GENERAL CLIENT INFORMATION (MVA)

(PLEASE PRINT)

NAME: _____

DATE OF BIRTH: ____/_____/_____ **(DAY/MONTH/YEAR)**

ADDRESS: STREET # _____

CITY: _____ **PROV:** _____ **POSTAL CODE** _____

PHONE: HOME _____ **WORK** _____

CELL _____ **EMAIL:** _____

FAMILY DOCTOR: _____

REFERRING DOCTOR: _____

HOW DID YOU FIND OUT ABOUT US?

☐ **Yellow Pages** ☐ **Website** ☐ **Word of Mouth** ☐ **Friends/Family**
☐ **Hospital** ☐ **Signage** ☐ **Insurance Company** ☐ **Advertising**
☐ **Other**_____

MOTOR VEHICLE INSURANCE INJURY INFORMATION

CLAIM #: _____

POLICY #: _____

DATE OF INJURY_____ **(DD/MM/YR)**

NAME OF MOTOR VEHICLE INSURANCE COMPANY:

_____

ADDRESS OF MOTOR VEHICLE COMPANY: _____

CLAIM ADJUSTOR NAME: _____

ADJUSTER PHONE # _____

ADJUSTER FAX # _____

POLICY HOLDER NAME: (IF DIFFERENT FROM SELF)

_____

D.O.B. ___/_____/_____ (DD/MM/YR) RELATIONSHIP: _____

EXTENDED HEALTH CARE COVERAGE

****THE GOVERNMENT REQUIRES THAT IN THE EVENT OF A MOTOR VEHICLE INJURY, WE MUST INVOICE A CLIENT'S EXTENDED HEALTH CARE BENEFITS FIRST. IT IS REQUIRED THAT WE EXHAUST ALL EXTENDED HEALTH CARE BENEFITS BEFORE WE BILL YOUR MOTOR VEHICLE INSURANCE COMPANY.**

DO YOU HAVE EXTENDED HEALTH CARE COVERAGE? YES_____NO_____

IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

NAME OF PROVIDER: _____

GROUP/BENEFIT #: _____

CERTIFICATE/CLAIM #: _____

POLICY HOLDER (IF DIFFERENT FROM SELF):

_____ RELATIONSHIP: _____

POLICY HOLDER DOB: _____/_____/_____ (DAY/MONTH/YEAR)

ADDITIONAL BENEFITS AVAILABLE THROUGH SPOUSE: YES____NO____

POLICY PROVIDER NAME AND BENEFIT NUMBER: _____

_____

SPOUSE NAME: _____

SPOUSE DATE OF BIRTH ____/_____/____ (DAY/MONTH/YEAR)

If you have any questions, please do not hesitate to ask.