Financial Services Commission Of Ontario

Dispute Resolution Services

Application for Mediation
FORM A

Mediation file number

Section 1 GENERAL INFORMATION This section MUST be completed.

1. What was the date of the motor vehicle accident?
Year Month Day

2. Who is making this application?
☐ Claimant ☐ Claimant's representative ☐ Insurance company ☐ Insurance company's representative

3. Have you applied for mediation before?
☐ No ☐ Yes

4. Language preferred
☐ English ☐ French ☐ Other, specify ►

5. Do you want the mediation to be conducted in French?
☐ No ☐ Yes

Do you want an in-person meeting with the other party?
☐ No ☐ Yes

Please note that it is within the mediator's discretion to conduct the mediation in person or by telephone conference.

Do you have any accessibility requirements for the mediation? (e.g., wheel chair access, sign language interpreter, visual aids, or any other accommodation)
☐ No ☐ Yes If Yes, describe ►

CLAIMANT

☐ Mr. ☐ Mrs. ☐ Ms. Last name First name Middle name

Street address Apt./Unit

City Province/State Postal Code/Zip Country

Home phone number ( ) Work phone number ( ) Ext. Fax number ( ) Birth date Year Month Day

1. What is the best way to reach you?
☐ phone ☐ mail ☐ Email ☐ fax ☐ through my representative

2. Where is the best place to reach you?
☐ home ☐ work ☐ other, specify ►

3. Email address (optional)

4. Is the Claimant under 18 years old? ☐ No ☐ Yes Or mentally incapable? ☐ No ☐ Yes If Yes, the person filing the application on behalf of the claimant must also complete ***Form P – Representing Minors and Mentally Incapable Persons*** – and sign this application form. Form P is available on the Commission website: www.fsco.gov.on.ca or by calling Mediation Inquiries in Toronto at (416) 590-7210 or Toll-Free at 1-800-517-2332, ext. 7210.

CLAIMANT'S REPRESENTATIVE

☐ Mr. ☐ Mrs. ☐ Ms. Last name ~~First name~~ ~~File reference number~~

~~Title~~ ~~Firm Name~~ Sal Guzzo, LL.B.

Street address 2600 Skymark Ave. Building 1, Suite 102 Apt./Unit

City Mississauga Province/State Ontario Postal Code/Zip L4W 5B2 Country Canada

Work phone number (905) 232-9222 Ext. 225 Fax number (905) 232-9226 Email address (required)

The representative is:
☐ Lawyer Law Society licence number
☐ Licensed paralegal Law Society licence number
☐ Not required to be licensed
Specify the type of exemption from the list of exemptions recognized in the Law Society's by-laws

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Section 1 continued

INSURANCE COMPANY

Company name

Claim representative name	Claim number
Policyholder name	Policy number

INSURANCE COMPANY'S REPRESENTATIVE

☐ Mr. ☐ Mrs. ☐ Ms. | Last name | First name | File reference number

Title	Firm name

Street address | Apt./Unit

City | Province/State | Postal Code/Zip | Country

Work phone number Ext. ( )	Fax number ( )	Email address

MEDIATION PROCEEDINGS

Did the Claimant notify the Insurance Company of the circumstances giving rise to a claim for a benefit and submit an application for the benefit within the times prescribed by the Statutory Accidents Benefits Schedule (SABS)?

☐ Yes
☐ No If No, give reason ►

Was the Claimant provided with notice by the Insurance Company in accordance with the SABS that it requires an examination

☐ Yes
☐ No

If Yes, did the claimant attend?

☐ Yes
☐ No If No, give reason ►

Does an issue in dispute relate to the denial by the Insurance Company of an invoiced amount on the grounds that a provider has not complied in whole or part with a request for information made by the Insurance Company on or after July 1, 2011?

☐ Yes If Yes, give reason ►
☐ No

Section 2 ISSUES IN DISPUTE Provide a **full** description of the accident benefits that are in dispute.
(Attach extra sheets if necessary)

Does this claim involve optional benefits? ☐ No ☐ Yes

Does this claim involve catastrophic impairment? ☐ No ☐ Yes

☐ WEEKLY BENEFITS

Which weekly benefit are you disputing?

☐ income replacement
☐ non-earner

What are you disputing?

☐ initial entitlement to benefits
☐ length of time benefits were paid
☐ amount of weekly benefits
☐ entitlement to benefits past 104 weeks
☐ other, specify ▼

Date submitted to insurer: Year Month Day

Date denied: Year Month Day

If the Claimant received income benefits, state weekly amount and duration of payments.

$

From: To:

Is the insurance company claiming a repayment of benefits?

☐ No ☐ Yes If yes, amount ▼

$

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Section 2 continued

☐ CAREGIVER BENEFITS

	Year Month Day	Year Month Day
Weekly amount in dispute?	Date submitted to insurer:	Date denied:
$	Name of service provider(s):	
From: To:		

What are you disputing?

- ☐ initial entitlement to benefits
- ☐ length of time benefits were paid
- ☐ amount of benefits
- ☐ entitlement to benefits past 104 weeks
- ☐ other, specify ►

☐ ATTENDANT CARE BENEFITS

	Year Month Day	Year Month Day
Monthly amount in dispute?	Date submitted to insurer:	Date denied:
$	Name of service provider(s):	
	Time period in dispute from:	to:

☐ MEDICAL BENEFITS 1

	Year Month Day	Year Month Day
Amount in dispute?	Date submitted to insurer:	Date denied:
$	Name of service provider(s):	
	Type of service(s):	
	Time period in dispute from:	to:

☐ MEDICAL BENEFITS 2

	Year Month Day	Year Month Day
Amount in dispute?	Date submitted to insurer:	Date denied:
$	Name of service provider(s):	
	Type of service(s):	
	Time period in dispute from:	to:

☐ MEDICAL BENEFITS 3

	Year Month Day	Year Month Day
Amount in dispute?	Date submitted to insurer:	Date denied:
$	Name of service provider(s):	
	Type of service(s):	
	Time period in dispute from:	to:

☐ MEDICAL BENEFITS 4

	Year Month Day	Year Month Day
Amount in dispute?	Date submitted to insurer:	Date denied:
$	Name of service provider(s):	
	Type of service(s):	
	Time period in dispute from:	to:

☐ REHABILITATION BENEFITS 1

	Year Month Day	Year Month Day
Amount in dispute?	Date submitted to insurer:	Date denied:
$	Name of service provider(s):	
	Type of service(s):	
	Time period in dispute from:	to:

☐ REHABILITATION BENEFITS 2

	Year Month Day	Year Month Day
Amount in dispute?	Date submitted to insurer:	Date denied:
$	Name of service provider(s):	
	Type of service(s):	
	Time period in dispute from:	to:

☐ REHABILITATION BENEFITS 3

	Year Month Day	Year Month Day
Amount in dispute?	Date submitted to insurer:	Date denied:
$	Name of service provider(s):	
	Type of service(s):	
	Time period in dispute from:	to:

Section 2 continued

☐ CASE MANAGER SERVICES BENEFITS		Year	Month	Day		Year	Month	Day
Amount in dispute?	Date submitted to insurer:				Date denied:			
$	Name of service provider(s):							
	Time period in dispute from:				to:			

☐ OTHER EXPENSES								
A ☐ lost educational expenses		Year	Month	Day		Year	Month	Day
Amount in dispute?	**A** Date submitted to insurer:				Date denied:			
$	Detail of expenses:							
	Time period in dispute from:				to:			
B ☐ expenses of visitors		Year	Month	Day		Year	Month	Day
Amount in dispute?	**B** Date submitted to insurer:				Date denied:			
$	Detail of expenses:							
	Time period in dispute from:				to:			
C ☐ damage to clothing, glasses, etc		Year	Month	Day		Year	Month	Day
Amount in dispute?	**C** Date submitted to insurer:				Date denied:			
$	Detail of expenses:							
	Date of replacement expenses:							
D ☐ housekeeping and home maintenance		Year	Month	Day		Year	Month	Day
Amount in dispute?	**D** Date submitted to insurer:				Date denied:			
$	Name of service provider(s):							
	Time period in dispute from:				to:			
E ☐ cost of examinations		Year	Month	Day		Year	Month	Day
Amount in dispute?	**E** Date submitted to insurer:				Date denied:			
$	Date of examination or report:							
	Type of examination(s):							
	Examination(s) provided by:							
E ☐ cost of examinations		Year	Month	Day		Year	Month	Day
Amount in dispute?	**E** Date submitted to insurer:				Date denied:			
$	Date of examination or report:							
	Type of examination(s):							
	Examination(s) provided by:							
E ☐ cost of examinations		Year	Month	Day		Year	Month	Day
Amount in dispute?	**E** Date submitted to insurer:				Date denied:			
$	Date of examination or report:							
	Type of examination(s):							
	Examination(s) provided by:							

☐ DEATH BENEFITS		Year	Month	Day		Year	Month	Day
Amount in dispute?	Date submitted to insurer:				Date denied:			
$	Name of deceased:							
	Relationship of deceased to claimant:							

☐ FUNERAL EXPENSES		Year	Month	Day		Year	Month	Day
Amount in dispute?	Date submitted to insurer:				Date denied:			
$	Name of deceased:							
	Relationship of deceased to claimant:							

☐ OTHER DISPUTES		Year	Month	Day		Year	Month	Day
Amount in dispute?	Date submitted to insurer:				Date denied:			
$	Detail of expenses:							
	Time period in dispute from:				to:			

☐ INTEREST	
Amount in dispute? Set out calculations.	
$	

Section 3 Document List — This section MUST be completed — (Attach extra sheets if necessary)

It is expected that both parties have exchanged key documents prior to filing this Application for Mediation.

Documents -1. List key documents in your possession which you will refer to in the mediation.

Extra sheets attached ☐

Documents -2. List key documents not currently in your possession which you intend to get from other sources.

Extra sheets attached ☐

Personal information requested on this form is collected under the authority of the Insurance Act, R.S.O. 1990, c. I.8 as amended. This information, including documents submitted with this application, will be used in the dispute resolution process for accident benefits.

Signature and Certification

I certify that all information in this Application and attachments is true and complete. I authorize the insurance company to release all medical reports and information relating to the issues in dispute to Mediation Services, Dispute Resolution Services, Financial Services Commission of Ontario. I realize that information filed with this Application may be given to the other party in this dispute.

Claimant name (please print)	Claimant Signature	Date	Year	Month	Day
Representative name (please print)	Representative Signature	Date	Year	Month	Day

Send the **original and one copy** of the **completed** application to Mediation Services at the address noted below. Keep an additional copy of the completed application for yourself.

Mediation Services
Dispute Resolution Services
Financial Services Commission of Ontario
5160 Yonge Street, 14th Floor, Box 85
Toronto, ON M2N 6L9

If you have any questions about this application, or want more information, contact:

Mediation Inquiries **In Toronto at: 416-590-7210 or Toll Free: 1-800-517-2332, ext. 7210** **Fax: 416-590-7077**

FSCO website: **www.fsco.gov.on.ca**

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