DRAFT - Authorized Communicator/Authorized Representative Form (Form CF-AUTH1)

For accidents that occur on or after January 1, 2027

Use this form if you are able to make your own decisions, but you want to authorize someone to help communicate your information and your decisions to your insurer, to help you receive information, or to act on your instructions.

If you have a legally appointed Substitute Decision Maker (SDM), this form may be used by your SDM to authorize someone to assist with communication about your claim. This form cannot be used to appoint or replace your SDM.

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- Person You Are Authorizing	Complete one authorization per person
Full Legal Name	
Firm/ Organization (if applicable)	
Relationship to Claimant (select ☒ one): ☐Family Member ☐ Friend ☐ Lawyer ☐ Paralegal ☐ Health provider ☐ Translator ☐Community Advocate ☐ Other (specify):	
Mailing address	

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

Telephone Number *(000) 000-0000*	Email

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

Part 3- Level of Authorization

Select one level of access. Check ☒ one box only

☐ Level 1 – Authorized Communicator (Communicate only)

The Authorized Person may:

- Communicate with the insurer about my claim
- Receive copies of correspondence
- Help explain information to me (e.g., language or accessibility support)

The Authorized Person may NOT:

- Make decisions on my behalf
- Authorize treatment, benefits, or payments
- Bind me or the insurer in any way

☐ Level 2 – Authorized Representative (May act on my behalf) By selecting this option, I authorize the person named in this form to act on my behalf, consistent with my consent and directions, for the purposes of administering my Care-First claim.

The Authorized Person may:

- Communicate with the insurer regarding my claim
- Submit information and forms on my behalf
- Facilitate the handling, assessment, and payment of my Care-First benefits claim, including taking actions that may affect my legal rights and my entitlement to Care-First benefits, and

- Facilitate the collection, use, and disclosure of information relating to my injury, diagnosis, assessment, treatment, or care arising from the automobile accident

The Authorized Person may NOT:

- Act contrary to or beyond my consent and directions
- Override statutory entitlements or limitations under the AIA
- Bind the insurer on coverage determinations beyond what the AIA allows

Part 4- What This Authorization Means

Information provided by my Authorized Person is treated as if it came from me.

Fraud, misrepresentation, or omissions apply to me as the claimant, regardless of who communicates.

The insurer may rely on information provided through this authorization unless it has reason to doubt its validity.

Part 5- Duration of Authorization

This authorization is valid (select ☒ one):

☐ For the life of this claim, unless withdrawn in writing

☐ Until this date (DD/MM/YYYY)

This authorization automatically ends when:

The claim is fully closed, and
No further Care-First benefits are payable

Note: If no expiry date is specified, the authorization will remain in effect until it is revoked or amended by you, or until the claim is resolved and closed, whichever is sooner. If you become unable to make decisions, a legally authorized decision-maker (such as an agent under a Personal Directive or a court-appointed guardian) may revoke, amend, or confirm this authorization.

Part 6- Withdrawal of Authorization

I understand that I may withdraw this authorization at any time by delivering, mailing, faxing, or emailing withdrawal notice signed by me to the insurer.

Withdrawal is effective on the date received by the insurer

Withdrawal does not affect actions already taken in good faith by the insurer before receipt of your notice.

Part 7- Acknowledgement and Certification

☐ **I am the claimant.** I understand the scope and limits of this authorization and confirm that I am capable of making decisions about my claim and that I am choosing to authorize the person named in this form. I understand that this form does not appoint or replace a Substitute Decision Maker.

☐ **I am the legally appointed Substitute Decision Maker (SDM)**. I am authorizing the person named in this form only to assist with or communicate about the claimant's claim. I confirm that I have legal authority to make financial decisions for the claimant.

	(DD/MM/YYYY)
Claimant / SDM Signature	Date

Part 8- Authorized Person Acknowledgment

I acknowledge that:

- I may act only within the level of authority selected
- I must provide accurate information
- I have no authority beyond what is expressly granted

Level of authorization: (select ☒ one)

☐Level 1- Authorized Communicator

☐Level 2- Authorized Representative

	(DD/MM/YYYY)
Authorized Person Signature	Date