Notification of loss transfer

First Party Insurer (The insurer responsible for paying Accident Benefits)

Company Name

Mailing Address

Unit Number	Street Number	Street Name	
City		Province	Postal Code
Claim Number	Policy Number	Name of Policyholder	
Classes of vehicles insured under policy		Classes of vehicles involved in incident	
Contact Person/Representative		Contact Person Phone Number	Contact Person Fax Number

Second Party Insurer (The insurer responsible for indemnifying the first party insurer)

Company Name

Mailing Address

Unit Number	Street Number	Street Name	
City		Province	Postal Code
Claim Number	Policy Number	Name of Policyholder	
Classes of vehicles insured under policy		Classes of vehicles involved in incident	
Contact Person/Representative		Contact Person Phone Number	Contact Person Fax Number

Name of insured person and accident details

Last name	First name	Date of accident (yyyy/mm/dd)

Does this notice deal with an accident that took place on or between June 22, 1990 and December 31, 1993? ◯ Yes ◯ No

Does this notice deal with an accident that took place on or after January1, 1994? ◯ Yes ◯ No

Accident benefits payments

Check which Accident benefits are being paid to the insured person.

Weekly benefits: ☐ Income replacement ☐ Education ☐ Caregiver ☐ Other disability

Other benefits: ☐ Medical ☐ Rehabilitation ☐ Attendant care ☐ Death benefits

☐ Funeral expenses ☐ Other expenses ☐ Loss of earning capacity

Details (if necessary)

Applicable fault determination rule

What is the rule number used to determine fault?

What is the percentage of Accident Benefits to be paid by second party insurer through loss transfer?

◯ 0% ◯ 25% ◯ 50% ◯ 75% ◯ 100%

Signature

Name	Signature	Date (yyyy/mm/dd)

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