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Insurance Claim Application

Return To ICBC
PO BOX 2121, STN TERMINAL
VANCOUVER BC V6B 0L6

Fax 1-877-686-4222

CLAIM NUMBER	ADJUSTER NAME	ADJUSTER NUMBER	TELEPHONE NUMBER	TOLL FREE NUMBER

APPLICANT'S NAME			HOME PHONE	PRIMARY EMAIL ADDRESS
ADDRESS			BUSINESS PHONE	ALTERNATE EMAIL ADDRESS
DATE OF LOSS (ddmmmyyyy)	DATE OF BIRTH (ddmmmyyyy)	DRIVER'S LICENCE NUMBER	MARITAL STATUS	GENDER ☐ Male ☐ Female ☐ Unspecified
PERSONAL HEALTH NUMBER		I was (select one): ☐ Driver ☐ Passenger ☐ Bicyclist ☐ Pedestrian		

DESCRIBE YOUR INJURIES AND SYMPTOMS YOU ARE EXPERIENCING	TRANSPORTED BY AMBULANCE ☐ Yes ☐ No
DESCRIBE ANY PRE-EXISTING INJURY	
FAMILY DOCTOR'S NAME	FAMILY DOCTOR'S PHONE
TREATING DOCTOR'S NAME	TREATING DOCTOR'S PHONE

OTHER MEDICAL INSURANCE PLANS ☐ Yes ☐ No	INSURANCE AND PLAN NO. (including plans you have from employment, travel, private and/or through your spouse/parent)
OTHER DISABILITY INSURANCE PLANS ☐ Yes ☐ No	INSURANCE AND PLAN NO. (including STD, LTD, wage loss replacement plan, private plan)

CURRENT STATUS
☐ Retired ☐ Student ☐ Employed ☐ Homemaker ☐ Unemployed

Provide employment history details for the 12 month period preceding the accident to determine benefit eligibility

OCCUPATION 1	EMPLOYER/ORGANIZATION NAME	
EMPLOYER ADDRESS		EMPLOYER PHONE NUMBER
EMPLOYMENT START DATE	EMPLOYMENT END DATE	EMPLOYMENT TYPE ☐ Full Time ☐ Part Time ☐ Casual ☐ Self-employed ☐ Seasonal worker
UNABLE TO WORK ☐ Yes ☐ No	ANTICIPATED LENGTH OF TIME OFF (if any)	GROSS EARNINGS $ _____ ☐ Hourly ☐ Weekly ☐ Monthly

OCCUPATION 2 (if applicable)	EMPLOYER/ORGANIZATION NAME	
EMPLOYER ADDRESS		EMPLOYER PHONE NUMBER
EMPLOYMENT START DATE	EMPLOYMENT END DATE	EMPLOYMENT TYPE ☐ Full Time ☐ Part Time ☐ Casual ☐ Self-employed ☐ Seasonal worker
UNABLE TO WORK ☐ Yes ☐ No	ANTICIPATED LENGTH OF TIME OFF (if any)	GROSS EARNINGS $ _____ ☐ Hourly ☐ Weekly ☐ Monthly

LIST ANY ADDITIONAL EMPLOYMENT INFORMATION (please attach additional pages if necessary)		
WERE INJURIES SUSTAINED IN THE COURSE OF EMPLOYMENT? ☐ Yes ☐ No	IF YES, HAVE YOU APPLIED FOR WCB BENEFITS? ☐ Yes ☐ No	IF NO, HAVE YOU APPLIED FOR EI BENEFITS? ☐ Yes ☐ No

Information collected on this form is done so in accordance with Section 26 of the *Freedom of Information and Protection of Privacy Act* and Section 9 of the *Insurance Corporation Act*. This information will be used primarily in the evaluation and settlement of your current claim. There is also the possibility it will be referenced on future claims you may have. Questions about the collection of this information may be directed to your adjuster, or call 604-661-2800 or contact the Privacy & FOI department at 151 W. Esplanade North Vancouver, BC V7M 3H9.

The above information is provided along with related medical information as a basis for my insurance claim and is true and complete. I agree to advise ICBC of any information or changes that may affect my claim. I understand that it is an offence to provide false or misleading information.

WITNESS TO APPLICANT'S SIGNATURE _____ APPLICANT/PARENT GUARDIAN'S SIGNATURE _____ DATE _____