Return this form to:

Application for Determination of Catastrophic Impairment (OCF-19)

Use this form for accidents that occur on or after November 1, 1996

Claim Number:	
Policy Number:	
Date of Accident: (YYYYMMDD)	

Note to the Applicant:

This form must be completed in full and submitted to your auto insurer if you wish to establish that you have suffered a catastrophic impairment as a result of your motor vehicle accident. Persons determined to have a catastrophic impairment are entitled to request extended medical, rehabilitation and/or attendant care benefits and other expenses. On the basis of this Application, your insurer may designate you as catastrophically impaired.

To the Physician*:

Consent: It is the responsibility of the physician to ensure that their collection, use and disclosure of information submitted are authorized by a consent form. The Ontario Claims Form 5 (OCF-5) Permission to Disclose Health Information may be used as a consent form, although additional disclosure and consent may be required depending on the manner in which the information is used and disclosed.

*If impairment is only a brain impairment, this form may be filled out by a neuropsychologist.

Part 1

Applicant Information (completed by the applicant or substitute decision maker)

Last Name		First Name and Initial	
Address		Date of Accident (YYYYMMDD)	
City		Province	Postal Code
Home Telephone	Work Telephone Ext		Email (Optional)

Applicant Status:

- ☐ Applicant is currently in a general hospital, rehabilitation centre, nursing home or chronic care facility.
- ☐ This is the first application for catastrophic determination.
- ☐ This is a reapplication for catastrophic determination.

Reason for Reapplication:

I authorize my treating physician* to collect, use, and disclose to my insurer or to a health professional, social worker, or vocational rehabilitation expert properly identified by my insurer to conduct an examination only such information relating to my health condition or injuries arising as a result of the automobile accident as is reasonably required for the purpose of determining whether I have a catastrophic impairment.

This authorization does not apply to a consultation between my health care provider and the insurer's physician* conducting an examination. Separate express consent is required for this consultation. This consent should be in writing.

I confirm that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.

Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)

The rest of this form must be completed by your physician*.

Part 2

Physician* Information

Name of Physician		College Registration Number	
Facility Name (if applicable)		AISI Facility Number (if applicable)	
Address			
City	Province	Postal Code	
Telephone Number Extension	Fax Number		Email (Optional)

Knowledge of Applicant

Part 3

Physician's* Report of Catastrophic Impairment

- ☐ Applicant is currently in my care and most recently seen on _____ (YYYYMMDD) Number of years in my care _____
- ☐ Applicant was seen for the purpose of preparing this application, on _____ (YYYYMMDD)
- ☐ Applicant was in my care but no longer actively followed. Date last seen by me: _____ (YYYYMMDD)
- ☐ I have reviewed the file but have not seen the applicant. The most relevant material reviewed is dated _____ (YYYYMMDD)
- ☐ I have seen this person _____ time(s) for the purpose of evaluating impairment.

Please refer to the following criteria for catastrophic impairment when completing this form.

Part 4

Criteria

Criteria

Based on my assessment, I believe the following criteria are applicable to this applicant. Please check all that apply.

- ☐ 1. paraplegia or quadriplegia;
- ☐ 2. if the accident occurred on or after September 1, 2010**,** the amputation of an arm or leg or another impairment causing the total and permanent loss of use of an arm or a leg;
- ☐ 3. if the accident occurred between October 1, 2003 and August 31, 2010**,** amputation or other impairment causing the total and permanent loss of use of both arms or both legs, or one or both arms and one or both legs;
- ☐ 4. if the accident occurred between November 1, 1996 and September 30, 2003, amputation or other impairment causing the total and permanent loss of use of both arms or both an arm and a leg;
- ☐ 5. the total loss of vision in both eyes;
- ☐ 6. brain impairment that, in respect of an accident, results in
  - (i) a score of 9 or less on the Glasgow Coma Scale according to a test administered within a reasonable period of time after the accident by a person trained for that purpose, or
  - (ii) a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale according to a test administered more than six months after the accident by a person trained for that purpose,
- ☐ 7. an impairment or combination of impairments that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in 55 per cent or more impairment of the whole person; or
- ☐ 8. an impairment that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder.

Note:
If an insured person is under the age of 16 years at the time of the accident and none of the Glasgow Coma Scale, the Glasgow Outcome Scale or the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, referred to in sections (6), (7) and (8) of the above criteria, can be applied by reason of the age of the insured person, then an impairment sustained in an accident by the insured person that can reasonably be believed to be a catastrophic impairment shall be deemed to be the impairment that is most analogous to the impairment referred to in sections (6), (7) and (8) of the above criteria, after taking into consideration the developmental implications of the impairment.
For the purpose of sections (7) and (8) of the above criteria, an impairment that is sustained by an insured person but is not listed in the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, shall be deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person.
If the accident occurred after September 30, 2003, sections (7) and (8) of the above criteria do not apply to the applicant unless,

- ☐ the insured person's physician* (or health practitioner if the accident occurred before September 1, 2010) states in writing that the insured person's condition is unlikely to cease to be a catastrophic impairment; or
- ☐ two years have elapsed since the accident

Physician* Explanation or Comments for Criteria Selected Above:
Please provide a description of the impairment(s) sustained in the automobile accident. Use the applicable definition of catastrophic impairment as a guide. If you are able, and it's relevant, refer to the whole person impairment rating based on the AMA Guides.

☐ Further findings you deem relevant are attached.

Part 5

Signature of Physician*

I confirm that the applicant suffered a catastrophic impairment as described in the relevant definition attached to this application. It is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer in connection with the person's entitlement to a benefit under a contract of insurance. It is an offence under the federal Criminal Code for anyone to knowingly make or use a false document with the intent it be acted on as genuine and the offence is punishable, on conviction, by a maximum of 10 years imprisonment.

Name of Physician* (please print)	Signature of Physician*	Date (YYYYMMDD)

Note: The fee for completing this form is not a health care benefit of the Ontario Ministry of Health. The fee and the cost of any examination(s) necessary to complete this form should be billed to the insurance company.

SAVE