

DRAFT- Application for Care-First Benefits (Form CF-1)

For accidents that occur on or after January 1, 2027

Alberta Care-First Benefits Initial Claims Process

If you have been injured in an automobile accident, regardless of who caused the accident you may be eligible for the following depending on your situation:

- Payment or reimbursement of medical expenses and personal expenses related to your injury (e.g., treatment and care, equipment and supplies, travel related expenses to appointments).
- Income replacement benefits if you are unable to work, or loss of studies benefits if you are unable to continue your studies, due to your injury or injuries,
- Caregiver support if you are unable to care for dependents due to your injuries.
- Assistance with undertaking the activities of daily living.
- Permanent impairment benefits for those who have sustained a permanent injury as a result of an automobile accident.

Your insurer must tell you about available benefits, reasonably help you with your claim, and ensure that you receive the benefits you are entitled to under the [Automobile Insurance Act \(AIA\)](#).

Did you know? The [Consumer Guide](#) is also a helpful resource you can refer to for more information about Care-First benefits, treatment and care options to support you in your recovery.



Do not complete this form if your injury occurred in an accident while working and is covered by the Workers' Compensation Board (WCB).

What to do if you are injured in an automobile accident:

1. **Contact your own insurer as soon as possible.** If you do not have automobile insurance:
 - i. and you were in an automobile, contact the insurer of the automobile you were in.
 - ii. If you were not in an automobile, contact the insurer of the automobile that injured you.
 - iii. If neither applies, contact the insurer of any other automobile involved in the accident.
 - iv. If none of those apply refer to the [Consumer Guide](#).

Once your claim is opened, your insurer will assign your file to an insurance case manager. This person is your main contact for questions about medical, income replacement, and recovery benefits.

2. **See a health care practitioner for an initial assessment of your injuries.** An early assessment can help you access Care-First benefits and start care as soon as possible. Your insurance case manager will explain whether pre-authorized care may apply.
3. **File a police report** as soon as possible. In Alberta, all automobile accidents involving injuries must be reported to the police. If police attended the scene, further action may not be needed.
4. **Collect and keep evidence** from the accident scene, including photos, dashcam footage, videos, and witness statements with contact information. While Care-First benefits are available without reference to fault, this information can help support your claim and can help determine whether the accident will affect your driving record.
5. **Complete and submit** this Application for Care-First Benefits (CF-1) to your insurer as soon as possible and keep a copy for your records.
 - To authorize someone to help communicate (e.g., translate) your information or decisions to your insurer, receive information, or act on your instructions, attach the [CF-AUTH1 Authorized Communicator/Authorized Representative Form](#).
 - A Substitute Decision Maker is someone legally allowed to sign and make claim decisions for you (the claimant); if this applies to you, see Part 6.

Important Notice Concerning Your Personal Information

The AIA authorizes and requires insurance companies to collect personal information to determine your entitlement to benefits and facilitate the handling, assessing and payment of your claim. Insurance

The logo for the province of Alberta, featuring the word 'Alberta' in a stylized, cursive font with a small square symbol at the end.

DRAFT- Application for Care-First Benefits (Form CF-1)

For accidents that occur on or after January 1, 2027

companies must protect your information and follow the [Personal Information Protection Act \(PIPA\)](#). For more information on the collection, use and disclosure of personal and health information, refer to the [Consumer Guide](#) or contact your insurance case manager or insurer.

| Part 1-Claimant Information | | |
|---|----------------------------|---|
| Last Name | First Name | Middle Name(s) |
| Date of Birth: (DD/MM/YYYY) | | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X |
| Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Adult Interdependent Partnership <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er) | | |
| Mailing Address: | | City or Town Choose an item. |
| Province/ Territory/ State | Country Choose an item. | Postal Code (X1X1X1) |
| Are you a resident of Alberta? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, specify your location of residence: | | |
| Contact information (provide all applicable) | | |
| Phone:(000)000-0000 | | Cell Phone:(000)000-0000 |
| Email: | | Other: |
| Part 2- Policy Information | | |
| *Important: If you have automobile insurance, send this form to your insurance company <i>If you do not have automobile insurance, the insurance company to which you send the form will be either the insurer of the automobile you were in at the time of the accident, the insurer of the automobile that injured you, or the insurer of any other automobile involved in the accident.</i> | | |
| *Insurance Company Name | | |
| Policy Number (if known) | | Claim Number (if known) |
| What is your relationship to the automobile insurance policyholder? (<input checked="" type="checkbox"/> select all that apply) | | |
| <input type="checkbox"/> I am the policyholder <input type="checkbox"/> I am the spouse or adult interdependent partner of the policyholder <input type="checkbox"/> I am a listed driver on the automobile insurance policy <input type="checkbox"/> I am an employee of the policyholder <input type="checkbox"/> I am a dependant of the policyholder or the policyholder's spouse or adult interdependent partner <input type="checkbox"/> I was a permitted occupant of the policyholder's automobile <input type="checkbox"/> I rented or leased an insured automobile for more than 30 days <input type="checkbox"/> I have no relationship to the policyholder | | |
| If you are not the policyholder, indicate the name of the policyholder and provide their contact information (if available) | | |
| Policy Holder Name: | | |
| Contact information (if known) | | |
| Are you aware of any other automobile insurance policies that would apply to you? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know If yes, list insurer(s) and policy number(s): | | |

| Part 3- Claimant's Accident Details | |
|-------------------------------------|--|
| Date of accident (DD/MM/YYYY) | Time of accident ____:____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. |
| Location of accident | |



DRAFT- Application for Care-First Benefits (Form CF-1)

For accidents that occur on or after January 1, 2027

| | | |
|--|--------------------------|--|
| Intersection or coordinates/ place of accident (state definite location) | | |
| City Choose an item. | Province/Territory/State | Country Choose an item. |
| Automobile information is collected to administer Care-First benefits and confirm that the injury arose from an automobile accident. It is not used to determine fault. (This helps identify the correct claim/policy and obtain records if needed.) | | |
| Type of automobile: <input type="checkbox"/> Car <input type="checkbox"/> SUV <input type="checkbox"/> Truck <input type="checkbox"/> Van <input type="checkbox"/> Motorcycle <input type="checkbox"/> Bus <input type="checkbox"/> Other (specify): _____ | | |
| License plate number (if known): | | Province/ jurisdiction of registration (if known): |
| Automobile Make (if known) | | Automobile Model (if known) |
| VIN (if known) | | |
| At the time of accident, you (the claimant) were a: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Cyclist <input type="checkbox"/> Other(specify): _____ | | |
| Indicate the type of automobile accident. Select <input checked="" type="checkbox"/> one: <input type="checkbox"/> Front impact <input type="checkbox"/> Rear impact <input type="checkbox"/> Side impact <input type="checkbox"/> Impact with rollover <input type="checkbox"/> Single automobile accident <input type="checkbox"/> I was not in an automobile <input type="checkbox"/> Other, or unknown | | |
| Provide a brief description of the accident including how your injury occurred: _____ | | |
| What was the purpose of your trip: (provide details such as where you were heading to or coming from) _____ | | |
| Did the accident happen while you were working? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe the work: _____ | | |
| <input type="checkbox"/> To the best of my knowledge, I am not eligible for benefits under the Workers' Compensation Board | | |
| Police Report In Alberta, you must report any automobile accident involving injury or fatality to the police. Was the accident reported to police? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify: Police Service/Reporting location: _____ Report file #: _____ | | |
| At the time of the accident, was a traffic ticket or suspension issued? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details _____ | | |
| Note: If this changes you must notify your insurance case manager. | | |
| Part 4- Claimant's Treatment to Date | | |
| Indicate the medical care you received following the accident: (select <input checked="" type="checkbox"/> all that apply) and provide details <input type="checkbox"/> None <input type="checkbox"/> Ambulance <input type="checkbox"/> Hospital <input type="checkbox"/> Urgent Care <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Physician <input type="checkbox"/> Nure Practitioner <input type="checkbox"/> Chiropractor <input type="checkbox"/> Other(specify): _____ _____ | | |



DRAFT- Application for Care-First Benefits (Form CF-1)

For accidents that occur on or after January 1, 2027

| |
|---|
| If you have a preferred health care practitioner, provide their name and contact information: |
| Part 4a- Injury Details |
| Describe your injuries and the symptoms you are currently experiencing from the accident: |
| Do you have an open claim with any insurance company, or are you receiving workplace disability benefits, for an unrelated/prior accident, injury, or illness? (E.g. automobile accident or work injury) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide claim number and name of the insurance company or benefit provider: |

Certain benefits and expenses require additional information. Your insurance case manager is there to help with your claim throughout the claims process. The questions below give your insurance case manager the information needed to identify which benefits or reimbursable expenses may apply, and whether additional details are required. Depending on your situation, this information may be used to determine your eligibility for benefits, such as:

- income replacement benefits;**
- caregiver benefit** (for people whose main role was providing unpaid care);
- loss of studies benefits for students;** or
- payment or reimbursement of expenses,** such as expenses for care of another person, where replacement care is needed because of your injury.

Your answers to the following questions may not on their own determine your entitlement or benefit amounts. Your insurance case manager will review your information, will let you know if additional details are needed, and will explain which benefits or expenses apply in your circumstances.

If you have questions regarding income replacement or other Care-First benefits, contact your insurance case manager. You can also refer to the [Consumer Guide](#).

| | |
|---|--|
| Part 5- Impact of the accident on Work, Studies, or Care Responsibilities | |
| Work or Studies | |
| At the time of the accident, were you working, including part-time or self-employment or working in a family enterprise? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure |
| Has your injury impacted your ability to perform all or most of your essential duties of your work, or work you would otherwise have been doing? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure |
| Have you experienced, or do you reasonably expect to experience, a reduction or loss of income because of injuries caused by the accident? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure |
| Caregiving | |
| At the time of the accident, were you regularly providing unpaid care to: <input type="checkbox"/> A child under 16 <input type="checkbox"/> A person regularly unable to hold employment due to a physical or mental impairment <input type="checkbox"/> Not applicable | |
| At the time of the accident, was providing unpaid care your main occupation or primary role? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure: |



DRAFT- Application for Care-First Benefits (Form CF-1)

For accidents that occur on or after January 1, 2027

If you were providing unpaid care, has your injury impacted your ability to continue providing that care?

Yes No
 Unsure

If your circumstances change after completing this part, inform your insurance case manager.

Part 6- Claimant's Substitute Decision Maker Information (if applicable)-

This Part must be completed by a Substitute Decision Maker if the claimant is a minor or a person who is unable to make the decisions required to complete and submit this form due to disability (e.g., cognitive impairment) or another legal limitation. A Substitute Decision Maker is a person who is legally authorized to make financial decisions on behalf of the claimant. For the purposes of this form and other Care-First forms, a Substitute Decision Maker may include a parent, legal guardian, a person appointed under an enduring power of attorney, a person appointed as a trustee by court order, or a person authorized under any other similar legal instrument.



Do not complete this Part if a Substitute Decision Maker is not required (e.g., the claimant is an adult who is able to make the decisions necessary to complete this form).

Is the claimant a minor (under 18 years of age)? Yes No

If the claimant is not a minor, is the claimant unable to complete this form due to disability (e.g., cognitive impairment) or other legal limitations? Yes No

What legal authority permits you to make decisions for the claimant?

Parent Legal Guardian Enduring Power of Attorney Court Order Other: (specify):

| | | | |
|--------------------------------|---------------------------|-----------------|----------------------|
| Last Name | First Name | Middle Name(s) | |
| Mailing address | | | |
| City or Town | Province/ Territory/State | Country | Postal Code (X1X1X1) |
| Choose an item. | | Choose an item. | |
| Telephone Number (000)000-0000 | Email | | |

Important:

This form cannot be submitted without supporting documentation demonstrating the Substitute Decision Maker's legal authority for decision related to a financial matter unless the claimant is a minor and the Substitute Decision Maker is their parent or legal guardian.

Supporting documentation attached (e.g., enduring power of attorney, court order):

Yes No No, not required for a minor's parent or legal guardian.

Please contact a lawyer for any inquiries about Substitution Decisions Makers or supporting documentation.

Part 7: Certification and Acknowledgement to Share Information

To be completed by the claimant, Substitute Decision Maker, or Authorized Representative

I certify that the information disclosed on this form is true and correct.

I understand that knowingly providing false, misleading, or incomplete information may result in my benefits being reduced, suspended, terminated, or denied under the AIA.

I understand that non-compliance with the AIA or other applicable laws may adversely affect any right to compensation under the AIA and may result in enforcement actions.

I understand that it is an offence under the *Criminal Code of Canada* for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.

DRAFT- Application for Care-First Benefits (Form CF-1)

For accidents that occur on or after January 1, 2027

I understand that I must promptly notify the insurer of any change in my circumstances that affects, or might affect, my entitlement to compensation or the amount of compensation payable under the AIA. I understand that information disclosed on this form, or obtained under the authority of Part 2, Division 7 of the AIA, may be collected, used, and disclosed only for the purposes authorized under the AIA, its regulations, and applicable privacy legislation.

These purposes include determining my entitlement to Care-First benefits, income replacement benefits, and other monetary benefits, and administering my claim, including processing benefit payments, coordinating required assessments and communicating with relevant parties.

I also understand that where reasonably necessary for these purposes and as permitted by the AIA, its regulations, and applicable privacy legislation, the insurance company, and persons acting on its behalf may collect personal information from, and disclose this information to or with:

- Other insurance companies;
- Workers Compensation Board (WCB);
- Insurance adjusters, agents and brokers (acting on behalf of an insurer);
- My employer(s) and former employer(s);
- Health care practitioners, health care facilities (hospitals) and assessment providers;
- Law enforcement;
- Accountants; financial advisors; solicitors; organizations that consolidate claims and underwriting information for the insurance industry; fraud prevention organizations;
- Databases or registers used by the insurance industry to analyze and check information provided against existing information; and my agents or representatives as designated by me from time to time, where permitted by the AIA.

Information may also be used or disclosed, in accordance with applicable privacy legislation, to support Government of Alberta data reporting and analysis for the purpose of monitoring and evaluating the effectiveness of Care-First system.

I understand that pursuant to the AIA, by making a claim for Care-First benefits, a health care practitioner who attends to, diagnoses, treats or is consulted by me in respect of my bodily injury, or the hospital or other health care facility at which the health care practitioner practices, must, on request, provide information to the insurance company about the nature and extent of my injuries, my diagnosis, my condition at the time health care was provided, the treatment(s) or care provided or recommended, my prognosis, and other information reasonably requested that relates to my bodily injury. I also understand that I may be required to undergo a medical assessment in accordance with the AIA.

I understand the insurance company and its agents may collect, use and disclose relevant information concerning my bodily injury, diagnosis, assessment, treatment and care received as a result of the automobile accident referred to in Parts 1 through 4 of this form, including services provided and any care and treatment request made under the Benefits Treatment and Care Regulation, for the purpose of determining my eligibility for compensation under the AIA and administering my claim.

- I am the claimant
 I am the claimant's Substitute Decision Maker
 I am the claimant's Authorized Representative and am signing with proper authority

(DD/MM/YYYY)

Name

Signature

Date

Forward this form and all attachments to your insurer

