DRAFT - Expense Request Form (Form CF-EXP-1)

For accidents that occur on or after January 1, 2027

This form is completed by the claimant, a Substitute Decision Maker, or an Authorized Representative on behalf of the claimant seeking payment or reimbursement for reasonable and necessary expenses as permitted under the Automobile Insurance Act (AIA) and its regulations.

Under the AIA and its attendant regulations, you may be eligible for expenses such as medical equipment, medical supplies, transportation, lodging and meal expenses.

Your insurer must endeavor to ensure that you are informed about the compensation available to you under the AIA, must reasonably assist you with making a claim for compensation, and must endeavour to ensure that you receive the compensation to which you are entitled.

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 for more information including travel rates and other expense limits. 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.

Important Notice Concerning Your Personal Information

The AIA authorizes and requires insurers to collect personal information to determine your entitlement to compensation and facilitate the handling, assessing and payment of your claim. Insurers must protect your information in accordance with 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 privacy officer.

Part 1-Claimant Information		
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 *(XIX1X1)*
Contact information (provide all applicable)		
Phone:*(000)000-0000*	Cell Phone:*(000)000-0000*	
Email:	Other:	

Part 2- Claim Information		
Insurance Company:		
Date of accident (if known) (DD/MM/YYYY)	Policy Number (if known)	Claim Number (if known)
If you are not the injured claimant, indicate the name of the injured claimant and provide their contact information below (if available) Injured claimant Name:		
Injured claimant contact information		
Relationship to the injured claimant?	☐ Spouse/ Adult Interdependent Partner ☐ Family Member ☐ Caregiver ☐ Other (specify)	

Alberta

Part 3- Transportation Expenses

You can apply for the payment or reimbursement of reasonable and necessary transportation expenses incurred as permitted under the AIA.
Attach relevant bills and receipts.

Date of trip	Purpose of Trip	Distance travelled (km)	Address traveled from	Address traveled to	Mode of transportation	Amount claimed
(DD/MM/YYYY)		Round Trip ☐			☐ Personal vehicle (car, truck, SUV etc.) Public transit (Bus / LRT) ☐ Private Bus ☐ Taxi / Vehicle for hire ☐ Other	$
(DD/MM/YYYY)		Round Trip ☐			☐ Personal vehicle (car, truck, SUV etc.) ☐ Public transit (Bus / LRT) ☐ Private Bus Taxi / Vehicle for hire ☐ Other	$
(DD/MM/YYYY)		Round Trip ☐			☐ Personal vehicle (car, truck, SUV etc.) ☐ Public transit (Bus / LRT) ☐ Private Bus ☐ Taxi / Vehicle for hire ☐ Other	$
					Total Amount Claimed	**$**

☐ Additional sheets attached

Part 4- Other Expenses

Use this Part to claim payment or reimbursement for other reasonable and necessary expenses as permitted under the AIA and its regulations. Do not use this Part to claim any expenses that have been, or will be, submitted on your behalf by a health care practitioner.

Your insurance case manager may require additional information about certain expenses. Depending on your circumstances, this information may be used to determine your eligibility for compensation and assist in the administration of your claim.

Contact your insurance case manager for more information about the eligible expenses for which you may claim compensation using this form and refer to the Consumer Guide for additional information.

Attach relevant documentation, bills and receipts.

Date of Purchase	Expense Description	Cost
		$
		$
		$
		$
		$
☐ Additional sheets attached	Total Amount Claimed	$

Part 5: 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 compensation 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.

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 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 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, 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**

Name	Signature	Date
		(DD/MM/YYYY)

Forward this form and all attachments to your insurer