| Use this form for accidents that occur on or after January   Claim Number:  |  |   |                         |   |                                     |  |   |                      |                 |   |
|---|--|---|-------------------------|---|-------------------------------------|--|---|----------------------|-----------------|---|
| Use this form for accidents that occur on or after January.   Claim Number:     Policy Number:     Date of Accident: (YYYYMMDD)   | Return this form to:                                     |   |                         |   |                                     | Expenses Claim Form (OCF-6)  |   |                      |                 |   |
| Claim Number:    Policy Number:   |  |   |                         |   |                                     | Use this form for accidents that occur on or after January 1, 1994 |   |                      |                 |   |
| Only use this form to claim expenses not submitted on your behalf by your health care provider.  You can apply for reasonable and necessary expenses incurred as a result of the accident and not covered under another plan. Sexpenses may include the costs of medical and rehabilitation treatment, lost educational expenses, caregivers, attendant care an housekeeping services, transportation expenses, expenses of visitors, and the cost to repair or replace lost or damaged clothing, dentures, glasses, prostheses, hearing aids, etc. Please attach all bills and receipts.  Part 1 Applicant Information  Last Name  Last Name  First Name and Initial  Gender  Male  Address  City  Province  Postal Code  Birth date (yyyy/mm/dd)  Home Telephone  Work Telephone  Ext  Part 2 Expenses  Item  Date  Description of Goods and Services and Name of Service Provider  Amo   |  |   |                         |   |                                     |  |   |                      |                 |   |
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| Applicant Information  Address  City Province Postal Code  Birth date (yyyy/mm/dd) Home Telephone Work Telephone Ext  Part 2  Expenses Attach all bills and receipts. If a bill or receipt is not available, please explain. If you need more space, please attach addition Item Date Description of Goods and Services and Name of Service Provider Amo  | You can apply for expenses may inc housekeeping services | reasonable a<br>lude the cos<br>vices, transp | and necessats of medica | ary expenses inc<br>al and rehabilitati<br>enses, expense | urred as<br>on treati<br>s of visit | s a result of t<br>ment, lost ed<br>ors, and the                   | Ith care provider.  he accident and no lucational expenses cost to repair or re | s, caregivers, atten | dant care an    |   |
| Address  City Province Postal Code  Birth date (yyyy/mm/dd) Home Telephone Work Telephone Ext  Part 2 Expenses   Attach all bills and receipts. If a bill or receipt is not available, please explain. If you need more space, please attach addition lateral | Applicant  | Last Name                                     |                         |   |                                     | First Name and Initial   |   |                      | Gender          |   |
| City Province Postal Code  Birth date (yyyy/mm/dd) Home Telephone Work Telephone Ext  Part 2 Expenses Item Date Description of Goods and Services and Name of Service Provider Amo  |  |   |                         |   |                                     |  |   |                      | ☐ Male ☐ Female |   |
| Birth date (yyyy/mm/dd) Home Telephone Work Telephone Ext  Part 2 Expenses Item Date Description of Goods and Services and Name of Service Provider Amo   |  | Address                                       |                         |   |                                     |  |   |                      |                 |   |
| Birth date (yyyy/mm/dd) Home Telephone Work Telephone Ext  Part 2 Expenses Item Date Description of Goods and Services and Name of Service Provider Amo   |  |   |                         |   | I                                   |  |   | T=                   |                 |   |
| Part 2 Attach all bills and receipts. If a bill or receipt is not available, please explain. If you need more space, please attach addition Expenses Item Date Description of Goods and Services and Name of Service Provider Amo   |  | City  |                         |   |                                     | •  |   | Postal Code          |                 |   |
| Expenses Item Date Description of Goods and Services and Name of Service Provider Amo   |  | Birth date (yyyy/mm/dd)                       |                         |   |                                     | elephone   |   | Work Telephone Ext   |                 | i |
|   | Expenses  additional sheets                              |   |                         |   |                                     |  |   |                      | 1               |   |
|   |  |   |                         |   |                                     |  |   |                      |                 |   |
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|   |  |   |                         |   |                                     |  |   |                      |                 |   |
| Total Amount  |  |   |                         |   |                                     |  |   | Total Amou           | nt              |   |
| Part 3 Signature  I certify that the information provided is true and correct. I understand that it is an offence under the <i>Insurance</i> knowingly make a false or misleading statement or representation to my insurer under a contract of insurance further understand that it is an offence under the federal <i>Criminal Code</i> for anyone, by deceit, falsehood, or or dishonest act, to defraud or attempt to defraud an insurance company. I further understand that the use and disclosure of information contained on this form is subject to the terms described on my Application for Accide Benefits.  Name of Applicant or Substitute Decision Maker (please print)  Signature of Applicant or Substitute Decision Maker  Date (yyyy)  |  | e. I<br>other<br>ent                          |                         |   |                                     |  |   |                      |                 |   |