Alberta

Expense Request (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 applicable regulations.

Under the AIA and applicable regulations, you may be eligible for expenses such as medical equipment, medical supplies, medication, transportation, parking, lodging, meals, care of another person, family-enterprise replacement labour, and other expenses permitted under the AIA and applicable regulations.

Your insurer must tell you about expenses that may be paid or reimbursed under the AIA, reasonably help you with your claim, and take steps to ensure that you receive the compensation you are entitled to under the AIA.

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.

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 insurance companies to collect personal information to determine your entitlement to compensation and facilitate the handling, assessing and payment of your claim. Insurance companies 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 your insurer's 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:	

If you are not the injured person, indicate the name of the injured person and provide their contact information below (if available)

Last Name	First Name	Middle Name(s)

Contact Information:

Relationship: ☐ Spouse/ Adult Interdependent Partner ☐ Family Member ☐ Caregiver ☐ Other (specify):

Part 2 – Claim Information

Insurance Company:

Date of Accident (if known) (DD/MM/YYYY)	Policy Number (if known)	Claim Number (if known)

Part 3 – Transportation Expenses

Use Part 3 only for transportation expenses that you paid directly and that are permitted under the AIA and applicable regulations. Do not claim transportation costs here if they have been or will be invoiced by a health care practitioner. Your insurer will assess the amount claimed based on the information provided and any applicable limits, thresholds, prior approval requirements, and supporting documentation requirements.

Date	Purpose of Trip	Mode of Transportation	Distance (km)	Amount Claimed
(DD/MM/YYYY)		Choose an item.	☐One-way ☐Round-Trip	$

Address traveled from:		Address traveled to:	

If your trip was more than 100 km one way, please explain why a closer service was not utilized.

Keep all receipts and supporting documents for your records.		
+ Add additional rows as required		
☐ Additional sheets attached	**Total Amount Claimed**	**$**

Part 4 – Other Expenses

Use Part 4 to claim payment or reimbursement for other reasonable and necessary expenses as permitted under the AIA and applicable regulations. Do not use this Part to claim expenses that have been or will be invoiced or submitted on your behalf by a health care practitioner. Choose the expense type that best describes the expense. For each expense, provide the date paid or incurred, a brief description of the expense, and the amount claimed.

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.

Expense Type	Date	Expense Description	Documents Attached	Cost
Choose an item.	(DD/MM/YYYY)		Choose an item.	$
Choose an item.	(DD/MM/YYYY)		Choose an item.	$
+ Add additional rows as required				

☐ Additional sheets attached	**Total Amount Claimed**	**$**

Part 5 – 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 compensation being claimed 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 payment or reimbursement of expenses 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 the 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 (as designated in Form CF-AUTH-1) and am signing with proper authority**

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

Forward this form and all attachments to your Insurer