

Notice of Loss and Proof of Claim

Form AB-1

This form is effective on November 20, 2004 for accidents that occur on or after October 1, 2004

<p style="text-align: center;">Send this form to the appropriate insurer:</p> <p style="text-align: center;">Fax # (____) _____ - _____</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2" style="text-align: center; background-color: #e0e0e0;">To be completed by Insurer</th> </tr> <tr> <td style="width: 30%; background-color: #e0e0e0;">Claim Number</td> <td></td> </tr> <tr> <td style="background-color: #e0e0e0;">Insurance Company</td> <td></td> </tr> <tr> <td style="background-color: #e0e0e0;">Claim Representative</td> <td></td> </tr> <tr> <td style="background-color: #e0e0e0;">Policy Number</td> <td></td> </tr> <tr> <td style="background-color: #e0e0e0;">Date of Accident: (DD-MM-YYYY)</td> <td></td> </tr> </table>	To be completed by Insurer		Claim Number		Insurance Company		Claim Representative		Policy Number		Date of Accident: (DD-MM-YYYY)	
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Section 1: Claimant Information

Part 1 – Claimant Information

Last Name		First Name		Middle Name(s)	
Address					
City, Town or County Calgary			Province Alberta		Postal Code
Telephone Number (Home) (Include area code)		Telephone Number (Work) (Include area code)		Fax Number (Include area code)	
Date Of Birth (DD/MM/YYYY)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		You can best be reached: <input type="checkbox"/> By telephone <input type="checkbox"/> At home <input type="checkbox"/> By personal visit <input type="checkbox"/> At work <input type="checkbox"/> Other		
When is the best time to reach you?			Day(s) of the week:		
Insurance Company				Policy Number	
Will this be an Alberta Workers' Compensation Board Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No			Are Extended Health Care Benefits Available? (e.g., Blue Cross or similar Employee benefits plans) <input type="checkbox"/> Yes <input type="checkbox"/> No Details:		
Are you currently employed or engaged in training activities? <input type="checkbox"/> Full Time <input type="checkbox"/> Self-employed <input type="checkbox"/> Student <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not employed					If you are making a claim for disability benefits, please also complete Form AB- 1a.

Part 2 – Claimant's Authorized Representative Information (if applicable)

Last Name		First Name		Middle Name(s)	
Address					
City, Town or County			Province		Postal Code
Relationship with Claimant <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other			Relevant Documentation Attached? If no, please authorize your representative by completing Part 5 of this form. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable		
Telephone Number (Home) (Include area code)		Telephone Number (Work) (Include area code)		Fax Number (Include area code)	