Notice to Applicant of Dispute Between Insurers

Name of Applicant

Last Name | First Name

Mr. ☐ Mrs. ☐ Ms. ☐

Street Address

City | Province | Postal code

Date of Accident — Day / Month / Year

This notice is to inform you that the insurer to whom you have applied for accident benefits claims that another insurer is responsible for paying these benefits. You may be required to assist the insurers in resolving their dispute by providing them with any information that may be needed to determine which insurer should be paying your accident benefits claim.

You will continue to receive accident benefits that you are entitled to from the insurer that you applied to while the insurers attempt to resolve their dispute.

You also have the right to object to your claim being transferred to another insurer. If you wish to object please complete Part 5 of this form and send it within 14 days to the insurer that is currently paying you accident benefits. If you object, you are entitled to participate in any proceeding that may take place to determine which insurer is responsible for paying accident benefits to you. If you do not object, you will not be permitted to dispute the transfer of your claim to another insurer.

If you have any questions about this notice, or about the process that insurers use to determine who is responsible for paying your claim, please contact the representative of the insurance company that is paying your accident benefits claim. The name and telephone number of the representative is listed in Part 1.

Part 1: Insurer that You Applied to for Accident Benefits

Company Name

Mailing Address

City | Province | Postal code

Contact Person/Representative | Phone No: ( )

Part 2: Insurer(s) Notified to Pay Benefits (by Insurer Listed in Part 1)

First Company Name

Mailing Address

City | Province | Postal code

Contact Person/Representative | Phone No: ( )

Attach additional sheets if necessary. ☐ **Additional sheets attached.**

Second Company Name

Mailing Address

City | Province | Postal code

Contact Person/Representative | Phone No: ( )

Attach additional sheets if necessary. ☐ **Additional sheets attached.**

Part 3: Reasons (Why Notice is Given to Other Insurers)

Details

Attach additional sheets if necessary. ☐ **Additional sheets attached.**

Part 4: Signature of Insurer Representative

Name | Date

Signature

Part 5: Objection to Transfer of Claim (optional)

You can object to your claim being transferred to the insurer(s) referred to in Part 2 by completing this section and returning the form to the insurer that you applied to in Part 1 within 14 days.

If you object, you are entitled to participate in any proceeding that may take place to determine which insurer is responsible for paying accident benefits to you. If you do not object, you will not be permitted to dispute the transfer of your claim to another insurer.

Please check the box below and return this form to the insurer listed in Part 1 within 14, days only if you wish to object to your claim being transferred to another insurance company.

☐ **I Object to the claim being transferred.**

Name | Date

Signature