



Application for Mediation FORM A

Mediation file number

Section 1 GENERAL INFORMATION

This section **MUST** be completed.

1. What was the date of the motor vehicle accident? Year Month Day		2. Who is making this application? <input type="checkbox"/> Claimant <input type="checkbox"/> Claimant's representative <input type="checkbox"/> Insurance company <input type="checkbox"/> Insurance company's representative	
3. Have you applied for mediation before? <input type="checkbox"/> No <input type="checkbox"/> Yes			
4. Language preferred <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other, specify ►		5. Do you want the mediation to be conducted in French? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you want an in-person meeting with the other party? Please note that it is within the mediator's discretion to conduct the mediation in person or by telephone conference. <input type="checkbox"/> No <input type="checkbox"/> Yes			

CLAIMANT

<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Last name	First name	Middle name
Street address			Apt./Unit		
City		Province/State		Postal Code/Zip	Country
Home phone number ()		Work phone number ()	Ext.	Fax number ()	Birth date Year Month Day
1. What is the best way to reach you? <input type="checkbox"/> phone <input type="checkbox"/> mail <input type="checkbox"/> fax <input type="checkbox"/> through my representative			2. Where is the best place to reach you? <input type="checkbox"/> home <input type="checkbox"/> work <input type="checkbox"/> other, specify ►		
3. When is the best time to reach you? Specify days of the week and time.					
4. Is the Claimant under 18 years old?		Or mentally incapable?			
<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes		If Yes, the person filing the application on behalf of the claimant	
must also complete Form P – Representing Minors and Mentally Incapable Persons – and sign this application form. Form P is available on the Commission website: www.fSCO.gov.on.ca or by calling the Mediation Hotline in Toronto at (416) 590-7210 or Toll-Free at 1-800-517-2332, ext. 7210.					

CLAIMANT'S REPRESENTATIVE

<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Last name	First name	File reference number
Title			Firm Name		
Street address			Apt./Unit		
City		Province/State		Postal Code/Zip	Country
Work phone number ()		Ext.	Fax number ()	Electronic mail address	
The representative is:					
<input type="checkbox"/> Lawyer		Law Society licence number		_____	
<input type="checkbox"/> Licensed paralegal		Law Society licence number		_____	
<input type="checkbox"/> Not required to be licensed		Specify the type of exemption from the list of exemptions recognized in the Law Society's by-laws			

Section 1 continued**INSURANCE COMPANY**

Company name

Claim representative name

Claim number

Policyholder name

Policy number

INSURANCE COMPANY'S REPRESENTATIVE Mr. Mrs. Ms.

Last name

First name

File reference number

Title

Firm name

Street address

Apt./Unit

City

Province/State

Postal Code/Zip

Country

Work phone number
() Ext.Fax number
()

Electronic mail address

Section 2 ISSUES IN DISPUTEProvide a **full** description of the accident benefits that are in dispute.

(Attach extra sheets if necessary)

Does this claim involve catastrophic impairment? No YesDoes the Claimant have optional benefits? No Yes **WEEKLY BENEFITS**

Which weekly benefit are you disputing?

- income replacement
 non-earner

What are you disputing?

- initial entitlement to benefits
 length of time benefits were paid
 amount of weekly benefits
 entitlement to benefits past 104 weeks
 other, specify ▼

If the Claimant received income benefits, state weekly amount and duration of payments.

\$ _____

From: _____ To: _____

Is the insurance company claiming a repayment of benefits?

- No Yes If yes, amount ▼

\$ _____

Year	Month	Day	Year	Month	Day
Date submitted to insurer:			Date denied:		

 CAREGIVER BENEFITS

Weekly amount in dispute?

\$ _____

From: _____ To: _____

What are you disputing?

- initial entitlement to benefits
 length of time benefits were paid
 amount of benefits
 entitlement to benefits past 104 weeks
 other, specify ▼

Year	Month	Day	Year	Month	Day
Date submitted to insurer:			Date denied:		
Name of service provider(s):					

Section 2 continued

<input type="checkbox"/> ATTENDANT CARE BENEFITS											
			Year	Month	Day				Year	Month	Day
Monthly amount in dispute?			Date submitted to insurer:				Date denied:				
\$			Name of service provider(s):								
			Time period in dispute from:				to:				
<input type="checkbox"/> MEDICAL BENEFITS 1											
			Year	Month	Day				Year	Month	Day
Amount in dispute?			Date submitted to insurer:				Date denied:				
\$			Name of service provider(s):								
			Type of service(s):								
			Time period in dispute from:				to:				
<input type="checkbox"/> MEDICAL BENEFITS 2											
			Year	Month	Day				Year	Month	Day
Amount in dispute?			Date submitted to insurer:				Date denied:				
\$			Name of service provider(s):								
			Type of service(s):								
			Time period in dispute from:				to:				
<input type="checkbox"/> MEDICAL BENEFITS 3											
			Year	Month	Day				Year	Month	Day
Amount in dispute?			Date submitted to insurer:				Date denied:				
\$			Name of service provider(s):								
			Type of service(s):								
			Time period in dispute from:				to:				
<input type="checkbox"/> MEDICAL BENEFITS 4											
			Year	Month	Day				Year	Month	Day
Amount in dispute?			Date submitted to insurer:				Date denied:				
\$			Name of service provider(s):								
			Type of service(s):								
			Time period in dispute from:				to:				
<input type="checkbox"/> REHABILITATION BENEFITS 1											
			Year	Month	Day				Year	Month	Day
Amount in dispute?			Date submitted to insurer:				Date denied:				
\$			Name of service provider(s):								
			Type of service(s):								
			Time period in dispute from:				to:				
<input type="checkbox"/> REHABILITATION BENEFITS 2											
			Year	Month	Day				Year	Month	Day
Amount in dispute?			Date submitted to insurer:				Date denied:				
\$			Name of service provider(s):								
			Type of service(s):								
			Time period in dispute from:				to:				
<input type="checkbox"/> REHABILITATION BENEFITS 3											
			Year	Month	Day				Year	Month	Day
Amount in dispute?			Date submitted to insurer:				Date denied:				
\$			Name of service provider(s):								
			Type of service(s):								
			Time period in dispute from:				to:				
<input type="checkbox"/> CASE MANAGER SERVICES BENEFITS											
			Year	Month	Day				Year	Month	Day
Amount in dispute?			Date submitted to insurer:				Date denied:				
\$			Name of service provider(s):								
			Time period in dispute from:				to:				

Section 3 Document List**This section MUST be completed****(Attach extra sheets if necessary)****It is expected that both parties have exchanged key documents prior to filing this Application for Mediation.****Documents -1.** List key documents in your possession which you will refer to in the mediation.Extra sheets attached **Documents -2.** List key documents not currently in your possession which you intend to get from other sources.Extra sheets attached **Personal information requested on this form is collected under the authority of the Insurance Act, R.S.O. 1990, c.1.8 as amended. This information, including documents submitted with this application, will be used in the dispute resolution process for accident benefits.****Signature and Certification****I certify that all information in this Application and attachments is true and complete. I authorize the insurance company to release all medical reports and information relating to the issues in dispute to Mediation Services, Dispute Resolution Services, Financial Services Commission of Ontario. I realize that information filed with this Application may be given to the other party in this dispute.**

Claimant name (please print)	Claimant Signature	Date	Year	Month	Day
Representative name (please print)	Representative Signature	Date	Year	Month	Day

Send the **original and one copy** of the **completed** application to Mediation Services at the address noted below. Keep an additional copy of the completed application for yourself.

**Mediation Services
Dispute Resolution Services
Financial Services Commission of Ontario
5160 Yonge Street, 14th Floor, Box 85
Toronto, ON M2N 6L9**

If you have any questions about this application, or want more information, contact:**Mediation Hotline In Toronto at: 416-590-7210 or Toll Free: 1-800-517-2332, ext. 7210****Fax: 416-590-7077****FSCO website: www.fSCO.gov.on.ca**