal Code	Home Telephone	Area Code		Date of Accident	year	month	day

## Part 2 Employment Income

Since the date of the accident, have you received any income from:

- Employment  Yes (Give details below)  No (Continue to part 3)  
Self-employment  Yes (Give details below)  No (Continue to part 3)

Name of Employer/Business				Employer Contact Name					
Job Title				Telephone Number	Area Code				
Employed From:	year	month	day	year	month	day	To:	Total Hours	Total Income Received \$

Name of Employer/Business				Employer Contact Name					
Job Title				Telephone Number	Area Code				
Employed From :	year	month	day	year	month	day	To:	Total Hours	Total Income Received \$

Name of Employer/Business				Employer Contact Name					
Job Title				Telephone Number	Area Code				
Employed From:	year	month	day	year	month	day	To:	Total Hours	Total Income Received \$

Name of Employer/Business				Employer Contact Name					
Job Title				Telephone Number	Area Code				
Employed From:	year	month	day	year	month	day	To:	Total Hours	Total Income Received \$

Name of Employer/Business				Employer Contact Name					
Job Title				Telephone Number	Area Code				
Employed From:	Year	month	day	year	month	day	To:	Total Hours	Total Income Received \$

**Part 3  
Private  
Disability  
Benefits**

**Have you received any private disability/income replacement benefits since the accident?**

Group Benefits	Short Term <input type="checkbox"/> Yes <input type="checkbox"/> No	Long Term <input type="checkbox"/> Yes <input type="checkbox"/> No
Private Benefits	Short Term <input type="checkbox"/> Yes <input type="checkbox"/> No	Long Term <input type="checkbox"/> Yes <input type="checkbox"/> No
Other	<input type="checkbox"/> Yes (Specify type of benefit) _____ <input type="checkbox"/> No	

If you have checked yes to any box above, give details below

Name of Insurance Company	Name of Policyholder	Policy/Group Certificate Number	How many weeks are you eligible to receive benefits?	Benefits Start Date	Total Amount Received
				year month day	\$
				year month day	\$

**Part 4  
Public  
Benefit  
Plans**

**Have you received any public benefits since the accident?**

CPP Disability Pension	<input type="checkbox"/> Yes <input type="checkbox"/> No
Workplace Safety and Insurance Board (other than permanent pensions)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employment Insurance (EI) Sick Benefits under the Employment Insurance Act	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other <input type="checkbox"/> Yes (specify type of benefit) _____ <input type="checkbox"/> No	

If you have checked yes to any box above, give details below.

Claim Number	Benefits	Total Amount Received
	Received From: year month day To: year month day	\$
	Received From: year month day To: year month day	\$

**Part 5  
Medical/  
Dental  
Benefits**

**Have you submitted any medical/dental receipts covering expenses incurred as a result of the accident to any of the following?**

Group Benefit Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No
Private Benefit Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other <input type="checkbox"/> Yes (specify type of benefit) _____ <input type="checkbox"/> No	

If you have checked yes to any box above, give details below.

Name of Insurance Company	Name of Policyholder	Policy Number	Type of Expense

**Part 6  
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 an 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 information contained on this form may be used and disclosed in the manner described in my Application for Accident Benefits.

Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)
---	---	-----------------