Return this form to:

Election of Income Replacement, Non-Earner or Caregiver Benefit (OCF-10)

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

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

Although you may be eligible for the Income Replacement Benefit, Non-Earner Benefit and/or the Caregiver Benefit, you can only receive one of these benefits. You must choose which benefit you wish to receive**. Please note that your choice of benefits cannot be changed after this form has been submitted to the insurance company unless the injury is determined to be catastrophic. If you need help in choosing the benefit, please contact your insurance company representative immediately**. Return this form no later than **30 days** from the day you received it. Make a copy for your own records. Please print clearly.

Part 1 Applicant Information

Last Name	First Name and Initial	Gender ☐ Male ☐ Female
Address		
City	Province	Postal Code
Birth date (yyyy/mm/dd)	Home Telephone ( )	Work Telephone ( ) Ext

Part 2 Benefit Election

I choose to receive the following benefit:

☐ Income Replacement Benefit ☐ Non-Earner Benefit ☐ Caregiver Benefit

Part 3 Signature

I certify 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 my 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. I further understand that the use and disclosure of information contained on this form is subject to the terms described on my Application for Accident Benefits.

Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (yyyy/mm/dd)