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

This form collects self-employment business and income information that your insurer needs to determine Income Replacement Benefits. If you also completed CF-1A, this form provides additional details about your self-employment income and work hours.

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

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.

Part 1- Claimant Information		
Insurance Company Name		
Date of Accident: (DD/MM/YYYY)	Policy Number:	Claim Number:
Last Name	First Name	Middle Name(s)

Part 2- Business Details			
CRA Business Number (if applicable)		Business Structure: ☐Sole Proprietorship ☐Partnership ☐Canadian-controlled private corporation (CCPC)	
Business Name			
Business Address			
Business Phone Number			
City or Town	Province/Territory/State	Postal Code (X1X1X1)	Country
Choose an item.			Choose an item.
Your occupation:			
Describe the nature of business activities and your day-to-day role in business operations:			
Date business commenced (DD/MM/YYYY)	Number of employees working at the business including yourself: ……		
Was the business actively operating at the time of the accident? ☐Yes ☐No			
Is the business currently operating, or did it close because of the automobile accident or injury?			
Is the business hiring a replacement/substitute for your duties? ☐Yes ☐No If yes, provide replacement name (if known), start date, duties covered, and expected cost (if any). If you do not know, write “unknown”.			
Had you opted into the EI program for self-employed individuals? ☐ Yes, attach supporting documentation ☐No			

Part 2a- Significant Influence Shareholder Information
Percentage of voting shares you own (if applicable): _____%
Describe your role in day-to-day financial and administrative operations (e.g., budgeting, payroll, signing authority, hiring):

Business income declared for tax purposes in the calendar year before the accident $_____

Part 3- Business Income Details

To calculate your benefit, your insurer needs your self-employment income for the 52 weeks immediately before the accident and the two consecutive 52-week periods before that (3 years total). If your income varies, your business uses a different year-end (fiscal year), or there were unusual events during these periods (for example, a start-up period, seasonal work, a major contract gained or lost, or an illness), provide details for each of the periods and explain below.

For each period, enter the amounts from your records. "Gross revenue" means total sales before expenses. "Allowable operating expenses" means expenses that are directly related to earning that revenue and are permitted for tax purposes. Your insurer may confirm the numbers using your supporting documents.

Period (from-to)	**Gross Revenue ($) minus**	**Allowable expenses ($)**	**= Net Business Income**
(DD/MM/YYYY) to (DD/MM/YYYY)	$	$	$
(DD/MM/YYYY) to (DD/MM/YYYY)	$	$	$
(DD/MM/YYYY) to (DD/MM/YYYY)	$	$	$
(DD/MM/YYYY) to (DD/MM/YYYY)	$	$	$

Provide available documents you have to support the period(s) reported, such as financial statements (profit and loss/income statement), bookkeeping reports, invoices/sales records, and bank deposit records. ☒Select and attach all applicable

☐Financial statements (income statement/profit & loss) ☐CRA Notice of Assessment ☐T1 General (self-employed) or T2 Corporate Return (incorporated) ☐General ledger/bookkeeping report ☐Payroll records ☐Sales journals/invoices ☐GST returns ☐Business bank statements ☐Other (specify): ……..

Part 4- Occupation and Experience Details

Your insurer needs your average weekly working hours before the accident to determine entitlement and calculate your benefit. Choose a typical period before the accident. If your work is seasonal or irregular, choose a longer period and explain.

Work period from (DD/MM/YYYY) to (DD/MM/YYYY) Average hours per week: _____hours/week

How did you determine your average hours? (select ☒ all that apply—use the most reliable records available)
☐ Timesheets ☐ Appointment/booking calendar ☐ Business invoices ☐ Bank deposits or financial records ☐ Personal estimate (provide details)

Work experience in your current occupation

Choose the option that matches your total experience (all periods combined)
Tip: Count every month in which you worked in this occupational group as a full month. Example: If you started on May 25 and left on June 2, this counts as 2 full months.

☐ Level 1 – Less than 36 months of experience
☐ Level 2 – 36 to 119 months of experience
☐ Level 3 – 120 months or more of experience

List any other employment held in the 5 years prior to the accident:

Describe your education, training, and certifications relevant to your work:

Part 5- Return to Work

Have you returned or attempted to return to regular or modified duties or hours?
☐No
☐Yes, start date: DD/MM/YYYY to end date (if applicable): DD/MM/YYYY/ ☐Ongoing

If yes, describe the limitations preventing you from continuing:

What accommodation or safety measures may be needed to help you return to work? Select ☒ all that apply and describe below.
☐ Modified work hours/days
☐ Modified work location
☐ Modified job requirements
☐ Assistive device(s)
☐ Additional support (e.g. colleagues helping with specific tasks)
☐ Reduced screen time/visual stimulation (e.g., computer use, bright light)
☐ Other(specify): _____
☐ None

If accommodation(s) have already been tried, explain what was done and the result.

Part 6- 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 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, verifying the self-employment business, income, work hours, business structure, ownership, and replacement or substitute labour information provided in this form, and administering my claim, including processing benefit payments, coordinating required assessments, verifying other wage loss benefits, 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, employment, business, financial, medical, and claims-related information from, and disclose this information to or with:

- Other insurance companies;

- Government agencies and benefit providers, including Employment Insurance (EI), Canada Pension Plan Disability (CPPD), and the Workers' Compensation Board (WCB), if applicable;
- Accountants, bookkeepers, payroll service providers, financial advisors, tax preparers, and auditors;
- Banks, credit unions, payment processors, and other financial institutions, where relevant to verifying business income or expenses;
- Business partners, co-owners, shareholders, directors, officers, employees, contractors, customers, clients, suppliers, landlords, and other persons or entities with information relevant to the operation of the business, if applicable;
- Insurance adjusters, agents, and brokers acting on behalf of an insurer;
- Health care practitioners, health care facilities, and assessment providers;
- Law enforcement;
- Solicitors, fraud prevention organizations, and organizations that consolidate claims and underwriting information for the insurance industry;
- 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 bodily injury and its impact on my ability to begin or continue self-employment activities, hold other employment, pursue studies, or provide care, for the purpose of determining my eligibility for income replacement benefits, loss of studies benefits, and other monetary benefits under the AIA and the Income Replacement and Other Monetary Benefits Regulation, and administering my claim, 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, the insurance company and its agents may collect, use, and disclose any business, employment-related, and financial information reasonably necessary to assess my entitlement. This includes business income and expense records, tax returns and assessments, bookkeeping records, financial statements, invoices, sales records, bank records, payroll records, proof of business ownership or shareholding, and information about replacement or substitute labour, as well as any other prescribed or reasonably required information, including information provided in CF-1A and any prescribed supporting forms.

I authorize the insurer and its agents to obtain from benefit providers, government agencies, financial institutions, business contacts, accountants, bookkeepers, tax preparers, employers, 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, the Income Replacement and Other Monetary Benefits Regulation, and applicable law.

☐ **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