This form is completed by the claimant, a Substitute Decision Maker, or an Authorized Representative on behalf of the claimant.

Under the *Automobile Insurance Act* (AIA), if you are entitled to other compensation for a similar wage loss, the priority of payments of income replacement is determined by the Income Replacement and Monetary Benefits Regulation. Income replacement benefits are secondary to other wage loss benefits (e.g., employer disability plans, Employment Insurance (EI), Canadian Pension Plan Disability (CPPD), if applicable. You must first apply for any other benefits for which you may be eligible.

This requirement does not prevent the insurer from making provisional payments while your eligibility for other benefits is being determined.

If you later receive, or are found to be entitled to, other wage loss benefits, your income replacement benefits may be adjusted. You must notify your insurance case manager if your circumstances change.

Income replacement benefits are not payable for the first 7 days after the date of the accident (the waiting period).

If you need help completing this form, or have questions about it, contact your insurance case manager. You can also refer to the Consumer Guide. You may be asked to provide supporting business and tax records.

Your insurance case manager may contact you for clarification or additional records to confirm the information reported on this form.

Part 1 - Claimant Information

Insurance Company Name:		
Date of Accident: (DD/MM/YYYY)	Policy Number:	Claim Number:
Last Name	First Name	Middle Name(s)
Date of Birth DD/MM/YYYY		
Mailing Address		City or Town Choose an item.
Province/ Territory/ State	Country Choose an item.	Postal Code (*X1X1X1*)

Part 2 – Claimant Status at the time of the Accident

This part collects initial information to help identify which parts of this form may need to be completed or for which follow-up information may be required. This part is not a determination of eligibility or entitlement.
Provide the best information available. Answer the questions below as applicable and follow the directions to the next question.
Attach supporting documents (for example, offer letters, contracts, or messages confirming upcoming work).

1. Did you have paid employment at the time of the accident?
   ☐Yes, **go to question 2**
   ☐No, **go to question 9**
2. Did you have one or more than one paid employment at the time of the accident?
   ☐ One, **go to question 3**
   ☐ More than one, **go to question 3**
3. Whether you had one or more than one paid employment, were you working for at least 28 hours per week (not including overtime) in any one paid employment?
   ☐ Yes, **go to question 4**
   ☐ No, **go to question 8**
4. Were you employed in that paid employment in each week of the year before the date of the accident?
   ☐ Yes, **go to question 6**
   ☐ No, **go to question 5**
5. Were you employed in that paid employment for at least two years before the date of the accident, with periods of work of at least eight consecutive months in duration and no period of more than four consecutive months without work? *For example, you have a job where you work from September to June and have July and August off*
   ☐ Yes, **go to question 6**
   ☐ No, **go to question 8**
6. Was that paid employment self-employment?
   ☐ Yes, **go to question 7**
   ☐ No, **go to question 7**
7. Is there a reason that you are earning less than you otherwise would have earned?
   ☐ Yes, provide details, attach any supporting information or documents and **go to question 11**

☐ No, **go to question 11**

8. If you had paid employment at the time of the accident and if the accident had not occurred, what paid employment would you likely have held within the first 180 days after the accident?
☐ I would have held one employment that was not self-employment
☐ I would have held one employment that was self-employment
☐ I would have held more than one employment (whether self-employed or not)
In your own words, describe the paid employment you believe you would have held within the first 180 days after the accident if the accident had not occurred.

☐ I would not have held paid employment during this period if the accident had not occurred. No further information is required for this question unless your circumstances change.
Go to question 11

9. At the time of the accident, which statement best describes your situation?
☐ I was unable to work at the time of the accident. Provide the reason below, then **go to question 11**.
In your own words, provide the reason you were unable to work at the time of the accident

☐ I was able to work and had employment in the two years immediately preceding the date of the accident.
Go to question 10
☐ I was able to work but did not have employment in the two years immediately preceding the date of the accident.
Go to question 10

10. If you did not have paid employment at the time of the accident, would you likely have started or returned to employment within the first 180 days after the accident if the accident had not occurred?
☐Yes, provide details, attach supporting information or documents and **go to question 11**

You may include any information that helps explain your situation. This can be informal and does not need to be official documentation. Examples include text messages, emails, contracts, schedules, or other records created **before the accident** that show the type of work you did or expected to do.
☐No, **go to question 11**

11. Were you a student or a minor?
☐**Student**: Select this if, at the time of the accident, you were attending secondary school or post-secondary studies full time, or you had been accepted or registered to start full-time post-secondary studies in an upcoming term.(for example, beginning university in the fall) **Go to question 13**

☐**Minor:** Select this if you were under 18 years old at the time of the accident. **Go to question 13**
☐No, **go to question 12**

12. Was your main occupation providing care without pay, for a person who is under 16 years of age or who is regularly unable to hold employment?
☐Yes, **go to question 13**
☐No, **go to question 13**

13. Were you working without pay in a family business?
☐Yes, **go to question 14**
☐ No, **go to question 14**

14. Do you have any other information that will assist your Insurer in determining your employment, education and training status?

Part 3 - Employment Information

Complete if you answered "Yes" to Question 1 in Part 2 above (paid employment at the time of the accident) **or** if you indicated in Questions 8–10 that you would have held paid employment had the accident not occurred. If this employment had not started by the date of the accident, complete the fields you can and attach any supporting information, such as an offer letter, contract, message, schedule, or other record.

If you had more than one employment, start with the employment you choose as your **primary** employment (typically your highest-earning employment). Your insurance case manager may request additional employer information if needed.

What was your last date of employment prior to the accident? (DD/MM/YYYY)

Are you or have you been absent from work or unable to work due to the accident?
☐Yes, from (DD/MM/YYYY) **to** (DD/MM/YYYY) (date returned to work) or / ☐Ongoing (if you have not returned to work)
☐No

Gross income (before taxes and deductions) **from all employment, self-employment and business income sources** for the 52 weeks immediately before the accident: $_____

Source(s) of income (select ☒ all that apply)☐Employment ☐Self-Employment ☐ Business Income ☐ I have not engaged in any employment during the 52 weeks immediately before the accident.

Income and employment verification: Your insurance case manager will verify income and employment details (including through employer verification) and will request supporting documents (e.g. T4, pay stubs) as needed.

Complete this section for your **primary** employment (your current, main, or most relevant employment). Add additional employer pages as needed.

Do not include self-employment: for self-employment complete CF-IRB-3 form.

Employer Name

Mailing Address

City or Town	Province/ Territory/State	Country	Postal Code*(X1X1X1)*
Choose an item.		Choose an item.	

Employment start date (DD/MM/YYYY) **to** (DD/MM/YYYY) / ☐ Ongoing

Position and essential job duties:

What is your average weekly pay before tax?	What is the average number of hours you work per week?
$.....	$.....

Time off work as a result of the accident (if you have not missed time from this employment due to bodily injury resulting from the accident, select "Not applicable".)

☐Not applicable
If applicable, complete below:
From (DD/MM/YYYY) To (DD/MM/YYYY) (full duties) ☐Returned to work on modified duties (DD/MM/YYYY) ☐Still off work

Describe how the accident has affected your ability to work (if applicable)

Employer Contact

Name		Position
Contact Number	Email	Business Phone Number

+ add **additional** section or attach pages as necessary

Part 4- Other Income or Benefit(s) **List all available income replacement benefits**

Since the accident, have you received, or do you expect to receive, any income or benefits from another source for the same time period as your income replacement benefits claim, including benefits related to this accident?
(For example, EI, employer disability plans, private disability coverage, CPP-D if applicable).
☐ Yes ☐No →**Skip to part 4a**
If yes, select ☒ all that apply:
☐Employment Insurance (EI)
☐Canada Pension Plan Disability (CPP-D)
☐Employer paid sick leave
☐Employer short-term disability (STD)
☐Employer long-term-disability (LTD)
☐Personal disability insurance
☐Other (specify):……..

Provide details only for the benefits you checked above. If you do not know the exact amount, write "unknown."

Income replacement type (Source)	**Amount and frequency of benefit payment**		**Policy or Plan #**	**Status**
Employment Insurance (EI)	$_____	Bi-weekly		Choose an item.

Canada Pension Plan Disability (CPP-D)		$_____per	Month		Choose an item.
Employer provided Sick Leave	Provider/Plan name	$_____per	☐Month ☐Week ☐Bi-weekly		Choose an item.
Employer provided short-term disability	Provider/Plan name	$_____per	☐Month ☐Week ☐Bi-weekly		Choose an item.
Employer provided long-term disability	Provider/Plan name	$_____per	☐Month ☐Week ☐Bi-weekly		Choose an item.
Personal disability insurance	Provider/Plan name	$_____per	☐Month ☐Week ☐Bi-weekly		Choose an item.
Other: [specify]	Provider/Plan name	$_____per	☐Month ☐Week ☐Bi-weekly		Choose an item.

Part 4a – Income Replacement Benefits You Were Already Receiving Before the Accident

Unrelated to this accident, at the time of the accident, were you receiving any income replacement benefits from any source (e.g., disability benefits, worker's compensation, EI, or other programs)? ☐Yes ☐No

If yes, provide details below (add additional rows as required)

Income replacement type (Source)	**Amount of benefit (if known)**	**Frequency of payment**	**Status**
Choose an item.	$_____	☐Bi-weekly ☐Weekly ☐Monthly	Choose an item.
Provider/Plan Name:		Policy or Plan #	

+ add **additional** section(s) or attach pages as necessary

Part 5 - Caregiver Benefit

Complete this part only if you answered "Yes" to Question 12 (your main occupation was unpaid caregiving at the time of the accident. Do not complete this part in relation to replacement care expenses unless your insurance case manager instructs you to do so. This part is for caregiver benefits. It is not for expenses paid to hire someone else to provide care, unless your insurance case manager asks you to complete it.

Caregiving information

How many care recipients do you provide care for? ☐1 ☐2 ☐3 ☐4 or more

Describe duties performed before the accident:

Describe limitations resulting from the accident:

Part 5 a. - Care recipient information

Complete this section for each care recipient

Full Name	Date of Birth (DD/MM/YYYY)	Relationship to claimant

If the care recipient is over 16, are they unable to hold employment regularly? ☐Yes ☐No

Does the care recipient reside with you? ☐Yes ☐No

If the care recipient doesn't reside with you is the reason due to the accident? ☐Yes ☐No
If yes, provide details about why the care recipient does not reside with you:

+ add **additional** section(s) or attach pages as necessary

Part 5 b. – Caregiver Benefit Confirmation

If two people care for the same care recipient only one person is entitled to a Caregiver Benefit

☐To the best of my knowledge, I confirm I am the only person providing information in relation to Caregiver Benefit eligibility for the listed care recipients

To assist with handling and processing your claim, your insurance case manager may request additional information from you or others such as your employer(s), former employer(s), health care practitioner(s), caregiver, or school.

Part 6 - Certification and Acknowledgment 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 that is material to the benefits being claimed 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 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.

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 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;
- Educational institutions;
- 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.

I understand that the insurance company and its agents may collect, use, and disclose information reasonably required concerning my employment, earnings, education, caregiving responsibilities, other available remuneration or benefits, and my bodily injury and its impact on my ability to begin or continue studies, hold employment, or provide care, for the purpose of determining my eligibility for income replacement benefits and other monetary benefits under the AIA and the Income Replacement and Monetary Benefits Regulation, and for administering my claim in relation to those benefits, as authorized or permitted by the AIA, its regulations, and applicable law

I understand that pursuant to the AIA, by submitting this form for the purpose of determining eligibility for income replacement benefits or other monetary benefits, an employer or former employer may, on request, be required to provide to the insurance company a statement of my earnings while I was employed by that employer or former employer and any other prescribed information relating to my employment. I understand that this may include information about my job, duties, hours of work, working conditions, qualifications, work history, remuneration, record of employment, return-to-work planning, and the effect of the accident on my employment, as prescribed under the AIA and its regulations.

I authorize the insurer and its agents to obtain from benefit providers, government agencies, and other relevant third parties any information reasonably required to determine my eligibility for income replacement benefits and other monetary benefits, and to verify, coordinate, or administer my claim, as permitted by the AIA, and the Income Replacement and Monetary Benefits Regulation.

☐ **I am the claimant**

☐ **I am the claimant's Substitute Decision Maker**
☐ **I am the claimant's Authorized Representative (as designated in Form CF-AUTH-1) and am signing with proper authority**

Name	**Signature**	**Date (DD/MM/YYYY)**

Forward this form and all attachments to your insurer