Français

Insurance Act

ONTARIO REGULATION 403/96

STATUTORY ACCIDENT BENEFITS SCHEDULE — ACCIDENTS ON OR AFTER NOVEMBER 1, 1996

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This is the English version of a bilingual regulation.

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PART I
GENERAL

TITLE

1. This Regulation may be cited as the *Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996*. O. Reg. 462/96, s. 2.

DEFINITIONS AND INTERPRETATION

2. (1) In this Regulation,

"accident" means an incident in which the use or operation of an automobile directly causes an impairment or directly causes damage to any prescription eyewear, denture, hearing aid, prosthesis or other medical or dental device; ("accident")

"assessment of attendant care needs" means a written assessment of attendant care needs that satisfies the requirements of section 39; ("évaluation des besoins en soins auxiliaires")

"attendant care benefit" means the benefit provided by section 16; ("indemnité de soins auxiliaires")

"business day" means a day that is not,

(a) Saturday, or

(b) a holiday within the meaning of subsection 29 (1) of the *Interpretation Act*, other than Easter Monday and Remembrance Day; ("jour ouvrable")

"caregiver benefit" means the benefit provided by Part IV; ("indemnité de soignant")

"case manager" means a person who provides services related to the coordination of goods or services for which payment is provided by a medical, rehabilitation or attendant care benefit; ("gestionnaire de cas")

"chiropractor" means a person authorized by law to practise chiropractic; ("chiropraticien")

"death benefit" means the benefit provided by section 25; ("prestation de décès")

"dentist" means a person authorized by law to practise dentistry; ("dentiste")

"designated assessment" means an assessment arranged or conducted by a designated assessment centre under section 43; ("évaluation désignée")

"designated assessment centre" means an assessment centre that was designated before January 1, 2005 under section 52 as that section read on February 28, 2006; ("centre d'évaluation désigné")

"disability certificate" means, in respect of a person, a certificate from a health practitioner of the person's choice that states the cause and nature of the person's impairment and contains an estimate of the duration of the disability in respect of which the person is making or has made a claim for a benefit set out in this Regulation; ("certificat d'invalidité")

"funeral benefit" means the benefit provided by section 26; ("indemnité pour frais funéraires")

"*Guideline*" means,

(a) a guideline issued by the Superintendent under subsection 268.3 (1) of the Act that is published in *The Ontario Gazette*,

(b) a Pre-approved Framework Guideline,

(c) a guideline that is included in the professional fee guidelines, the *Transportation Expense Guidelines* or the *Optional Indexation Benefit Guidelines*, as published in *The Ontario Gazette* by the Ontario Insurance Commission or Financial Services Commission of Ontario,

(d) a guideline published in *The Ontario Gazette* that is an amended version of a guideline referred to in clause (a), (b) or (c); ("directive")

"health practitioner", in respect of a particular impairment, means a physician or,

(a) a chiropractor, if the impairment is one that a chiropractor is authorized by law to treat,

(b) a dentist, if the impairment is one that a dentist is authorized by law to treat,

(b.1) an occupational therapist, if the impairment is one that an occupational therapist is authorized by law to treat,

(c) an optometrist, if the impairment is one that an optometrist is authorized by law to treat,

(d) a psychologist, if the impairment is one that a psychologist is authorized by law to treat,

(e) a physiotherapist, if the impairment is one that a physiotherapist is authorized by law to treat; ("praticien de la santé")

(f) a registered nurse with an extended certificate of registration, if the impairment is one that the nurse is authorized by law to treat, or

(g) a speech-language pathologist, if the impairment is one that a speech-language pathologist is authorized by law to treat;

"impairment" means a loss or abnormality of a psychological, physiological or anatomical structure or function; ("déficience")

"income replacement benefit" means the benefit provided by Part II; ("indemnité de remplacement de revenu")

"insured automobile", in respect of a particular motor vehicle liability policy, means any automobile covered by the policy; ("automobile assurée")

"insured person", in respect of a particular motor vehicle liability policy, means,

(a) the named insured, any person specified in the policy as a driver of the insured automobile, the spouse of the named insured and any dependant of the named insured or spouse, if the named insured, specified driver, spouse or dependant,

(i) is involved in an accident in or outside Ontario that involves the insured automobile or another automobile, or

(ii) is not involved in an accident but suffers psychological or mental injury as a result of an accident in or outside Ontario that results in a physical injury to his or her spouse, child, grandchild, parent, grandparent, brother, sister, dependant or spouse's dependant,

(b) in respect of accidents in Ontario, a person who is involved in an accident involving the insured automobile, and

(c) in respect of accidents outside Ontario, a person who is an occupant of the insured automobile and who is a resident of Ontario or was a resident of Ontario at some point during the 60 days before the accident; ("personne assurée")

"medical benefit" means the benefit provided by section 14; ("indemnité pour frais médicaux")

"member of a health profession" means a member of a College as defined in the *Regulated Health Professions Act, 1991*; ("membre d'une profession de la santé")

"non-earner benefit" means the benefit provided by Part III; ("indemnité de personne sans revenu d'emploi")

"occupational therapist" means a person authorized by law to practise occupational therapy; ("ergothérapeute")

"optometrist" means a person who is authorized by law to practise optometry; ("optométriste")

"person in need of care" means, in respect of an insured person, another person who is less than 16 years of age or who requires care because of physical or mental incapacity; ("personne ayant besoin de soins")

"personal and vocational characteristics" include,

(a) employment history,

(b) education and training,

(c) vocational aptitudes,

(d) vocational skills,

(e) physical abilities,

(f) cognitive abilities, and

(g) language abilities; ("caractéristiques personnelles et professionnelles")

"personal information" means information that is personal information for the purposes of the *Personal Information Protection and Electronic Documents Act* (Canada) and personal health information for the purposes of the *Personal Health Information Protection Act, 2004*; ("renseignements personnels")

"physician" means a person authorized by law to practise medicine; ("médecin")

"*Pre-approved Framework Guideline*" means a guideline,

(a) that is issued by the Superintendent under subsection 268.3 (1.1) of the Act and published in *The Ontario Gazette*, and

(b) which establishes, in respect of one or more impairments, a treatment framework; ("directive relative à un cadre de traitement préapprouvé")

"psychologist" means a person authorized by law to practise psychology; ("psychologue")

"physiotherapist" means a person authorized by law to practice physiotherapy; ("physiothérapeute")

"registered nurse with an extended certificate of registration" means a person authorized by law to practise nursing who holds an extended certificate of registration under the *Nursing Act, 1991*; ("infirmière autorisée ou infirmier autorisé titulaire d'un certificat d'inscription supérieur")

"rehabilitation benefit" means the benefit provided by section 15; ("indemnité de réadaptation")

"social worker" means a member of the Ontario College of Social Workers and Social Service Workers who holds a certificate of registration for social work under the *Social Work and Social Service Work Act, 1998*; ("travailleur social")

"speech-language pathologist" means a person authorized by law to practise speech-language pathology; ("orthophoniste")

"spouse" has the same meaning as in Part VI of the *Insurance Act*; ("conjoint") O. Reg. 403/96, s. 2 (1); O. Reg. 114/00, s. 1 (1, 2); O. Reg. 281/03, s. 1 (1-4); O. Reg. 458/03, s. 1; O. Reg. 314/05, s. 1 (1, 2); O. Reg. 546/05, s. 1; O. Reg. 533/06, s. 1; O. Reg. 295/07, s. 1.

(1.1) For the purposes of this Regulation, a catastrophic impairment caused by an accident that occurs before October 1, 2003 is,

(a) paraplegia or quadriplegia;

(b) the amputation or other impairment causing the total and permanent loss of use of both arms;

(c) the amputation or other impairment causing the total and permanent loss of use of both an arm and a leg;

(d) the total loss of vision in both eyes;

(e) brain impairment that, in respect of an accident, results in,

(i) a score of 9 or less on the Glasgow Coma Scale, as published in Jennett, B. and Teasdale, G., *Management of Head Injuries*, Contemporary Neurology Series, Volume 20, F.A. Davis Company, Philadelphia, 1981, 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, as published in Jennett, B. and Bond, M., *Assessment of Outcome After Severe Brain Damage*, Lancet i:480, 1975, according to a test administered more than six months after the accident by a person trained for that purpose;

(f) subject to subsections (2) and (3), 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

(g) subject to subsections (2) and (3), 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. O. Reg. 281/03, s. 1 (5); O. Reg. 314/05, s. 1 (1, 2).

(1.2) For the purposes of this Regulation, a catastrophic impairment caused by an accident that occurs after September 30, 2003 is,

(a) paraplegia or quadriplegia;

(b) the amputation or other impairment causing the total and permanent loss of use of both arms or both legs;

(c) the amputation or other impairment causing the total and permanent loss of use of one or both arms and one or both legs;

(d) the total loss of vision in both eyes;

(e) subject to subsection (1.4), brain impairment that, in respect of an accident, results in,

(i) a score of 9 or less on the Glasgow Coma Scale, as published in Jennett, B. and Teasdale, G., *Management of Head Injuries*, Contemporary Neurology Series, Volume 20, F.A. Davis Company, Philadelphia, 1981, 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, as published in Jennett, B. and Bond, M., *Assessment of Outcome After Severe Brain Damage*, Lancet i:480, 1975, according to a test administered more than six months after the accident by a person trained for that purpose;

(f) subject to subsections (1.4), (2.1) and (3), 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

(g) subject to subsections (1.4), (2.1) and (3), 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. O. Reg. 281/03, s. 1 (5).

(1.3) Subsection (1.4) applies 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 clause (1.2) (e), (f) or (g) can be applied by reason of the age of the insured person. O. Reg. 281/03, s. 1 (5).

(1.4) For the purposes of clauses (1.2) (e), (f) and (g), an impairment sustained in an accident by an insured person described in subsection (1.3) 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 clause (1.2) (e), (f) or (g), after taking into consideration the developmental implications of the impairment. O. Reg. 281/03, s. 1 (5).

(2) Clauses (1.1) (f) and (g) do not apply in respect of an insured person who sustains an impairment as a result of an accident that occurs before October 1, 2003 unless,

(a) the insured person's health practitioner states in writing that the insured person's condition has stabilized and is not likely to improve with treatment; or

(b) three years have elapsed since the accident. O. Reg. 403/96, s. 2 (2); O. Reg. 281/03, s. 1 (6).

(2.1) Clauses (1.2) (f) and (g) do not apply in respect of an insured person who sustains an impairment as a result of an accident that occurs after September 30, 2003 unless,

(a) the insured person's health practitioner states in writing that the insured person's condition is unlikely to cease to be a catastrophic impairment; or

(b) two years have elapsed since the accident. O. Reg. 281/03, s. 1 (7).

(3) For the purpose of clauses (1.1) (f) and (g) and (1.2) (f) and (g), 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. O. Reg. 403/96, s. 2 (3); O. Reg. 281/03, s. 1 (8).

(4) For the purpose of this Regulation, a person suffers a complete inability to carry on a normal life as a result of an accident if, and only if, as a result of the accident, the person sustains an impairment that continuously prevents the person from engaging in substantially all of the activities in which the person ordinarily engaged before the accident. O. Reg. 403/96, s. 2 (4).

(5) For the purpose of this Regulation, a person is employed if, for salary, wages, other remuneration or profit, the person is engaged in employment, including self-employment, or is the holder of an office, and "employment" has a corresponding meaning. O. Reg. 403/96, s. 2 (5).

(6) For the purpose of this Regulation, a person is a dependant of another person if the person is principally dependent for financial support or care on the other person or the other person's spouse. O. Reg. 403/96, s. 2 (6); O. Reg. 114/00, s. 1 (3); O. Reg. 314/05, s. 1 (3).

(7) For the purpose of this Regulation, an aide or attendant for a person includes a family member or friend who acts as the person's aide or attendant, even if the family member or friend does not possess any special qualifications. O. Reg. 403/96, s. 2 (7).

(8) For the purpose of this Regulation, payments of severance pay or termination pay are not payments for loss of income. O. Reg. 403/96, s. 2 (8).

(9) For the purpose of this Regulation, payments for loss of income under an income continuation benefit plan shall be deemed to include the following payments:

1. Payments of disability pension benefits under the *Canada Pension Plan*.
2. Periodic payments of insurance, if the insurance,
    i. is offered by the insurer only to persons who are employed at the time the contract for the insurance is entered into, and
    ii. is offered by the insurer only on the basis that the maximum benefit payable is limited to an amount calculated with reference to the insured person's income from employment. O. Reg. 482/01, s. 1.

(10) Subsection (9) only applies in respect of accidents that occur on or after January 1, 2002. O. Reg. 482/01, s. 1.

APPLICATION

3. (1) In this section,

"New Regulation" means Ontario Regulation 34/10 (Statutory Accident Benefits Schedule — Effective September 1, 2010), made under the Act. O. Reg. 35/10, s. 1.

(1.1) Subject to subsection (1.3), the benefits set out in this Regulation shall be provided under every contract evidenced by a motor vehicle liability policy in respect of accidents that occur on or after November 1, 1996 and before September 1, 2010. O. Reg. 35/10, s. 1.

(1.2) Section 24 and Parts X, XI, XII, XIII and XV do not apply after August 31, 2010. O. Reg. 35/10, s. 1.

(1.3) No amount referred to in this Regulation shall be paid after August 31, 2010. O. Reg. 35/10, s. 1.

(1.4) An amount that would, but for subsection (1.3), be paid under this Regulation after August 31, 2010 shall be paid under the New Regulation, but in the amount determined,

(a) under this Regulation, other than section 24; or

(b) under subsections 25 (1), (3), (4) and (5) of the New Regulation. O. Reg. 35/10, s. 1.

(1.5) None of the following actions shall be taken on or after September 1, 2010 in respect of an accident that occurred on or after November 1, 1996 and before September 1, 2010:

1. The delivery of a disability certificate for the purpose of section 20, 35 or 37.
2. The delivery of a notice to an insurer under subsection 32 (1) of a person's intention to apply for a benefit.
3. A request under clause 37 (1) (a) by an insurer.
4. The delivery of a treatment confirmation form for the purpose of section 37.1 or 37.2.
5. The delivery by an insurer of a notice for the purpose of section 37.3.
6. The delivery of a treatment plan for the purpose of section 38.
7. The delivery by an insurer of a notice for the purpose of section 38.1.

8. The delivery of an application under section 38.2 for approval of an assessment or examination.

9. The delivery under section 39 of an assessment of attendant care needs.

10. The delivery by an insurer of a notice for the purpose of subsection 39 (5).

11. The delivery of an application under section 40 for a determination of whether an impairment sustained by the insured person is a catastrophic impairment.

12. The delivery by an insurer of any notice requiring an insured person to be examined under section 42. O. Reg. 35/10, s. 1.

(1.6) Any action referred to in subsection (1.5) that is not taken before September 1, 2010 may instead be taken under the corresponding provision of the New Regulation and, for that purpose, any time limit set out in the New Regulation applies as if any action previously taken under this Regulation was taken under the New Regulation. O. Reg. 35/10, s. 1.

(2) The benefits set out in this Regulation shall be provided in respect of accidents that occur in Canada or the United States of America, or on a vessel plying between ports of Canada or the United States of America. O. Reg. 403/96, s. 3 (2).

(3) Benefits payable under this Regulation in respect of an insured person shall be paid by the insurer that is liable to pay under subsection 268 (2) of the *Insurance Act*. O. Reg. 403/96, s. 3 (3).

(4) Subject to Part IX, the insurer shall pay the benefits under this Regulation despite section 225, subsection 233 (1), section 240 and subsection 265 (3) of the *Insurance Act*. O. Reg. 403/96, s. 3 (4).

PART II
INCOME REPLACEMENT BENEFIT

ELIGIBILITY CRITERIA

4. (1) The insurer shall pay an insured person who sustains an impairment as a result of an accident an income replacement benefit if the insured person meets any of the following qualifications:

1. The insured person was employed at the time of the accident and, as a result of and within 104 weeks after the accident, suffers a substantial inability to perform the essential tasks of that employment.

2. The insured person,

   i. was not employed at the time of the accident,

   ii. was employed for at least 26 weeks during the 52 weeks before the accident or was receiving benefits under the *Employment Insurance Act* (Canada) at the time of the accident,

   iii. was 16 years of age or more or was excused from attendance at school under the *Education Act* at the time of the accident, and

   iv. as a result of and within 104 weeks after the accident, suffers a substantial inability to perform the essential tasks of the employment in which the insured person spent the most time during the 52 weeks before the accident.

3. The insured person,

   i. was entitled at the time of the accident to start work within one year under a legitimate contract of employment that was made before the accident and that is evidenced in writing, and

   ii. as a result of and within 104 weeks after the accident, suffers a substantial inability to perform the essential tasks of the employment he or she was entitled to start under the contract. O. Reg. 403/96, s. 4.

(2) Despite subsection (1), paragraph 3 of that subsection applies only if the accident occurs before April 15, 2004. O. Reg. 458/03, s. 2.

PERIOD OF BENEFIT

5. (1) Subject to subsection (2), an income replacement benefit is payable during the period that the insured person suffers a substantial inability to perform the essential tasks of the employment in respect of which he or she qualifies for the benefit under section 4. O. Reg. 403/96, s. 5 (1).

(2) The insurer is not required to pay an income replacement benefit,

(a) for the first week of the disability;

(b) for any period longer than 104 weeks of disability, unless, as a result of the accident, the insured person is suffering a complete inability to engage in any employment for which he or she is reasonably suited by education, training or experience;

(c) in the case of an insured person who qualifies for the benefit under paragraph 3 of section 4, for the period before the day he or she would have been entitled under the contract to begin employment;

(d) for any period longer than 12 weeks after the accident, in the case of an insured person whose impairment is a Grade I whiplash-associated disorder that comes within a *Pre-approved Framework Guideline*, if the accident occurred after April 14, 2004; or

(e) for any period longer than 16 weeks after the accident, in the case of an insured person whose impairment is a Grade II whiplash-associated disorder that comes within a *Pre-approved Framework Guideline*, if the accident occurred after April 14, 2004. O. Reg. 403/96, s. 5 (2); O. Reg. 458/03, s. 3; O. Reg. 295/07, s. 2.

AMOUNT OF BENEFIT

6. (1) The amount of the income replacement benefit shall be,

(a) for each of the first 104 weeks of disability, 80 per cent of the insured person's net weekly income from employment determined in accordance with section 61; and

(b) for each week after the first 104 weeks of disability, the greater of the amount specified in clause (a) and $185. O. Reg. 403/96, s. 6 (1).

(2) The insurer may deduct from the amount of the income replacement benefit payable to an insured person 80 per cent of the net income received by the insured person in respect of any employment subsequent to the accident. O. Reg. 403/96, s. 6 (2).

(3) For the purpose of subsection (2), the net income received by an insured person in respect of employment subsequent to the accident shall be determined by subtracting the following amounts from the gross income received by the person in respect of the employment subsequent to the accident:

1. The premium payable by the person under the *Employment Insurance Act* (Canada) on the gross income.
2. The contribution payable by the person under the *Canada Pension Plan* on the gross income.
3. The income tax payable by the person under the *Income Tax Act* (Canada) and the *Income Tax Act* (Ontario) on the gross income. O. Reg. 403/96, s. 6 (3).

(4) For the purpose of subsection (2), net income from self-employment for an insured person who was self-employed at the time of the accident shall be determined without making any deductions for,

(a) expenses that were not reasonable or necessary to prevent a loss of revenue;

(b) salary expenses that were paid to replace the person's active participation in the business, except to the extent that those expenses were reasonable for that purpose; and

(c) non-salary expenses that were different in nature or greater than the non-salary expenses incurred before the accident, except to the extent that those expenses were necessary to prevent or reduce any losses resulting from the accident. O. Reg. 403/96, s. 6 (4).

(5) If the insured person was self-employed at the time of the accident and the person incurs losses from self-employment as a result of the accident, the insurer shall add to the amount of the income replacement benefit payable to the person 80 per cent of the losses from self-employment incurred as a result of the accident. O. Reg. 403/96, s. 6 (5).

(6) For the purpose of subsection (5), losses from self-employment shall be determined in the same manner as losses from the business in which the person was self-employed would be determined under subsection 9 (2) of the *Income Tax Act* (Canada) and the *Income Tax Act* (Ontario), without making any deductions for,

(a) expenses that were not reasonable or necessary to prevent a loss of revenue;

(b) salary expenses that were paid to replace the person's active participation in the business, except to the extent that those expenses were reasonable for that purpose;

(c) non-salary expenses that were different in nature or greater than the non-salary expenses incurred before the accident, except to the extent that those expenses were necessary to prevent or reduce any losses resulting from the accident;

(d) expenses that are eligible for capital cost allowance or an allowance on eligible capital property; or

(e) losses deductible under section 111 of the *Income Tax Act* (Canada). O. Reg. 403/96, s. 6 (6).

COLLATERAL PAYMENTS FOR LOSS OF INCOME AND MAXIMUM AMOUNT OF BENEFIT

7. (1) Despite subsections 6 (1) and (5), but subject to subsection 6 (2), the weekly amount of an income replacement benefit payable to a person shall be the lesser of the following amounts:

1. The amount determined under subsections 6 (1) and (5), reduced by,
    i. net weekly payments for loss of income that are being received by the person as a result of the accident under the laws of any jurisdiction or under any income continuation benefit plan, and

ii. net weekly payments for loss of income that are not being received by the person but are available to the person as a result of the accident under the laws of any jurisdiction or under any income continuation benefit plan, unless the person has applied to receive the payments for loss of income.

2. The greater of the following amounts:

i. $400.

ii. If the optional income replacement benefit referred to in section 27 has been purchased and is applicable to the person, the amount fixed by the optional benefit. O. Reg. 403/96, s. 7 (1); O. Reg. 462/96, s. 4; O. Reg. 281/03, s. 2 (1, 2).

(2) For the purposes of paragraph 1 of subsection (1), the amount determined under subsections 6 (1) and (5) shall not be reduced by,

(a) benefits under the *Employment Insurance Act* (Canada) that are being received by or are available to the person;

(b) payments under a sick leave plan that are not being received by the person but are available to the person; or

(c) payments under a workers' compensation law or plan that are not being received by the person and to which the person is not entitled because the person has elected under the workers' compensation law or plan to bring an action. O. Reg. 403/96, s. 7 (2); O. Reg. 281/03, s. 2 (3).

(3) For the purpose of this section, net weekly payments for loss of income shall be determined by subtracting from the gross weekly amount of payments for loss of income the income tax payable by the person under the *Income Tax Act* (Canada) and the *Income Tax Act* (Ontario) on the gross weekly amount of payments for loss of income. O. Reg. 403/96, s. 7 (3).

(4) For the purpose of subsection (3), the person whose net weekly payments for loss of income are to be determined shall be deemed to be a resident of Ontario. O. Reg. 403/96, s. 7 (4).

GROSS INCOME CALCULATIONS

8. (1) An insured person who is eligible for an income replacement benefit under paragraph 1 of section 4 and who was not self-employed at any time during the four weeks before the accident shall designate one of the following time periods:

1. The four weeks before the accident.

2. The 52 weeks before the accident. O. Reg. 403/96, s. 8 (1).

(2) An insured person who is eligible for an income replacement benefit under paragraph 1 of section 4 and who was self-employed at any time during the four weeks before the accident shall designate one of the following time periods:

1. The 52 weeks before the accident.

2. The last fiscal year completed before the accident for the business in which the person was self-employed, if the business completed a fiscal year before the accident. O. Reg. 403/96, s. 8 (2).

(3) For the purpose of determining the amount of an insured person's income replacement benefit, the gross annual income from employment for a person who qualifies for a benefit under paragraph 1 of section 4 shall be deemed to be the following amount:

1. In the case of a person who designated the four weeks before the accident under paragraph 1 of subsection (1), the person's gross income from employment for the four weeks before the accident, multiplied by 13.

2. In the case of a person who designated the 52 weeks before the accident under paragraph 2 of subsection (1) or paragraph 1 of subsection (2), the person's gross income from employment for the 52 weeks before the accident.

3. In the case of a person who designated the last fiscal year completed before the accident under paragraph 2 of subsection (2), the person's gross income from employment for that fiscal year. O. Reg. 403/96, s. 8 (3); O. Reg. 462/96, s. 5.

(4) For the purpose of determining the amount of an insured person's income replacement benefit, the gross annual income from employment for a person who qualifies for a benefit under paragraph 2 of section 4 shall be deemed to be the person's gross income from employment for the 52 weeks before the accident. O. Reg. 403/96, s. 8 (4).

(5) For the purpose of determining the amount of an insured person's income replacement benefit, the gross annual income from employment for a person who qualifies for a benefit under paragraph 3 of section 4 shall be deemed to be the gross income payable under the contract of employment, extrapolated to reflect an annual income. O. Reg. 403/96, s. 8 (5).

(6) A determination of gross income under subsection (3) or (4) shall include any benefits received under the *Employment Insurance Act* (Canada) or a predecessor of that Act in respect of the relevant period. O. Reg. 403/96, s. 8 (6).

(7) If a person qualifies for an income replacement benefit under paragraph 1 or 2 of section 4 and also qualifies under paragraph 3 of section 4, the person's gross annual income from employment shall be determined under subsection (3) or (4), as the case may be, until the day he or she would have been entitled to begin employment under the contract described in

paragraph 3 of section 4, and thereafter the person's gross annual income from employment shall be determined in accordance with subsection (5). O. Reg. 403/96, s. 8 (7).

ADJUSTMENT AFTER AGE 65

9. (1) Despite sections 6 and 7, if a person is receiving an income replacement benefit immediately before attaining 65 years of age, the weekly amount of the benefit shall be adjusted, on the later of the date the person attains 65 years of age and the second anniversary of the date the person began receiving the benefit, to the amount determined in accordance with the following formula:

$$A = B \times 0.02 \times C$$

where,

A = the amount to which the weekly amount of the income replacement benefit shall be adjusted,

B = the weekly amount of the income replacement benefit that the person was entitled to receive immediately before the adjustment, including any additions required by subsection 6 (5) but without making any deductions permitted by subsection 6 (2),

C = the lesser of,

i. 35, and

ii. the number of years during which the person qualified for the income replacement benefit before the adjustment is made.

O. Reg. 403/96, s. 9 (1).

(2) An income replacement benefit that has been adjusted under subsection (1) is payable until the person dies. O. Reg. 403/96, s. 9 (2).

(3) Section 5 and subsections 6 (2) to (6) do not apply to an income replacement benefit that has been adjusted under subsection (1). O. Reg. 403/96, s. 9 (3).

ENTITLEMENT ARISING AFTER AGE 65

10. (1) Despite sections 6 and 7, if a person becomes entitled to receive an income replacement benefit after attaining 65 years of age, the weekly amount of the benefit shall be the amount determined under section 7 multiplied by the factor set out in Column 2 of the Table to this subsection opposite the number of weeks that have elapsed since the person became entitled to receive the benefit.

TABLE

Column 1	Column 2
Number of weeks since Entitlement Arose	Factor
Less than 52 weeks	1.0
52 weeks or more but less than 104 weeks	0.8
104 weeks or more but less than 156 weeks	0.6
156 weeks or more but less than 208 weeks	0.3
208 weeks or more	0.0

O. Reg. 403/96, s. 10 (1).

(2) An income replacement benefit is no longer payable to a person to whom subsection (1) applies if more than 208 weeks have elapsed since the person became entitled to the benefit. O. Reg. 403/96, s. 10 (2).

(3) Subsections 6 (2) to (6) do not apply to the income replacement benefit paid to a person to whom subsection (1) applies. O. Reg. 403/96, s. 10 (3).

10.1 The age distinctions in sections 9 and 10 apply despite the *Human Rights Code*. O. Reg. 536/06, s. 1.

TEMPORARY RETURN TO EMPLOYMENT

11. A person receiving an income replacement benefit may return to or start an employment at any time during the 104 weeks following the onset of the disability in respect of which the benefit is paid without affecting his or her entitlement to resume receiving benefits under this Part if, as a result of the accident, he or she is unable to continue in the employment. O. Reg. 403/96, s. 11.

PART III
NON-EARNER BENEFIT

12. (1) The insurer shall pay an insured person who sustains an impairment as a result of an accident a non-earner benefit if the insured person meets any of the following qualifications:

1. The insured person suffers a complete inability to carry on a normal life as a result of and within 104 weeks after the accident and does not qualify for an income replacement benefit.
2. The insured person suffers a complete inability to carry on a normal life as a result of and within 104 weeks after the accident, received a caregiver benefit as a result of the accident and there is no longer a person in need of care.
3. The insured person suffers a complete inability to carry on a normal life as a result of and within 104 weeks after the accident and,
    i. was enrolled on a full-time basis in elementary, secondary or post-secondary education at the time of the accident, or
    ii. completed his or her education less than one year before the accident and was not employed, after completing his or her education and before the accident, in an employment that reflected his or her education and training. O. Reg. 403/96, s. 12 (1).

(2) Subject to subsection (3), the amount of the non-earner benefit shall be $185 for each week that the insured person is eligible to receive the benefit. O. Reg. 403/96, s. 12 (2).

(3) If a person qualifies for a non-earner benefit under paragraph 3 of subsection (1) and more than 104 weeks have elapsed since the onset of the disability, the amount of the non-earner benefit shall be $320 for each week that the insured person continues to be eligible to receive the benefit. O. Reg. 403/96, s. 12 (3).

(4) The insurer may deduct the following amounts from the amount payable to an insured person as a non-earner benefit:

1. Net weekly payments for loss of income that are being received by the insured person as a result of the accident under the laws of any jurisdiction or under any income continuation benefit plan.
2. Net weekly payments for loss of income that are not being received by the insured person but are available to the insured person as a result of the accident under the laws of any jurisdiction or under any income continuation benefit plan, unless the insured person has applied to receive the payments for loss of income. O. Reg. 403/96, s. 12 (4); O. Reg. 462/96, s. 6.

(5) For the purpose of subsection (4), subsections 7 (2) and (3) apply with necessary modifications. O. Reg. 403/96, s. 12 (5).

(6) Subject to subsection (7), the non-earner benefit is payable during the period that the insured person suffers a complete inability to carry on a normal life. O. Reg. 403/96, s. 12 (6).

(7) The insurer,

(a) is not required to pay a non-earner benefit for the first 26 weeks after the onset of the complete inability to carry on a normal life; and

(b) is not required to pay a non-earner benefit for any period before the insured person attains 16 years of age. O. Reg. 403/96, s. 12 (7).

(8) Sections 9 and 10 apply, with necessary modifications, to a non-earner benefit and, for that purpose, the reference in subsection 10 (1) to "the amount determined under section 7" shall be deemed to be a reference to the amount referred to in subsection (2) of this section. O. Reg. 403/96, s. 12 (8).

PART IV
CAREGIVER BENEFIT

13. (1) The insurer shall pay an insured person who sustains an impairment as a result of an accident a caregiver benefit if the insured person meets all of the following qualifications:

1. At the time of the accident,
    i. the insured person was residing with a person in need of care, and
    ii. the insured person was the primary caregiver for the person in need of care and did not receive any remuneration for engaging in caregiving activities.
2. As a result of and within 104 weeks after the accident, the insured person suffers a substantial inability to engage in the caregiving activities in which he or she engaged at the time of the accident. O. Reg. 403/96, s. 13 (1).

(2) The caregiver benefit shall pay for reasonable and necessary expenses incurred as a result of the accident in caring for a person in need of care. O. Reg. 403/96, s. 13 (2).

(3) The amount of the caregiver benefit shall not exceed,

(a) for the first person in need of care,

    (i) $250 per week, or

(ii) if the optional caregiver and dependant care benefit referred to in section 27 has been purchased and is applicable to the insured person, the amount fixed by the optional benefit; and

(b) for each additional person in need of care,

(i) $50 per week, or

(ii) if the optional caregiver and dependant care benefit referred to in section 27 has been purchased and is applicable to the insured person, the amount fixed by the optional benefit. O. Reg. 403/96, s. 13 (3).

(4) The insurer is not required to pay a caregiver benefit for any period longer than 104 weeks of disability, unless, as a result of the accident, the insured person is suffering a complete inability to carry on a normal life. O. Reg. 403/96, s. 13 (4).

PART V
MEDICAL, REHABILITATION AND ATTENDANT CARE BENEFITS

MEDICAL BENEFIT

14. (1) The insurer shall pay an insured person who sustains an impairment as a result of an accident a medical benefit. O. Reg. 403/96, s. 14 (1).

(2) The medical benefit shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident for,

(a) medical, surgical, dental, optometric, hospital, nursing, ambulance, audiometric and speech-language pathology services;

(b) chiropractic, psychological, occupational therapy and physiotherapy services;

(c) medication;

(d) prescription eyewear;

(e) dentures and other dental devices;

(f) hearing aids, wheelchairs or other mobility devices, prostheses, orthotics and other assistive devices;

(g) transportation for the insured person to and from treatment sessions, including transportation for an aide or attendant;

(h) other goods and services of a medical nature that the insured person requires. O. Reg. 403/96, s. 14 (2).

(3) The insurer is not liable to pay a medical benefit for goods or services that are experimental in nature. O. Reg. 403/96, s. 14 (3).

(4) The insurer is not liable to pay a medical benefit for expenses related to professional services described in clause (2) (a), (b) or (h) rendered to an insured person that exceed the maximum rate or amount of expenses established under the *Guidelines* applicable to the claim. O. Reg. 281/03, s. 3.

(4.1) If the *Guidelines* applicable to the claim establish a range of rates or amounts for expenses related to professional services rendered to an insured person,

(a) the highest rate or amount in the range shall be deemed, for the purposes of subsection (4), to be the maximum rate or amount established under the *Guidelines* applicable to the claim; and

(b) an insurer that is liable to pay a medical benefit for expenses related to the services described in clause (2) (a), (b) or (h) shall not pay less than the lowest amount or rate in the range unless the insured person's claim is for less than the lowest amount or rate in the range. O. Reg. 281/03, s. 3.

(5) Subject to subsection (6), the insurer is not liable to pay a medical benefit under clause (2) (g) for expenses related to transportation unless the expenses are authorized by, and are calculated by applying the rates set out in, the *Transportation Expense Guidelines* published in *The Ontario Gazette* by the Ontario Insurance Commission or Financial Services Commission of Ontario, as they may be amended from time to time. O. Reg. 403/96, s. 14 (5); O. Reg. 303/98, s. 1 (2).

(6) The insurer is not liable to pay a medical benefit under clause (2) (g) for expenses related to,

(a) the first 50 kilometres of transportation in the insured person's automobile to and from a treatment session if the accident occurred before April 15, 2004; or

(b) the first 50 kilometres of transportation to and from a treatment session if the accident occurred after April 14, 2004, unless the insured person sustained a catastrophic impairment as a result of the accident. O. Reg. 458/03, s. 4.

REHABILITATION BENEFIT

15. (1) The insurer shall pay an insured person who sustains an impairment as a result of an accident a rehabilitation benefit. O. Reg. 403/96, s. 15 (1).

(2) The rehabilitation benefit shall pay for reasonable and necessary measures undertaken by an insured person to reduce or eliminate the effects of any disability resulting from the impairment or to facilitate the insured person's reintegration into his or her family, the rest of society and the labour market. O. Reg. 403/96, s. 15 (2).

(3) Measures to reintegrate an insured person into the labour market include measures that are reasonable and necessary to enable the person to,

(a) engage in employment that is as similar as possible to employment in which he or she engaged before the accident; or

(b) lead as normal a work life as possible. O. Reg. 403/96, s. 15 (3).

(4) In determining whether a measure is reasonable and necessary for the purpose of subsection (3), the insurer shall consider the insured person's personal and vocational characteristics. O. Reg. 403/96, s. 15 (4).

(5) The rehabilitation benefit shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident for a purpose referred to in subsection (2) for,

(a) life skills training;

(b) family counselling;

(c) social rehabilitation counselling;

(d) financial counselling;

(e) employment counselling;

(f) vocational assessments;

(g) vocational or academic training;

(h) workplace modifications and workplace devices, including communications aids, to accommodate the needs of the insured person;

(i) home modifications and home devices, including communications aids, to accommodate the needs of the insured person, or the purchase of a new home if it is more reasonable to purchase a new home to accommodate the needs of the insured person than to renovate the insured person's existing home;

(j) vehicle modifications to accommodate the needs of the insured person, or the purchase of a new vehicle if it is more reasonable to purchase a new vehicle to accommodate the needs of the insured person than to modify an existing vehicle;

(k) transportation for the insured person to and from counselling and training sessions, including transportation for an aide or attendant;

(l) other goods and services that the insured person requires, except services provided by a case manager. O. Reg. 403/96, s. 15 (5); O. Reg. 281/03, s. 4 (1).

(6) The insurer is not liable to pay a rehabilitation benefit for expenses related to professional services described in any of clauses (5) (a) to (g) or clause (5) (l) rendered to an insured person that exceed the maximum rate or amount of expenses established under the *Guidelines* applicable to the claim. O. Reg. 281/03, s. 4 (2).

(6.1) If the *Guidelines* applicable to the claim establish a range of rates or amounts for expenses related to professional services rendered to an insured person,

(a) the highest rate or amount in the range shall be deemed, for the purpose of subsection (6), to be the maximum rate or amount established under the *Guidelines* applicable to the claim; and

(b) an insurer that is liable to pay a rehabilitation benefit for expenses related to the services described in any of clauses (5) (a) to (g) or clause (5) (l) shall not pay less than the lowest amount or rate in the range unless the insured person's claim is for less than the lowest amount or rate in the range. O. Reg. 281/03, s. 4 (2).

(7) For the purpose of clause (5) (i), expenses incurred to renovate the insured person's home shall be deemed not to be reasonable and necessary expenses if the renovations are only for the purpose of giving the insured person access to areas of the home that are not needed for ordinary living. O. Reg. 403/96, s. 15 (7).

(8) The amount of the rehabilitation benefit for the purchase of a new home shall not exceed the value of the renovations to the insured person's existing home that would have been required to accommodate the needs of the insured person. O. Reg. 403/96, s. 15 (8).

(9) For the purpose of clause (5) (j), expenses incurred to purchase or modify a vehicle to accommodate the needs of an insured person shall be deemed not to be reasonable and necessary expenses if they are incurred within five years after the last expenses incurred for that purpose in respect of the same accident. O. Reg. 403/96, s. 15 (9).

(10) The amount of the rehabilitation benefit for the purchase of a new vehicle shall not exceed the cost of the new vehicle, less the trade-in value of the existing vehicle. O. Reg. 403/96, s. 15 (10).

(11) Subject to subsection (12), the insurer is not liable to pay a rehabilitation benefit under clause (5) (k) for expenses related to transportation unless the expenses are authorized by, and are calculated by applying the rates set out in, the *Transportation Expense Guidelines* published in *The Ontario Gazette* by the Ontario Insurance Commission or Financial Services Commission of Ontario, as they may be amended from time to time. O. Reg. 403/96, s. 15 (11); O. Reg. 303/98, s. 2 (2).

(12) The insurer is not liable to pay a rehabilitation benefit under clause (5) (k) for expenses related to,

(a) the first 50 kilometres of transportation in the insured person's automobile to and from a counselling or training session if the accident occurred before April 15, 2004; or

(b) the first 50 kilometres of transportation to and from a counselling or training session if the accident occurred after April 14, 2004, unless the insured person sustained a catastrophic impairment as a result of the accident. O. Reg. 458/03, s. 5.

ATTENDANT CARE BENEFIT

16. (1) The insurer shall pay an insured person who sustains an impairment as a result of an accident an attendant care benefit. O. Reg. 403/96, s. 16 (1).

(1.1) Despite subsection (1), if the accident occurred after April 14, 2004, no attendant care benefit is payable to an insured person whose impairment is a Grade I or Grade II whiplash-associated disorder that comes within a *Pre-approved Framework Guideline*. O. Reg. 295/07, s. 3.

(2) The attendant care benefit shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident for,

(a) services provided by an aide or attendant; or

(b) services provided by a long-term care facility, including a nursing home, home for the aged or chronic care hospital. O. Reg. 403/96, s. 16 (2).

(3) Subsection (2) does not apply to expenses for which payment may be obtained under clause 14 (2) (g), 15 (5) (k) or subsection 24 (1.6). O. Reg. 403/96, s. 16 (3); O. Reg. 533/06, s. 2.

(4) The monthly amount payable by the attendant care benefit shall be determined in accordance with Form 1. O. Reg. 403/96, s. 16 (4).

(5) The amount of the attendant care benefit payable in respect of an insured person shall not exceed the amount determined under the following rules:

1. If the accident occurred before October 1, 2003, the amount of the attendant care benefit payable in respect of the insured person shall not exceed,
   i. $3,000 per month, if the insured person did not sustain a catastrophic impairment as a result of the accident, or
   ii. $6,000 per month, if the insured person sustained a catastrophic impairment as a result of the accident.
2. If the accident occurred on or after October 1, 2003 and the optional medical, rehabilitation and attendant care benefit referred to in section 27 has not been purchased and does not apply to the insured person, the amount of the attendant care benefit payable in respect of the insured person shall not exceed,
   i. $3,000 per month, if the insured person did not sustain a catastrophic impairment as a result of the accident, or
   ii. $6,000 per month, if the insured person sustained a catastrophic impairment as a result of the accident.
3. If the accident occurred on or after October 1, 2003 and the optional medical, rehabilitation and attendant care benefit referred to in section 27 has been purchased and applies to the insured person, the amount of the attendant care benefit payable in respect of the insured person shall not exceed the monthly limit under subsection 27 (5). O. Reg. 281/03, s. 5; O. Reg. 458/03, s. 6 (2).

CASE MANAGER SERVICES

17. (1) The insurer shall pay all reasonable and necessary expenses incurred by or on behalf of an insured person as a result of the accident for services provided by a qualified case manager in accordance with a treatment plan if,

(a) the insured person sustains a catastrophic impairment as a result of the accident; or

(b) the accident occurred on or after October 1, 2003 and the optional medical, rehabilitation and attendant care benefit referred to in section 27 has been purchased and applies to the insured person. O. Reg. 281/03, s. 6.

(2) The insurer is not liable under subsection (1) to pay expenses related to professional services rendered to an insured person that exceed the maximum rate or amount of expenses established under the *Guidelines* applicable to the claim. O. Reg. 281/03, s. 6.

(3) If the *Guidelines* applicable to the claim establish a range of rates or amounts for expenses related to professional services rendered to an insured person,

(a) the highest rate or amount in the range shall be deemed, for the purpose of subsection (2), to be the maximum rate or amount established under the *Guidelines* applicable to the claim; and

(b) an insurer that is liable under subsection (1) to pay expenses related to the services rendered to the insured person shall not pay less than the lowest amount or rate in the range, unless the insured person's claim is for less than the lowest amount or rate in the range. O. Reg. 281/03, s. 6.

DURATION OF MEDICAL, REHABILITATION AND ATTENDANT CARE BENEFITS

18. (1) No medical or rehabilitation benefit is payable for expenses incurred,

(a) more than 10 years after the accident, in the case of an insured person who was 15 years of age or more at the time of the accident; or

(b) after the insured person attains 25 years of age, in the case of an insured person who was less than 15 years of age at the time of the accident. O. Reg. 403/96, s. 18 (1).

(2) No attendant care benefit is payable for expenses incurred more than 104 weeks after the accident. O. Reg. 403/96, s. 18 (2).

(3) Subsections (1) and (2) do not apply in respect of an insured person who sustains a catastrophic impairment as a result of the accident. O. Reg. 403/96, s. 18 (3).

(4) Subsections (1) and (2) do not apply if the optional medical, rehabilitation and attendant care benefit referred to in section 27 has been purchased and is applicable to the insured person. O. Reg. 403/96, s. 18 (4).

MAXIMUM LIMITS ON MEDICAL, REHABILITATION AND ATTENDANT CARE BENEFITS

19. (1) The sum of the medical and rehabilitation benefits paid in respect of an insured person shall not exceed, for any one accident,

(a) $100,000; or

(b) if the insured person sustained a catastrophic impairment as a result of the accident, $1,000,000. O. Reg. 403/96, s. 19 (1).

(2) The amount of the attendant care benefit paid in respect of an insured person shall not exceed, for any one accident,

(a) $1,000,000, if the insured person sustained a catastrophic impairment as a result of the accident;

(b) nil, if the accident occurred after April 14, 2004 and the insured person's impairment is a Grade I or Grade II whiplash-associated disorder that comes within a *Pre-approved Framework Guideline*; or

(c) $72,000 in any other case. O. Reg. 458/03, s. 7; O. Reg. 295/07, s. 4.

(3) If the optional medical, rehabilitation and attendant care benefit referred to in section 27 was purchased and applies to the insured person, the maximum limits fixed by the optional benefit apply and subsection (1) and clauses (2) (a) and (c) do not apply. O. Reg. 458/03, s. 7.

(4) For the purpose of subsection (1), the medical and rehabilitation benefits paid in respect of an insured person include any amount paid in respect of the insured person under section 17. O. Reg. 403/96, s. 19 (4).

PART VI
PAYMENT OF OTHER EXPENSES

LOST EDUCATIONAL EXPENSES

20. (1) The insurer shall pay for lost educational expenses incurred by or on behalf of an insured person who sustains an impairment as a result of an accident if,

(a) at the time of the accident, the insured person was enrolled in a program of elementary, secondary, post-secondary or continuing education; and

(b) as a result of the accident, the insured person is unable to continue the program. O. Reg. 403/96, s. 20 (1).

(2) The amount payable under this section shall not exceed $15,000. O. Reg. 403/96, s. 20 (2).

(2.1) The insurer may require a person who claims or is receiving benefits under this section to furnish a disability certificate as often as is reasonably necessary. O. Reg. 546/05, s. 2.

(2.2) If an insurer requires a disability certificate, the person shall furnish a new disability certificate, completed as of a date after the date of the insurer's request, within 15 business days after receiving the insurer's request. O. Reg. 546/05, s. 2.

(2.3) If the person fails to comply with subsection (2.2), no amount is payable for lost educational expenses until the person furnishes the completed disability certificate. O. Reg. 546/05, s. 2.

(3) In this section,

"lost educational expenses" means expenses incurred before the accident for tuition, books, equipment or room and board in respect of the program term or program year in which the insured person was enrolled at the time of the accident, if the expenses are related to the program that the insured person is unable to continue. O. Reg. 403/96, s. 20 (3).

EXPENSES OF VISITORS

21. (1) If an insured person sustains an impairment as a result of an accident, the insurer shall pay for reasonable and necessary expenses incurred by the following persons as a result of the accident in visiting the insured person during his or her treatment or recovery:

1. The spouse, children, grandchildren, parents, grandparents, brothers and sisters of the insured person.
2. An individual who was living with the insured person at the time of the accident.
3. An individual who has demonstrated a settled intention to treat the insured person as a child of the individual's family.
4. An individual whom the insured person has demonstrated a settled intention to treat as a child of the insured person's family. O. Reg. 403/96, s. 21 (1); O. Reg. 114/00, s. 2; O. Reg. 314/05, s. 2.

(2) No payment is required under this section for expenses incurred more than 104 weeks after the accident. O. Reg. 403/96, s. 21 (2).

(3) Subsection (2) does not apply if the insured person sustained a catastrophic impairment as a result of the accident. O. Reg. 403/96, s. 21 (3).

HOUSEKEEPING AND HOME MAINTENANCE

22. (1) The insurer shall pay for reasonable and necessary additional expenses incurred by or on behalf of an insured person as a result of an accident for housekeeping and home maintenance services if, as a result of the accident, the insured person sustains an impairment that results in a substantial inability to perform the housekeeping and home maintenance services that he or she normally performed before the accident. O. Reg. 403/96, s. 22 (1).

(2) The amount payable under this section shall not exceed $100 per week. O. Reg. 403/96, s. 22 (2).

(3) No payment is required under this section for expenses incurred more than 104 weeks after the onset of the disability. O. Reg. 403/96, s. 22 (3).

(4) Subsection (3) does not apply if the insured person sustained a catastrophic impairment as a result of the accident. O. Reg. 403/96, s. 22 (4).

DAMAGE TO CLOTHING, GLASSES, HEARING AIDS, ETC.

23. The insurer shall pay for all reasonable expenses incurred by or on behalf of an insured person in repairing or replacing,

(a) clothing worn by the insured person at the time of an accident that was lost or damaged as a result of the accident; or

(b) prescription eyewear, dentures, hearing aids, prostheses and other medical or dental devices that were lost or damaged as a result of an accident. O. Reg. 403/96, s. 23.

COST OF EXAMINATIONS

24. (1) The insurer shall pay the following expenses incurred by or on behalf of an insured person:

1. Reasonable fees charged by a health practitioner for preparing a disability certificate required under section 20, 35 or 37.
2. Fees charged in accordance with a *Pre-approved Framework Guideline* by a health practitioner for preparing a treatment confirmation form for the purposes of section 37.1.
3. Fees charged in accordance with a *Pre-approved Framework Guideline* by a member of a health profession for conducting an assessment or examination and preparing a report for the purposes of section 37.1.
4. Reasonable fees charged by a health practitioner for reviewing a treatment plan under section 38, and for approving it if appropriate.
5. Reasonable fees charged by a member of a health profession or a social worker for preparing an application under section 38.2 for approval of an assessment or examination.
6. Reasonable fees charged by a member of a health profession for preparing an assessment of attendant care needs under section 39.
7. Reasonable fees charged by a health practitioner for preparing an application under section 40 for a determination of whether the insured person has sustained a catastrophic impairment.
8. Fees charged for a designated assessment of the insured person.

9. Subject to subsection 24.1 (2), reasonable fees charged by a member of a health profession for consulting with a person who is conducting or has conducted an examination of the insured person under section 42, if the conditions set out in subsection 24.1 (1) are satisfied.

10. Reasonable fees and expenses in accordance with section 42.1 that are charged for an assessment or examination of the insured person and the preparation of a report of the assessment or examination.

11. Reasonable fees, other than fees referred to in any of paragraphs 1 to 10, that are charged by a member of a health profession or a social worker for conducting an assessment or examination and preparing a report if the assessment or examination is reasonably required in connection with a benefit that is claimed or in connection with the preparation of a treatment plan, disability certificate, assessment of attendant care needs or application for the determination of a catastrophic impairment, and,

    i. the assessment or examination relates to ancillary goods or services described in section 37.2 and is contemplated by a treatment confirmation form submitted in accordance with section 37.1,

    ii. the insured person applied for approval of the assessment or examination either in a treatment plan submitted under section 38 or by way of a separate application submitted under section 38.2, or

    iii. the insurer approved the expense or the approval of the insurer is not required by reason of subsection (1.2). O. Reg. 546/05, s. 3 (1).

(1.1) Despite subsection (1), an insurer is not required to pay for an assessment or examination referred to in subparagraph 11 ii of subsection (1) if the expense for the assessment or examination is incurred,

(a) before the insurer approves the expense;

(b) before the insurer receives the report of an examination under section 42, if the insurer requires the insured person to be examined under that section; or

(c) before the insurer receives the report of a designated assessment, in the case of an application for approval of an assessment or examination under section 38.2, if the insured person is required to undergo a designated assessment. O. Reg. 546/05, s. 3 (1).

(1.2) Despite subsection (1.1), the prior approval of an insurer is not required for the following:

1. An assessment or examination for the purposes of preparing a treatment plan under section 38 in circumstances in which an immediate risk of harm to the insured person or a person in the insured person's care makes obtaining the prior approval of the insurer impractical.

2. Not more than three assessments or examinations for the purposes of preparing a treatment plan under section 38 if not more than one assessment or examination is done by the same person and the cost of each assessment or examination does not exceed $200.

3. An assessment or examination for the purposes of preparing a disability certificate under section 20, 35 or 37 if the cost of the assessment or examination does not exceed $200.

4. REVOKED: O. Reg. 546/05, s. 3 (2).

5. An assessment or examination for the purposes of preparing an assessment of attendant care needs under section 39, but not an assessment or examination relating to an impairment that comes within a *Pre-approved Framework Guideline* unless the *Guideline* expressly states that the prior approval of the insurer is not required for the assessment or examination.

6. An assessment or examination for the purposes of determining if an insured person has a catastrophic impairment, if the insured person is hospitalized or is in a long-term care facility at the time of the assessment or examination.

7. An assessment or examination conducted after the insurer notifies the insured person that, before the assessment or examination is conducted, the insurer does not require the submission of a treatment plan under section 38 or an application for approval of an assessment or examination under section 38.2.

8. REVOKED: O. Reg. 546/05, s. 3 (3).

O. Reg. 281/03, s. 7 (1); O. Reg. 546/05, s. 3 (2, 3).

(1.3)-(1.5) REVOKED: O. Reg. 546/05, s. 3 (4).

(1.6) Subject to subsection (4), the insurer shall pay reasonable expenses incurred by or on behalf of an insured person for transportation expenses incurred in transporting the insured person to and from an assessment or examination referred to in subsection (1), including transportation expenses for an aide or an attendant. O. Reg. 281/03, s. 7 (1).

(2) The insurer is not liable under subsection (1) for expenses related to professional services rendered to an insured person that exceed the maximum rate or amount of expenses established under the *Guidelines* applicable to the claim. O. Reg. 281/03, s. 7 (1).

(2.1) If the *Guidelines* applicable to the claim establish a range of rates or amounts for expenses related to professional services rendered to an insured person,

(a) the highest rate or amount in the range shall be deemed, for the purpose of subsection (2), to be the maximum rate or amount established under the *Guidelines* applicable to the claim; and

(b) an insurer that is liable to pay expenses related to the services rendered to the insured person shall not pay less than the lowest amount or rate in the range, unless the insured person's claim is for less than the lowest amount or rate in the range. O. Reg. 281/03, s. 7 (1).

(3) Subject to subsection (4), the insurer is not liable under subsection (1.6) to pay for expenses related to transportation unless the expenses are authorized by, and are calculated by applying the rates set out in, the *Transportation Expense Guidelines* published in *The Ontario Gazette* by the Ontario Insurance Commission or Financial Services Commission of Ontario, as they may be amended from time to time. O. Reg. 403/96, s. 24 (3); O. Reg. 303/98, s. 4 (2); O. Reg. 281/03, s. 7 (2).

(4) The insurer is not liable under subsection (1.6) to pay for expenses related to,

(a) the first 50 kilometres of transportation in the insured person's automobile to and from an examination or assessment if the examination or assessment relates to an accident that occurred before April 15, 2004; or

(b) the first 50 kilometres of transportation to and from an examination or assessment if the examination or assessment relates to an accident that occurred after April 14, 2004, unless the insured person sustained a catastrophic impairment as a result of the accident. O. Reg. 458/03, s. 8.

(5) Vocational assessments referred to in clause 15 (5) (f) are not assessments for the purposes of this section. O. Reg. 281/03, s. 7 (4).

24.1 (1) The following conditions must be satisfied for the purposes of paragraph 9 of subsection 24 (1):

1. The consulting fees must be charged by one of the following persons:
   i. the health practitioner who prepared the disability certificate, if the examination relates to a claim in respect of which a disability certificate is required under this Regulation,
   ii. the health practitioner who approved the treatment plan, if the examination relates to a claim for medical or rehabilitation benefits,
   iii. the member of the health profession who prepared the assessment of attendant care needs, if the examination relates to an application under section 39, or
   iv. the health practitioner who prepared the application, if the examination relates to an application under section 40 to assist the insurer determine whether the insured person has sustained a catastrophic impairment.
2. The consultation must be arranged by mutual agreement of the person who is conducting or has conducted the examination under section 42 and the health practitioner or member of the health profession involved in the consultation.
3. The fees must be reasonable and, subject to subsection (2), shall not exceed the amount ordinarily charged for a 30 minute professional consultation by telephone. O. Reg. 546/05, s. 4.

(2) If under a *Guideline* a maximum rate or amount for expenses is established that applies to the claim with respect to which the examination under section 42 and consultation relate and the payment of the fees for the consultation would result in the expenses exceeding this maximum rate or amount, only the portion of the fees for the consultation that would not result in the expenses for the claim exceeding the maximum rate or amount shall be paid. O. Reg. 546/05, s. 4.

PART VII
DEATH AND FUNERAL BENEFITS

DEATH BENEFIT

25. (1) The insurer shall pay a death benefit in respect of an insured person if he or she dies as result of an accident,

(a) within 180 days after the accident; or

(b) within 156 weeks after the accident, if during that period the insured person was continuously disabled as a result of the accident. O. Reg. 403/96, s. 25 (1).

(2) The death benefit shall provide for the following payments:

1. A payment to the insured person's spouse of,
   i. $25,000, or
   ii. if the optional death and funeral benefit referred to in section 27 has been purchased and is applicable to the insured person, the amount fixed by the optional benefit.

2. A payment to each of the insured person's dependants, and to each person to whom the insured person had an obligation at the time of the accident to provide support under a domestic contract or court order, of,

   i. $10,000, or

   ii. if the optional death and funeral benefit referred to in section 27 has been purchased and is applicable to the insured person, the amount fixed by the optional benefit.

3. If no payment is required by paragraph 1, an additional payment to the insured person's dependants and the persons, other than a former spouse of the insured person, to whom the insured person had an obligation at the time of the accident to provide support under a domestic contract or court order, to be divided equally among the persons entitled, in an amount equal to $25,000 if the accident occurred before October 1, 2003 or, if the accident occurred on or after October 1, 2003,

   i. $25,000, or

   ii. if the optional death and funeral benefit referred to in section 27 has been purchased and is applicable to the insured person, the amount fixed by the optional benefit.

4. A payment of $10,000 to each former spouse of the insured person to whom the insured person was obligated at the time of the accident to provide support under a domestic contract or court order.

5. A payment of $10,000 to,

   i. a person in respect of whom the insured person was a dependant at the time of the accident,

   ii. the spouse of a person in respect of whom the insured person was a dependant at the time of the accident, if the spouse was the insured person's primary caregiver at the time of the accident and the person in respect of whom the insured person was a dependant at the time of the accident dies before the insured person or within 30 days after the insured person, or

   iii. the dependants of a person in respect of whom the insured person was a dependant at the time of the accident, if no payment is required by subparagraph i or ii, to be divided equally among the persons entitled. O. Reg. 403/96, s. 25 (2); O. Reg. 114/00, s. 3 (1); O. Reg. 281/03, s. 8 (1); O. Reg. 314/05, s. 3 (1-3).

(3) No payment shall be made under this section to a person who dies before the insured person or within 30 days after the insured person. O. Reg. 403/96, s. 25 (3).

(4) If at the time of the accident the insured person had more than one spouse who is entitled to a payment under this section, the payment shall be divided equally among them. O. Reg. 403/96, s. 25 (4); O. Reg. 114/00, s. 3 (2); O. Reg. 314/05, s. 3 (4).

(4.1) If at the time of the accident the insured person was a dependant in respect of more than one person who is entitled to a payment under this section, the payment shall be divided equally among the persons in respect of whom the insured person was a dependant. O. Reg. 281/03, s. 8 (2).

(5) If requested by the insurer, a person who conducts an autopsy of the insured person shall provide a copy of his or her report to the insurer. O. Reg. 403/96, s. 25 (5).

(6) In this section,

"spouse" means a person who was, at the time of the accident,

(a) a spouse, or

(b) if the accident occurred before the definition of "same-sex partner" in Part VI of the Act was repealed, a same-sex partner within the meaning of that Part as it read on January 1, 2004. O. Reg. 314/05, s. 3 (5).

FUNERAL BENEFIT

26. (1) The insurer shall pay a funeral benefit in respect of an insured person who dies as a result of an accident. O. Reg. 403/96, s. 26 (1).

(2) The funeral benefit shall pay for funeral expenses incurred in an amount not exceeding,

(a) $6,000; or

(b) if the optional death and funeral benefit referred to in section 27 has been purchased and is applicable to the insured person, the amount fixed by the optional benefit. O. Reg. 403/96, s. 26 (2).

PART VIII
OPTIONAL BENEFITS

DESCRIPTION OF OPTIONAL BENEFITS

27. (1) Every insurer shall offer the following optional benefits:

1. An optional income replacement benefit that fixes the amount referred to in subparagraph ii of paragraph 2 of subsection 7 (1) at $600, $800 or $1,000, as selected by the named insured under the policy, for the purpose of determining the weekly amount of an income replacement benefit.
2. An optional caregiver and dependant care benefit that,
    i. fixes the maximum payment for expenses incurred in caring for a person in need of care at $325 per week for the first person in need of care and $75 per week for each additional person in need of care, instead of the amounts specified in subclauses 13 (3) (a) (i) and 13 (3) (b) (i), and
    ii. provides for the dependant care benefit described in section 28.
3. An optional medical, rehabilitation and attendant care benefit that provides for the following maximum limits on medical, rehabilitation and attendant care benefits, instead of the limits specified in subsections 19 (1) and (2), and that provides for no limitation on the period of time for which expenses shall be paid for medical, rehabilitation and attendant care benefits:
    i. The sum of the medical and rehabilitation benefits paid in respect of an insured person shall not exceed, for any one accident,
        A. $1,100,000, or
        B. $2,000,000, if the insured person sustained a catastrophic impairment as a result of the accident.
    ii. The amount of the attendant care benefit paid in respect of an insured person shall not exceed, for any one accident,
        A. $2,000,000, if the insured person sustained a catastrophic impairment as a result of the accident,
        B. $1,072,000 in any case in which the insured person did not sustain as a result of the accident,
            1. a catastrophic impairment, or
            2. an impairment in an accident occurring after April 14, 2004 that is a Grade I or Grade II whiplash-associated disorder that comes within a *Pre-approved Framework Guideline*, or
        C. nil, if the accident occurred after April 14, 2004 and the insured person's impairment is a Grade I or Grade II whiplash-associated disorder that comes within a *Pre-approved Framework Guideline*.
    iii. Despite the limits established by subparagraphs i and ii, the overall total of the medical, rehabilitation and attendant care benefits paid in respect of an insured person for any one accident shall not exceed,
        A. $1,172,000, or
        B. $3,000,000, if the insured person sustained a catastrophic impairment as a result of the accident.
4. An optional death and funeral benefit that,
    i. fixes the amount payable under paragraph 1 of subsection 25 (2) at $50,000, instead of the amount specified in subparagraph 1 i of subsection 25 (2),
    ii. fixes the amount payable under paragraph 2 of subsection 25 (2) at $20,000, instead of the amount specified in subparagraph 2 i of subsection 25 (2),
    iii. fixes the amount payable under paragraph 3 of subsection 25 (2) at $50,000 if the accident occurred on or after October 1, 2003, instead of the amount specified in subparagraph 3 i of subsection 25 (2), and
    iv. fixes the maximum payment for funeral expenses at $8,000 instead of the amount specified in clause 26 (2) (a).
5. An optional indexation benefit, as described in section 29. O. Reg. 403/96, s. 27 (1); O. Reg. 114/00, s. 4 (1); O. Reg. 281/03, s. 9 (1); O. Reg. 458/03, s. 9 (1); O. Reg. 295/07, s. 5.

(2) The optional benefits referred to in subsection (1) are applicable only to,

(a) the named insured;

(b) the spouse of the named insured;

(c) the dependants of the named insured and of the named insured's spouse; and

(d) the persons specified in the policy as drivers of the insured automobile. O. Reg. 403/96, s. 27 (2); O. Reg. 114/00, s. 4 (2); O. Reg. 314/05, s. 4.

(3) An optional benefit may be purchased at any time before an accident in respect of which a claim is made. O. Reg. 403/96, s. 27 (3).

(3.1) If a person purchases an optional benefit referred to in subsection (1), the insurer shall issue to the person the endorsement set out in Ontario Policy Change Form 47 (OPCF 47), as approved by the Commissioner of Insurance on December 3, 1996 under section 227 of the *Insurance Act*. O. Reg. 551/96, s. 1; O. Reg. 303/98, s. 5.

(4) For the purpose of paragraph 3 of subsection (1), the medical and rehabilitation benefits paid in respect of an insured person include any amount paid in respect of the insured person under section 17. O. Reg. 403/96, s. 27 (4).

(5) The maximum monthly attendant care benefit payable in respect of an insured person shall not exceed $6,000 if the benefit is payable in respect of an accident that occurs on or after October 1, 2003. O. Reg. 458/03, s. 9 (2).

DEPENDANT CARE BENEFIT

28. (1) The dependant care benefit shall pay for reasonable and necessary additional expenses incurred by or on behalf of an insured person as a result of an accident in caring for the insured person's dependants, if the insured person meets the following qualifications:

1. The insured person sustained an impairment as a result of the accident.
2. The insured person was employed at the time of the accident.
3. The insured person is not receiving a caregiver benefit. O. Reg. 403/96, s. 28 (1).

(2) No payment is required under this section in respect of an expense incurred after the insured person dies. O. Reg. 403/96, s. 28 (2).

(3) The amount payable under this section shall not exceed $75 per week for the first dependant and $25 per week for each additional dependant. O. Reg. 403/96, s. 28 (3).

(4) The total amount payable under this section shall not exceed $150 per week. O. Reg. 403/96, s. 28 (4).

OPTIONAL INDEXATION BENEFIT

29. (1) The optional indexation benefit shall provide that the following amounts shall be subject to annual indexation in accordance with subsections (2) and (3):

1. The weekly amount of any income replacement or non-earner benefit payable under this Regulation, without regard to any reductions made under subparagraphs i and ii of paragraph 1 of subsection 7 (1).
2. The following amounts:
   i. The amounts specified in subparagraphs i and ii of paragraph 2 of subsection 7 (1).
   ii. The amounts specified in subsections 12 (2) and (3).
   iii. The amounts specified in subclauses 13 (3) (a) (i) and (ii) and 13 (3) (b) (i) and (ii).
   iv. The amounts specified in clauses 16 (5) (a) and (b).
3. If the optional medical, rehabilitation and attendant care benefit referred to in section 27 was purchased and is applicable to the insured person, the following amounts:
   i. The outstanding balance with respect to medical and rehabilitation benefits, as calculated under subsection (4).
   ii. The outstanding balance with respect to attendant care benefits, as calculated under subsection (6).
   iii. The outstanding balance with respect to medical, rehabilitation and attendant care benefits, as calculated under subsection (8).
4. If paragraph 3 does not apply, the following amounts:
   i. The outstanding balance with respect to medical and rehabilitation benefits, as calculated under subsection (10).
   ii. The outstanding balance with respect to attendant care benefits, as calculated under subsection (12). O. Reg. 403/96, s. 29 (1); O. Reg. 462/96, s. 7 (1).

(2) The indexation shall be performed on January 1 of every year following an accident to which the optional indexation benefit applies by adjusting the amount to be indexed by the percentage change in the Consumer Price Index for Canada (All Items), as published by Statistics Canada under the authority of the *Statistics Act* (Canada), for the period from September in the year immediately preceding the previous year to September of the previous year. O. Reg. 403/96, s. 29 (2).

(3) Subsection (2) is subject to the *Optional Indexation Benefit Guidelines* published in *The Ontario Gazette* by the Ontario Insurance Commission or Financial Services Commission of Ontario, as they may be amended from time to time, except that those guidelines shall not provide for an adjustment of the amount to be indexed by a percentage greater than the percentage change in the applicable Consumer Price Index. O. Reg. 403/96, s. 29 (3); O. Reg. 303/98, s. 6.

(4) For the purpose of subparagraph i of paragraph 3 of subsection (1), the outstanding balance with respect to medical and rehabilitation benefits is calculated by subtracting the total of medical and rehabilitation benefits paid by the insurer in the

year preceding January 1 of the year to which the optional indexation benefit applies from the indexation balance calculated under subsection (5). O. Reg. 403/96, s. 29 (4).

(5) The indexation balance for the purpose of subsection (4) is,

(a) in the first year the optional indexation benefit applies, the amount specified in sub-subparagraph A or B, as the case may be, of subparagraph i of paragraph 3 of subsection 27 (1);

(b) in each subsequent year, the outstanding balance for the previous year, as calculated under subsection (4) and indexed under subsection (2). O. Reg. 403/96, s. 29 (5).

(6) For the purpose of subparagraph ii of paragraph 3 of subsection (1), the outstanding balance with respect to attendant care benefits is calculated by subtracting the total of attendant care benefits paid by the insurer in the year preceding January 1 of the year to which the optional indexation benefit applies from the indexation balance calculated under subsection (7). O. Reg. 403/96, s. 29 (6).

(7) The indexation balance for the purpose of subsection (6) is,

(a) in the first year the optional indexation benefit applies, the amount specified in sub-subparagraph A or B, as the case may be, of subparagraph ii of paragraph 3 of subsection 27 (1);

(b) in each subsequent year, the outstanding balance for the previous year, as calculated under subsection (6) and indexed under subsection (2). O. Reg. 403/96, s. 29 (7).

(8) For the purpose of subparagraph iii of paragraph 3 of subsection (1), the outstanding balance with respect to medical, rehabilitation and attendant care benefits is calculated by subtracting the total of medical, rehabilitation and attendant care benefits paid by the insurer in the year preceding January 1 of the year to which the optional indexation benefit applies from the indexation balance calculated under subsection (9). O. Reg. 403/96, s. 29 (8).

(9) The indexation balance for the purpose of subsection (8) is,

(a) in the first year the optional indexation benefit applies, the amount specified in sub-subparagraph A or B, as the case may be, of subparagraph iii of paragraph 3 of subsection 27 (1);

(b) in each subsequent year, the outstanding balance for the previous year, as calculated under subsection (8) and indexed under subsection (2). O. Reg. 403/96, s. 29 (9).

(10) For the purpose of subparagraph i of paragraph 4 of subsection (1), the outstanding balance with respect to medical and rehabilitation benefits is calculated by subtracting the total of medical and rehabilitation benefits paid by the insurer in the year preceding January 1 of the year to which the optional indexation benefit applies from the indexation balance calculated under subsection (11). O. Reg. 403/96, s. 29 (10); O. Reg. 462/96, s. 7 (2).

(11) The indexation balance for the purpose of subsection (10) is,

(a) in the first year the optional indexation benefit applies, the amount specified in clause 19 (1) (a) or (b), as the case may be;

(b) in each subsequent year, the outstanding balance for the previous year, as calculated under subsection (10) and indexed under subsection (2). O. Reg. 403/96, s. 29 (11).

(12) For the purpose of subparagraph ii of paragraph 4 of subsection (1), the outstanding balance with respect to attendant care benefits is calculated by subtracting the total of attendant care benefits paid by the insurer in the year preceding January 1 of the year to which the optional indexation benefit applies from the indexation balance calculated under subsection (13). O. Reg. 403/96, s. 29 (12); O. Reg. 462/96, s. 7 (3).

(13) The indexation balance for the purpose of subsection (12) is,

(a) in the first year the optional indexation benefit applies, the amount specified in clause 19 (2) (a) or (b), as the case may be;

(b) in each subsequent year, the outstanding balance for the previous year, as calculated under subsection (12) and indexed under subsection (2). O. Reg. 403/96, s. 29 (13).

PART IX
GENERAL EXCLUSIONS

30. (1) The insurer is not required to pay an income replacement benefit, a non-earner benefit or a benefit under section 20, 21 or 22 in respect of a person who was the driver of an automobile at the time of the accident,

(a) if the driver knew or ought reasonably to have known that he or she was operating the automobile while it was not insured under a motor vehicle liability policy;

(b) if the driver was driving the automobile without a valid driver's licence;

(c) if the driver is an excluded driver under the contract of automobile insurance; or

(d) if the driver knew or ought reasonably to have known that he or she was operating the automobile without the owner's consent. O. Reg. 403/96, s. 30 (1).

(2) The insurer is not required to pay an income replacement benefit, a non-earner benefit or a benefit under section 20, 21 or 22,

(a) in respect of any person who has made, or who knows of, a material misrepresentation that induced the insurer to enter into the contract of automobile insurance or who intentionally failed to notify the insurer of a change in the risk material to the contract;

(b) in respect of an occupant of an automobile at the time of the accident who knew or ought reasonably to have known that the driver was operating the automobile without the owner's consent;

(c) in respect of a person who, at the time of the accident,

(i) was engaged in an act for which the person is convicted of a criminal offence, or

(ii) was an occupant of an automobile that was being used in connection with an act for which the person is convicted of a criminal offence; or

(d) in respect of a person who is convicted under section 254 of the *Criminal Code* (Canada) of failing to comply with a lawful demand to provide a breath sample in connection with the accident. O. Reg. 403/96, s. 30 (2); O. Reg. 281/03, s. 10 (1).

(3) Clause (2) (b) does not prevent an excluded driver or any other occupant of an automobile driven by the excluded driver from recovering accident benefits under a motor vehicle liability policy in respect of which the excluded driver or other occupant is a named insured. O. Reg. 403/96, s. 30 (3).

(4) If a person sustains an impairment as a result of an accident and,

(a) at the time of the accident, the person was engaged in, or was an occupant of an automobile that was being used in connection with, an act for which the person is charged with a criminal offence; or

(b) the person is charged under section 254 of the *Criminal Code* (Canada) with failing to comply with a lawful demand to provide a breath sample in connection with the accident,

the insurer shall hold in trust any amounts payable under an income replacement benefit, a non-earner benefit or a benefit under section 20, 21 or 22 until the charge is finally disposed of, at which time the amounts and any income on the amounts,

(c) shall be returned to the insurer, if the person is found guilty of the offence or an included offence; or

(d) shall be paid to the person entitled to the payment, if the person is not found guilty of the offence or an included offence. O. Reg. 403/96, s. 30 (4).

(5) In this section,

"criminal offence" means,

(a) operating an automobile while the ability to operate the automobile is impaired by alcohol or a drug,

(b) operating an automobile while the concentration of alcohol in the operator's blood exceeds the limit permitted by law,

(c) failing to comply with a lawful demand to provide a breath sample, or

(d) any other criminal offence, whether or not the offence is related to the operation of an automobile. O. Reg. 403/96, s. 30 (5); O. Reg. 281/03, s. 10 (2).

PART X
PROCEDURES FOR CLAIMING BENEFITS

Failure to Comply with Time Limits

31. (1) A person's failure to comply with a time limit set out in this Part does not disentitle the person to a benefit if the person has a reasonable explanation. O. Reg. 403/96, s. 31 (1).

(2) Subsection (1) does not apply to the time limits set out in section 51. O. Reg. 403/96, s. 31 (2).

Notice and Application for Benefits

32. (1) A person shall notify the insurer of his or her intention to apply for a benefit under this Regulation. O. Reg. 281/03, s. 11 (1).

(1.1) A person shall notify the insurer under subsection (1) no later than,

(a) the 30th day after the circumstances arose that gave rise to the entitlement to the benefit, or as soon as practicable after that day, if those circumstances arose as a result of an accident that occurred before October 1, 2003; or

(b) the seventh day after the circumstances arose that give rise to the entitlement to the benefit, or as soon as practicable after that day, if those circumstances arose as a result of an accident that occurred on or after October 1, 2003. O. Reg. 281/03, s. 11 (1).

(2) The insurer shall promptly provide the person with,

(a) the appropriate application forms;

(b) a written explanation of the benefits available under this Regulation;

(c) information to assist the person in applying for benefits; and

(d) information on any possible elections relating to income replacement, non-earner and caregiver benefits. O. Reg. 403/96, s. 32 (2).

(2.1) If an insurer that is subject to a Guideline referred to in subsection 68 (3.2) determines, acting reasonably that there is a likelihood that the person may, in connection with the accident, deliver one or more documents referred to in subsection 68 (3.2), the insurer shall provide the following information to the central processing agency referred to in that subsection:

1. The name, address, gender and date of birth of the person.
2. The date of the accident.
3. Particulars of the automobile insurance policy under which the person alleges he or she is entitled to a benefit or benefits, including,
   i. the name of the insurer,
   ii. the policy number, and
   iii. the name of the person to whom the policy was issued.
4. The claim number assigned by the insurer.
5. Any other information reasonably required by the central processing agency to enable it to carry out its obligations to the insurer under this Regulation. O. Reg. 533/06, s. 3.

(2.2) An insurer's obligation to provide the information referred to in subsection (2.1) may be discharged by,

(a) providing the information to the central processing agency; or

(b) confirming, correcting or supplementing the information previously provided to the central processing agency. O. Reg. 533/06, s. 3.

(3) The person shall submit a signed application for the benefit to the insurer within 30 days after receiving the application forms. O. Reg. 403/96, s. 32 (3); O. Reg. 533/06, s. 4 (1).

(3.1) If an insurer receives an incomplete application for a benefit under this Regulation, the insurer shall notify the person within 10 business days after receiving the incomplete application that the application is incomplete and shall indicate what is missing. O. Reg. 281/03, s. 11 (2); O. Reg. 546/05, s. 5 (1); O. Reg. 533/06, s. 4 (2).

(3.2) Subsection (3.1) applies only if,

(a) the insurer, after a reasonable review of the incomplete application, is unable to determine without the missing information if a benefit is payable; or

(b) the application has not been signed by the person. O. Reg. 533/06, s. 4 (3).

(4) If a person is required by an insurer to submit an additional application in respect of a benefit that the person is receiving or may be eligible to receive, the person shall submit the additional application to the insurer within 30 days after receiving the additional application forms from the insurer. O. Reg. 403/96, s. 32 (4).

(5) If subsection (3.1) applies in respect of an incomplete application, no benefit is payable before the person provides the missing information or signs the application, as the case may be. O. Reg. 281/03, s. 11 (2); O. Reg. 533/06, s. 4 (4).

(6) Despite any shorter time limit in this Regulation, if a person fails without a reasonable explanation to notify an insurer under subsection (1) within the time required under subsection (1.1), the insurer may delay determining if the person is entitled to a benefit under section 35, 38, 39 or 41 and may delay paying the benefit until the later of,

(a) 45 days after the day the insurer receives the person's application; or

(b) 10 business days after the day the person complies with any request made by the insurer under subsection 33 (1) or (1.1). O. Reg. 546/05, s. 5 (2).

PRE-CLAIM EXAMINATION

32.1 (1) This section applies if,

(a) as a result of an accident, an insured person was admitted to a hospital or long-term care facility and is still in the hospital or facility or was discharged within the previous three days;

(b) the insured person may be entitled to medical benefits for an assistive device referred to in clause 14 (2) (f), rehabilitation benefits under clause 15 (5) (i) or attendant care benefits under section 16; and

(c) no application has yet been made for a benefit to which the insured person may be entitled as a result of the accident. O. Reg. 546/05, s. 6.

(2) At the insured person's request or with his or her consent, the insurer may arrange for the insured person to be examined at the insurer's expense for the purposes of assisting the insurer in determining if the insured person is entitled to receive a benefit described in clause (1) (b) that would assist the insured person after his or her discharge from the hospital or long-term care facility. O. Reg. 546/05, s. 6.

(3) An examination under this section shall be conducted by one or more members of one or more health professions who are chosen by the insurer. O. Reg. 546/05, s. 6.

(4) The insurer shall notify the insured person of the name of the person or persons who will conduct the examination and the day, time and place for the examination. O. Reg. 546/05, s. 6.

(5) The insurer shall, before the examination, obtain the written and signed consent of the insured person for the examination. O. Reg. 546/05, s. 6.

(6) The person or persons who conducted the examination shall, within five business days after conducting the examination, prepare a written report and, if applicable, an assessment of attendant care needs and provide a copy to,

(a) the insurer;

(b) the insured person; and

(c) if the insured person has a health practitioner, that health practitioner. O. Reg. 546/05, s. 6.

(7) An examination under this section is voluntary and any failure or refusal of an insured person to consent to an examination under this section does not affect any rights the insured person may have to apply for or receive benefits as a result of the accident. O. Reg. 546/05, s. 6.

(8) The report of an examination under this section shall not be relied on by an insurer in making a determination that an insured person is not entitled to a benefit under this Regulation. O. Reg. 546/05, s. 6.

DUTY OF APPLICANT TO PROVIDE INFORMATION

33. (1) A person applying for a benefit under this Regulation shall, within 10 business days after receiving a request from the insurer, provide the insurer with the following:

1. Any information reasonably required to assist the insurer in determining the person's entitlement to a benefit.
2. A statutory declaration as to the circumstances that gave rise to the application for a benefit.
3. The number, street and municipality where the person ordinarily resides.
4. Proof of the person's identity. O. Reg. 403/96, s. 33 (1); O. Reg. 546/05, s. 7.

(1.1) If requested by the insurer, a person who applies for a benefit under this Regulation as a result of an accident shall submit to an examination under oath, but is not required to,

(a) submit to more than one examination under oath in respect of matters relating to the same accident; or

(b) submit to an examination under oath during a period when the person is incapable of being examined under oath because of his or her physical, mental or psychological condition. O. Reg. 281/03, s. 12 (1).

(1.2) A person is entitled to be represented at his or her own expense at the examination under oath by such counsel or other representative of his or her choice as the law otherwise permits. O. Reg. 281/03, s. 12 (1).

(1.3) The insurer shall make reasonable efforts to schedule the examination under oath for a time and location that are convenient for the person and shall give the person reasonable advance notice of the following:

1. The date and location of the examination.
2. That the person is entitled to be represented in the manner described in subsection (1.2).
3. The reason or reasons for the examination.
4. That the scope of the examination will be limited to matters that are relevant to the person's entitlement to benefits. O. Reg. 281/03, s. 12 (1).

(1.4) The insurer shall limit the scope of the examination under oath to matters that are relevant to the person's entitlement to benefits under this Regulation. O. Reg. 281/03, s. 12 (1).

(2) The insurer is not liable to pay a benefit in respect of any period during which the insured person failed to comply with subsection (1) or (1.1). O. Reg. 281/03, s. 12 (2).

(3) Subsection (2) does not apply in respect of a non-compliance with subsection (1.1) if,

(a) the insurer fails to comply with subsection (1.3) or (1.4); or

(b) the insurer interferes with the insured person's right to be represented as described in subsection (1.2). O. Reg. 281/03, s. 12 (2).

(4) If an insured person who failed to comply with subsection (1) or (1.1) subsequently complies with that subsection, the insurer,

(a) shall resume payment of the benefit, if a benefit was being paid; and

(b) shall pay all amounts that were withheld during the period of non-compliance, if the insured person provides a reasonable explanation for the delay in complying with the subsection. O. Reg. 281/03, s. 12 (2).

34. REVOKED: O. Reg. 546/05, s. 8.

INCOME REPLACEMENT, NON-EARNER OR CAREGIVER BENEFITS AND HOUSEKEEPING OR HOME MAINTENANCE EXPENSES

35. (1) In this section and section 37,

"specified benefit" means an income replacement benefit, non-earner benefit, caregiver benefit or a payment for housekeeping or home maintenance services under section 22. O. Reg. 546/05, s. 9.

(2) An insured person who applies for a specified benefit shall submit with the application a disability certificate completed no earlier than 10 business days before the date the application is submitted. O. Reg. 546/05, s. 9.

(3) Within 10 business days after the insurer receives the application and completed disability certificate, the insurer shall,

(a) pay the specified benefit;

(b) send a request to the insured person under subsection 33 (1) or (1.1); or

(c) notify the insured person that the insurer requires the insured person to be examined under section 42. O. Reg. 546/05, s. 9.

(4) If the insurer sends a request to the insured person under subsection 33 (1) or (1.1), the insurer shall, within 10 business days after the insured person complies with the request,

(a) pay the specified benefit; or

(b) notify the insured person that the insurer requires the insured person to be examined under section 42. O. Reg. 546/05, s. 9.

(5) Every income replacement benefit, non-earner benefit or caregiver benefit shall be paid at least once every second week, subject to any prepayment of the benefit by the insurer. O. Reg. 546/05, s. 9.

(6) An insurer may make a determination that an insured person is not entitled to a specified benefit if,

(a) the insured person failed or refused to submit the completed disability certificate required under subsection (2);

(b) the insurer has received the report of the examination under section 42, if the insurer has required the insured person to be examined under that section;

(c) the insurer is entitled under subsection (10) to refuse to pay the specified benefit; or

(d) the insured person is not entitled to the specified benefit for reasons unrelated to whether the insured person has an impairment that entitles the insured person to the specified benefit. O. Reg. 546/05, s. 9.

(7) If an insurer determines that an insured person is not entitled to receive a specified benefit by reason of clause (6) (a), (c) or (d), the insurer shall give the insured person a copy of its determination,

(a) within 10 business days after receiving the application, if the insured person is not entitled to the specified benefit by reason of clause (6) (a) or (d); or

(b) within 10 business days after the insured person failed or refused to comply with subsection 42 (10), if the insured person is not entitled to the specified benefit by reason of clause (6) (c). O. Reg. 546/05, s. 9.

(8) Within five business days after receiving the report of the examination of the insured person under section 42, the insurer shall give a copy of the report and of the insurer's determination to the insured person and to the health practitioner who completed the disability certificate submitted with the application. O. Reg. 546/05, s. 9.

(9) The insurer shall set out in its determination the specified benefits and expenses the insurer agrees to pay, the specified benefits and expenses the insurer refuses to pay and the reasons for the insurer's decision. O. Reg. 546/05, s. 9.

(10) If the insured person fails or refuses to comply with subsection 42 (10), the insurer,

(a) may make a determination that the insured person is not entitled to any specified benefit; and

(b) may refuse to pay specified benefits relating to the period after the insured person failed or refused to comply with subsection 42 (10) and before the insured person submits to the examination or provides the material required by that subsection. O. Reg. 546/05, s. 9.

(11) If the insured person subsequently complies with subsection 42 (10), the insurer shall,

(a) reconsider the application and make a new determination under this section; and

(b) pay all amounts, if any, that were withheld during the period of non-compliance, if the insurer determines that the insured person is entitled to any specified benefits and the insured person provides not later than the 10th business day after the failure or refusal to comply, or as soon as practicable after that day, a reasonable explanation for not complying with subsection 42 (10). O. Reg. 546/05, s. 9.

(12) If the insurer determines after receipt of the report under section 42 that the insured person is entitled to a specified benefit, the insurer shall pay the specified benefit within 10 business days after receiving the report. O. Reg. 546/05, s. 9.

(13) If an insured person fails to submit a completed disability certificate with his or her application for a specified benefit, no specified benefits are payable for the period after the day the insurer receives the application and before the day the insurer receives the completed disability certificate. O. Reg. 546/05, s. 9.

(14) If the insurer fails to provide a copy of the report of the examination under section 42 or its determination in respect of the claim by the 15th business day after the day the examination was completed or was required under paragraph 2 or 3 of subsection 42 (11) to be completed, the insurer shall pay all specified benefits to which the application relates for the period commencing on that day and ending on the day the insurer gives the insured person the report or determination. O. Reg. 546/05, s. 9.

ELECTION OF INCOME REPLACEMENT, NON-EARNER OR CAREGIVER BENEFIT

36. (1) Only one of the following benefits may be paid to a person in respect of a period of time:

1. An income replacement benefit.

2. A non-earner benefit.

3. A caregiver benefit. O. Reg. 403/96, s. 36 (1).

(2) If a person's application indicates that he or she may qualify for more than one of the benefits referred to in subsection (1), the insurer shall notify the person that he or she must elect within 30 days after receiving the notice which benefit he or she wishes to receive. O. Reg. 403/96, s. 36 (2).

(3) The insurer shall deliver the notice under subsection (2) within 10 business days after receiving the person's application. O. Reg. 403/96, s. 36 (3); O. Reg. 546/05, s. 10.

DETERMINATION OF CONTINUING ENTITLEMENT TO SPECIFIED BENEFITS

37. (1) If an insurer wishes to determine if an insured person is still entitled to a specified benefit, the insurer,

(a) shall request that the insured person submit within 15 business days a new disability certificate completed as of a date on or after the date of the request; and

(b) may notify the insured person that the insurer requires the insured person to be examined under section 42. O. Reg. 546/05, s. 11.

(2) An insurer shall not discontinue paying a specified benefit to an insured person unless,

(a) the insured person fails or refuses to submit a completed disability certificate as required under clause (1) (a);

(b) the insurer has received the report of the examination under section 42, if the insurer required the insured person to be examined under that section;

(c) the insurer is entitled under subsection (7) to refuse to pay the specified benefit;

(d) the insured person has resumed his or her pre-accident employment duties;

(e) the insurer is no longer required to pay the specified benefit by reason of clause 5 (2) (d) or (e), subsection 22 (3) or 33 (2) or section 55 or 56; or

(f) the insured person is not entitled to the specified benefit for a reason unrelated to whether he or she has an impairment that entitles the insured person to receive the specified benefit. O. Reg. 546/05, s. 11.

(3) If an insured person fails to submit a completed disability certificate as required under clause (1) (a), no specified benefits are payable for the period commencing the 15th business day after the day the insured person received the insurer's request and ending, if the insured person subsequently submits a completed disability certificate, the day the insurer receives the completed disability certificate. O. Reg. 546/05, s. 11.

(4) If the insurer determines that the person is not entitled to receive any specified benefit by reason of clause (2) (a), (c), (d), (e) or (f), the insurer shall give to the insured person a copy of its determination. O. Reg. 546/05, s. 11.

(5) Within five business days after receiving the report of an examination under section 42, the insurer shall give a copy of the report and the insurer's determination with respect to the specified benefit to the insured person and to the health practitioner who completed the disability certificate. O. Reg. 546/05, s. 11.

(6) The determination of the insurer shall specify,

(a) the specified benefits and expenses the insurer agrees to pay;

(b) the specified benefits and expenses the insurer refuses to pay;

(c) the reasons for the insurer's decision; and

(d) if the insurer determines that the insured person is not entitled to a specified benefit, the date that payment of the benefit will be stopped. O. Reg. 546/05, s. 11.

(7) If the insured person fails or refuses to comply with subsection 42 (10), the insurer may,

(a) make a determination that the insured person is no longer entitled to the specified benefit; and

(b) despite subsection (9), refuse to pay specified benefits relating to the period after the insured person failed or refused to comply with subsection 42 (10) and before the insured person submits to the examination or provides the material required under that subsection. O. Reg. 546/05, s. 11.

(8) If the insured person subsequently complies with subsection 42 (10), the insurer shall,

(a) reconsider the insured person's entitlement to the specified benefit and make a determination;

(b) subject to the insurer's determination, resume payment of the specified benefit; and

(c) pay all amounts, if any, that were withheld during the period of non-compliance if the insured person provides not later than the 10th business day after the failure or refusal to comply, or as soon as practicable after that day, a reasonable explanation for not complying with subsection 42 (10). O. Reg. 546/05, s. 11.

(9) If an insurer requires an insured person to be examined under section 42 and determines that the insured person is not entitled to a specified benefit, the insurer shall not stop payment of the specified benefit unless it has provided to the insured person a copy of the report of the examination and its determination under this section. O. Reg. 546/05, s. 11.

PRE-APPROVED FRAMEWORK GUIDELINES

37.1 (1) This section applies if an insured person,

(a) submits or intends to submit an application for a benefit in accordance with section 32; and

(b) claims medical or rehabilitation benefits in respect of an impairment that comes within a *Pre-approved Framework Guideline*. O. Reg. 281/03, s. 15.

(2) The insured person shall submit to the insurer, within the time specified in the *Pre-approved Framework Guideline* applicable to the impairment, a treatment confirmation form that satisfies the following requirements:

1. The treatment confirmation form shall be prepared by a health practitioner who is authorized by law to treat the impairment that is the subject of the form and who will be the health practitioner responsible for providing goods and services under the treatment confirmation form.

2. The treatment confirmation form shall contain details concerning the impairment and specify the *Pre-approved Framework Guideline* under which benefits are claimed.

3. The treatment confirmation form shall include a statement by the health practitioner who prepared the form,

   i. disclosing any conflict of interest that he or she has that relates to the goods or services to be provided under the *Pre-approved Framework Guideline*,

   ii. confirming that he or she has made reasonable inquiries to determine if any person who referred the insured person to a person who will provide goods or services under the *Pre-approved Framework Guideline* has a conflict of interest relating to the treatment, and

   iii. disclosing any conflict of interest that a person who referred the insured person to a person who will provide goods or services under the *Pre-approved Framework Guideline* has that relates to the treatment.

4. The treatment confirmation form shall be signed by the insured person, unless the insurer waives this requirement. O. Reg. 281/03, s. 15; O. Reg. 533/06, s. 5.

(3) A lawyer or other representative who acts for the insured person in respect of the application for a benefit or in respect of any civil proceeding arising from the accident shall, at the time the treatment confirmation form is submitted, give the insurer and the insured person written notice disclosing any conflict of interest that the lawyer or representative has relating to the claim for benefits. O. Reg. 281/03, s. 15.

(4) If a conflict of interest is disclosed in the treatment confirmation form or by a person under subsection (3), the insurer may refuse the application. O. Reg. 281/03, s. 15.

(5) Within five business days after receiving a treatment confirmation form, the insurer shall send a notice that complies with the following rules to the insured person and to the health practitioner, acknowledging receipt of the treatment confirmation form:

1. The notice shall state whether the policy referred to in the treatment confirmation form was in force at the time of the accident.
2. If the insurer refuses the application by reason of a conflict of interest, the notice shall state the reason the application is refused, what the conflict of interest is and that the insured person may submit a new application.
3. If the treatment confirmation form includes a claim for ancillary goods or services referred to in section 37.2, the notice shall comply also with the requirements of that section. O. Reg. 281/03, s. 15.

(6) Despite subsection (4), the insurer shall not refuse an application because of a conflict of interest if there is no other person within 50 kilometres of the insured person's residence who is able to provide the goods or services to which the conflict of interest relates. O. Reg. 281/03, s. 15.

(7) If an insured person submits an application under section 32 and a treatment confirmation form under this section in respect of an impairment and the claim is accepted by the insurer, the insurer is liable to pay benefits of a type described in section 14 or 15 in respect of the impairment only in accordance with,

(a) the *Pre-approved Framework Guideline* to which the treatment confirmation form relates; and

(b) the requirements of section 37.2, if that section applies in respect of the claim. O. Reg. 281/03, s. 15.

(8) If the insured person has submitted an application under section 32 to the insurer, the insurer shall pay a benefit referred to in subsection (7) within 30 days after receiving an invoice for goods or services,

(a) that have been provided under the *Pre-approved Framework Guideline* to which the treatment confirmation form relates;

(b) that the insurer has agreed under section 37.2 to pay for and that have been provided; or

(c) that the insurer is required under subsection 37.2 (9) to pay for and that have been provided. O. Reg. 281/03, s. 15; O. Reg. 546/05, s. 12 (1).

(9) An insurer is not liable to pay benefits under more than one treatment confirmation form relating to the same *Pre-approved Framework Guideline*. O. Reg. 281/03, s. 15.

(10) An insured person may receive benefits under two or more *Pre-approved Framework Guidelines* if permitted under the *Guidelines*. O. Reg. 281/03, s. 15.

(11) An insured person shall submit an amended treatment confirmation form if, during the course of treatment under a *Pre-approved Framework Guideline*, he or she changes the health practitioner who is responsible for providing goods and services under the treatment confirmation form. O. Reg. 281/03, s. 15.

(12) The insurer is liable to pay for goods and services under an amended treatment confirmation form only to the extent the goods and services have not already been provided under the *Pre-approved Framework Guideline*. O. Reg. 281/03, s. 15.

(13) REVOKED: O. Reg. 546/05, s. 12 (2).

(14) If goods or services available under a *Pre-approved Framework Guideline* are not provided within the times specified in the applicable *Guideline*, any claim for medical or rehabilitation benefits to which the *Guideline* would otherwise apply shall, subject to section 37.2, be submitted in accordance with section 38. O. Reg. 281/03, s. 15.

(15) If a court or arbitrator determines in any dispute about an insured person's entitlement to medical or rehabilitation benefits or related assessments or examinations that a *Pre-approved Framework Guideline* applies to the insured person and the insured person received benefits or underwent assessments or examinations under the *Pre-approved Framework Guideline*,

(a) the benefits shall be deemed to have been reasonable and necessary for the purposes of sections 14 and 15; and

(b) the assessments and examinations shall be deemed to have been reasonably required for the purposes of section 24. O. Reg. 281/03, s. 15.

37.2 (1) In this section, ancillary goods or services, in respect of an impairment to which a *Pre-approved Framework Guideline* applies, are goods or services for which the *Guideline*,

(a) requires the insurer's approval; and

(b) permits a claim to be made in a treatment confirmation form under section 37.1. O. Reg. 281/03, s. 15.

(2) If a treatment confirmation form under section 37.1 includes a claim for ancillary goods or services, the insurer shall,

(a) include in the notice required under subsection 37.1 (5) a statement of which ancillary goods and services, if any, the insurer agrees to pay for; and

(b) notify the insured person that the insurer requires the insured person to be examined under section 42, if the insurer has not agreed to pay for all of the ancillary goods and services included in the claim. O. Reg. 546/05, s. 13.

(3) A notice referred to in clause (2) (b) must be given to the insured person within five business days after the day the insurer receives the treatment confirmation form. O. Reg. 546/05, s. 13.

(4) If the insurer fails to comply with the requirements of subsection 37.1 (5) or subsection (3) of this section within the time required under those subsections, the insurer shall pay for all ancillary goods and services delivered under the treatment confirmation form. O. Reg. 546/05, s. 13.

(5) Within five business days after receiving the report of an examination under section 42, the insurer shall give a copy of the report and the insurer's determination with respect to payment for the ancillary goods and services to the insured person and the health practitioner who prepared the treatment confirmation form. O. Reg. 546/05, s. 13.

(6) The determination of the insurer shall specify the ancillary goods and services the insurer agrees to pay for, the ancillary goods and services the insurer refuses to pay for and the reasons for the insurer's decision. O. Reg. 546/05, s. 13.

(7) If an insured person fails or refuses to comply with subsection 42 (10), the insurer may make a determination that the insured person is not entitled to payment for the ancillary goods and services to which the examination relates. O. Reg. 546/05, s. 13.

(8) If an insured person subsequently complies with subsection 42 (10), the insurer shall reconsider the insured person's claim and make a determination under this section. O. Reg. 546/05, s. 13.

(9) If the insurer fails to provide a copy of the report of the examination under section 42 or its determination in respect of the claim by the day determined in the following manner, the insurer shall pay for all ancillary goods and services provided in accordance with the treatment confirmation form:

1. If the attendance of the insured person was not required for the examination under section 42, the day is the 10th business day after the day the material required under subsection 42 (10) was provided.

2. If the attendance of the insured person was required for the examination, the day is the 15th business day after the day the examination was completed or was required under paragraph 2 or 3 of subsection 42 (11) to be completed. O. Reg. 546/05, s. 13.

37.3 (1) This section applies to a claim for medical or rehabilitation benefits under section 37.1 or 37.2 in respect of an impairment that is asserted by the insurer to come within a *Pre-approved Framework Guideline* if the insurer gives the insured person a notice informing the insured person that the insurer will pay for the goods and services described in the *Pre-approved Framework Guideline* without the submission of a treatment confirmation form under either of those sections. O. Reg. 533/06, s. 6.

(2) If an insurer gives notice under subsection (1), the notice shall satisfy the following criteria:

1. The notice must specify which *Pre-approved Framework Guideline* the insurer asserts to be applicable to the claimant's impairment and confirm that the insurer will pay for goods and services under section 37.1 in accordance with the *Pre-approved Framework Guideline* without the submission of a treatment confirmation form under that section.

2. The notice must describe the expenses for ancillary goods or services, if any, as referred to in section 37.2, that the insurer will pay without the submission of a treatment confirmation form and shall specify,

   i. the types of expenses,

   ii. any restrictions on the amount of the expenses, and

   iii. any restrictions on when the expenses may be incurred.

3. The notice must disclose any conflict of interest that the insurer has relating to any person who will provide goods or services to whom the insured person is referred by the insurer. O. Reg. 533/06, s. 6.

(3) If an insurer gives notice under subsection (1),

(a) the insurer shall, if the insured person has submitted an application under section 32 to the insurer, pay the expenses described in the notice within 30 days after receiving an invoice for them; and

(b) if there is a dispute about whether, for the purpose of subsection 14 (2) or 15 (5), an expense described in the notice is reasonable or necessary, the insurer shall pay the expense pending resolution of the dispute in accordance with sections 279 to 283 of the Act. O. Reg. 533/06, s. 6.

(4) An insured person who receives a notice under subsection (1) may, despite the notice, submit a treatment confirmation form in accordance with section 37.1 or a treatment plan in accordance with section 38, in which case this section shall not apply. O. Reg. 533/06, s. 6.

38. (1) Subject to subsection (2.1), this section applies to,

(a) any claim for medical or rehabilitation benefits other than,

(i) a claim payable under section 37.1, and

(ii) a claim for ancillary goods and services referred to in section 37.2; and

(b) applications for assessments or examinations that are submitted with a treatment plan under subsection (2). O. Reg. 281/03, s. 16 (1); O. Reg. 546/05, s. 14 (1).

(1.1) An insurer is not liable to pay any expense in respect of medical benefits or rehabilitation benefits that was incurred before the insured person submits an application for the benefit that satisfies the requirements of subsection (2) unless the expense is for an ambulance or other goods or services provided on an emergency basis not more than five business days after the accident to which the application relates. O. Reg. 546/05, s. 14 (2).

(2) An application under this section must be signed by the insured person, unless the insurer waives that requirement, and must include, unless section 38.1 applies,

(a) a treatment plan that complies with subsection (3), prepared by a member of a health profession or by a social worker; and

(b) a statement by a health practitioner approving the treatment plan referred to in clause (a) and stating that he or she is of the opinion,

(i) that the expenses contemplated by the treatment plan are reasonable and necessary for the insured person's treatment or rehabilitation, and

(ii) that the impairment sustained by the insured person does not come within a *Pre-approved Framework Guideline*. O. Reg. 281/03, s. 16 (2); O. Reg. 546/05, s. 14 (3).

(2.1) An insurer may refuse to accept a treatment plan under this section that provides for goods or services to be received in respect of any period during which the insured person is entitled to receive goods or services under a *Pre-approved Framework Guideline*, unless the *Guideline* allows the insured person to receive both, and the insurer's refusal is final and not subject to review. O. Reg. 281/03, s. 16 (2).

(2.2) Nothing in subsection (2.1) prevents an insured person, while receiving goods or services under a *Pre-approved Framework Guideline*, from submitting a treatment plan applicable to a period other than the period referred to in that subsection. O. Reg. 281/03, s. 16 (2).

(3) The treatment plan shall include a statement by the person who prepared the plan,

(a) disclosing any conflict of interest that he or she has relating to the treatment plan;

(b) indicating that he or she has made reasonable inquiries to determine whether any person who referred the insured person to a person who will provide goods or services contemplated by the treatment plan has a conflict of interest relating to the treatment plan; and

(c) disclosing any conflict of interest that a person who referred the insured person to a person who will provide goods or services contemplated by the treatment plan has relating to the treatment plan. O. Reg. 403/96, s. 38 (3); O. Reg. 546/05, s. 14 (4); O. Reg. 533/06, s. 7.

(3.1) REVOKED: O. Reg. 546/05, s. 14 (5).

(4) A lawyer or other representative who acts for the insured person in respect of the application or in respect of any civil proceeding arising from the accident shall, at the time the application is submitted, give the insurer and the insured person written notice disclosing any conflict of interest that the lawyer or other representative has relating to the treatment plan. O. Reg. 403/96, s. 38 (4).

(5) If a conflict of interest is disclosed under subsection (3) or (4), the insurer may, within 10 business days after receiving the application, give the insured person notice that the application is refused and that the insured person may submit a new application. O. Reg. 403/96, s. 38 (5); O. Reg. 546/05, s. 14 (6).

(6) Subsection (5) does not apply if there is no other person within 50 kilometres of the insured person's residence who is able to provide the goods or services from which the conflict of interest arises. O. Reg. 403/96, s. 38 (6).

(7) On receiving the application, the insurer shall promptly determine whether the insurer is required to pay for the goods and services contemplated by the treatment plan. O. Reg. 403/96, s. 38 (7).

(8) If no notice is given under subsection (5), the insurer shall give the insured person one of the following notices:

1. A notice,

i. that discloses any conflict of interest the insurer has relating to the treatment plan,

ii. that describes the goods and services, if any, contemplated by the treatment plan that the insurer agrees to pay for, and

iii. that advises the insured person, if the insurer has not agreed to pay for all goods and services contemplated by the treatment plan, that the insurer requires the insured person to be examined under section 42 relating to the goods and services the insurer has not agreed to pay for.

2. A notice advising the insured person that the insurer,

i. believes that the insured person may have an impairment to which a *Pre-approved Framework Guideline* applies, and

ii. requires the insured person to be examined under section 42 to assist the insurer in determining if the insured person has an impairment to which a *Pre-approved Framework Guideline* applies. O. Reg. 281/03, s. 16 (4); O. Reg. 546/05, s. 14 (7).

(8.1) A notice under subsection (8) must be given,

(a) within 10 business days after the insurer receives the application, in the case of a notice described in paragraph 1 of subsection (8); or

(b) within five business days after the insurer receives the application, in the case of a notice described in paragraph 2 of subsection (8). O. Reg. 281/03, s. 16 (4); O. Reg. 546/05, s. 14 (8).

(8.2) If the insurer fails to give a notice under subsection (8) in accordance with subsection (8.1), the following rules apply:

1. In the case of a notice under paragraph 2 of subsection (8),

i. the insurer shall not take the position that the insured person has an impairment to which a *Pre-approved Framework Guideline* applies, and

ii. the insurer shall give a notice described in paragraph 1 of subsection (8) in accordance with subsection (8.1).

2. In the case of a notice under paragraph 1 of subsection (8), the insurer shall pay for all goods and services provided under the treatment plan that relate to the period starting on the 11th business day after the day the insurer received the application and ending on the day the insurer gives the notice described in paragraph 1 of subsection (8). O. Reg. 281/03, s. 16 (4); O. Reg. 546/05, s. 14 (9, 10).

(9) If the insurer discloses a conflict of interest relating to the treatment plan, the insured person may, within 10 business days after receiving the notice under paragraph 1 of subsection (8), withdraw the application and submit a new application. O. Reg. 403/96, s. 38 (9); O. Reg. 281/03, s. 16 (5); O. Reg. 546/05, s. 14 (11).

(10) Subsection (9) does not apply if there is no other person within 50 kilometres of the insured person's residence who is able to provide the goods or services from which the conflict of interest arises. O. Reg. 403/96, s. 38 (10).

(11) If the application is not withdrawn under subsection (9), the insurer shall pay for goods and services the insurer agreed to pay for in the notice under paragraph 1 of subsection (8) within 30 days after receiving an invoice for them. O. Reg. 281/03, s. 16 (6).

(12), (12.1) REVOKED: O. Reg. 546/05, s. 14 (12).

(12.2) If an insurer gives a notice described in paragraph 2 of subsection (8), the insured person may submit a treatment confirmation form under section 37.1 and, pending the insurer's determination, may receive goods and services in accordance with the *Pre-approved Framework Guideline* and such ancillary goods and services as the insurer believes to be appropriate for the insured person's impairment. O. Reg. 546/05, s. 14 (13).

(12.3) REVOKED: O. Reg. 546/05, s. 14 (13).

(13) Within five business days after receiving the report of an examination under section 42, the insurer shall give a copy of the report and the insurer's determination to the insured person and to the health practitioner who approved the treatment plan. O. Reg. 546/05, s. 14 (13).

(14) The determination of the insurer shall specify,

(a) the goods and services contemplated by the treatment plan that the insurer agrees to pay for, the goods and services the insurer refuses to pay for and the reasons for the insurer's decision, in the case where the insurer gave a notice referred to in paragraph 1 of subsection (8); or

(b) whether the insurer has determined that the insured person has an impairment to which a *Pre-approved Framework Guideline* applies and the reasons for the insurer's decision, in the case where the insurer gave a notice referred to in paragraph 2 of subsection (8). O. Reg. 546/05, s. 14 (13).

(15) If an insured person fails or refuses to comply with subsection 42 (10), the insurer may make a determination that the insured person is not entitled to the goods and services contemplated by the treatment plan. O. Reg. 546/05, s. 14 (13).

(16) If an insured person subsequently complies with subsection 42 (10), the insurer shall reconsider the insured person's claim and make a determination under this section. O. Reg. 546/05, s. 14 (13).

(17) If the insurer fails to provide a copy of the report of the examination under section 42 or its determination in respect of the claim by the day determined under subsection (17.1),

(a) the insurer shall pay for all goods and services provided in accordance with the treatment plan during the period commencing on that day and ending on the day the insurer gives the insured person the report or determination; and

(b) the insurer shall not take the position that the insured person has an impairment to which a *Pre-approved Framework Guideline* applies. O. Reg. 546/05, s. 14 (13).

(17.1) For the purposes of subsection (17), the day is determined as follows:

1. If the attendance of the insured person was not required for the examination under section 42, the day is the 10th business day after the day the material required under subsection 42 (10) was provided.
2. If the attendance of the insured person was required for the examination, the day is the 15th business day after the day the examination was completed or was required under paragraph 2 or 3 of subsection 42 (11) to be completed. O. Reg. 546/05, s. 14 (13).

(17.2) An insurer shall pay an expense in respect of medical or rehabilitation benefits that it has agreed to pay or that it is required under this section to pay within 30 days after receiving an invoice for the expense. O. Reg. 546/05, s. 14 (13).

(18) REVOKED: O. Reg. 546/05, s. 14 (13).

(19) If, after giving notice under subparagraph 1 i of subsection (8), it comes to the attention of the insurer that a person described in subsection (3) or (4) has a conflict of interest relating to the treatment plan, the insurer may give the insured person notice requiring the insured person, within 10 business days after receiving the notice, to amend the treatment plan to remove the conflict of interest. O. Reg. 403/96, s. 38 (19); O. Reg. 281/03, s. 16 (12); O. Reg. 546/05, s. 14 (14).

(20) If the insured person does not comply with a notice under subsection (19), the insurer is not required to pay for any further expenses for goods or services from which the conflict of interest arises. O. Reg. 403/96, s. 38 (20).

(21) Subsection (20) does not apply if there is no other person within 50 kilometres of the insured person's residence who is able to provide the goods or services from which the conflict of interest arises. O. Reg. 403/96, s. 38 (21).

(22)-(25) REVOKED: O. Reg. 281/03, s. 16 (13).

38.1 (1) This section applies to a claim for a medical or rehabilitation benefit under section 38 if the insurer gives the insured person a notice informing the insured person that the insurer will pay the expenses without the submission of a treatment plan under that section. O. Reg. 281/03, s. 17.

(2) If the insurer gives the insured person a notice under subsection (1),

(a) the notice shall describe the expenses that the insurer will pay without the submission of a treatment plan and shall specify,

(i) the types of expenses,

(ii) any restrictions on the amount of the expenses, and

(iii) any restrictions on when the expenses may be incurred;

(b) the insurer shall pay expenses described in the notice within 30 days after receiving an invoice for them; and

(c) if there is a dispute about whether, for the purpose of subsection 14 (2) or 15 (5), an expense described in the notice is reasonable or necessary, the insurer shall pay the expense pending resolution of the dispute in accordance with sections 279 to 283 of the Act. O. Reg. 281/03, s. 17.

(3) The insurer shall give the insured person a notice disclosing any conflict of interest that the insurer has relating to any person who will provide goods or services to whom the insured person is referred by the insurer. O. Reg. 281/03, s. 17; O. Reg. 533/06, s. 8 (1).

(4) Every member of a health profession and social worker who refers an insured person to another person to obtain goods or services in respect of which a medical or rehabilitation benefits will be paid by an insurer under this section shall give the insurer and the insured person written notice disclosing any conflict of interest the member of the health profession or social worker has relating to the provision of the goods or services. O. Reg. 546/05, s. 15; O. Reg. 533/06, s. 8 (2).

(5) If a conflict of interest is disclosed under subsection (4), the insurer may give the insured person a notice requiring the insured person to submit a treatment plan to the insurer under section 38 and, if a notice is given under this subsection,

(a) the insurer is relieved of any obligation under this section to pay expenses other than expenses incurred before the notice was given;

(b) subsections (1) to (4) do not apply; and

(c) the insured person may submit an application and treatment plan under section 38. O. Reg. 281/03, s. 17.

APPLICATION FOR APPROVAL OF AN ASSESSMENT OR EXAMINATION

38.2 (1) This section applies to an application prepared by a member of a health profession or social worker for approval of an assessment or examination of an insured person if the application is not submitted as part of a treatment plan under section 38. O. Reg. 546/05, s. 16 (1).

(2) The application shall include a statement by the member of a health profession or social worker who is to conduct the assessment or examination,

(a) disclosing any conflict of interest that he or she has relating to the assessment or examination to which the application relates;

(b) indicating that he or she has made reasonable inquiries to determine whether any person who referred the insured person to him or her has a conflict of interest relating to the assessment or examination and, if there is a conflict of interest, disclosing the conflict of interest that the person has; and

(c) stating that the assessment or examination is reasonably required in relation to a benefit. O. Reg. 281/03, s. 17; O. Reg. 546/05, s. 16 (2); O. Reg. 533/06, s. 9.

(3) A lawyer or other representative who acts for the insured person in respect of the application or with respect to any civil proceeding arising from the accident shall, at the time the application is submitted, give the insurer and the insured person written notice disclosing any conflict of interest that the lawyer or other representative has relating to the application. O. Reg. 281/03, s. 17.

(4) If a conflict of interest is disclosed under subsection (2) or (3), the insurer may refuse the application and, within two business days after receiving the application, give the insured person notice that the application is refused and that the insured person may submit a new application. O. Reg. 281/03, s. 17.

(5) Despite subsection (4), the insurer shall not refuse the application because of a conflict of interest if there is no other person within 50 kilometres of the insured person's residence who is able to conduct the assessment or examination. O. Reg. 281/03, s. 17.

(6) If the insurer has not refused the application under subsection (4), the insurer shall give the insured person and the person who prepared the application a notice,

(a) within two business days after receiving the application if the application is received before March 1, 2006 and the amount to be charged is $180 or less;

(b) within five business days after receiving the application if the application is received before March 1, 2006 and the amount to be charged exceeds $180; or

(c) within three business days after receiving the application, if the application is received on or after March 1, 2006. O. Reg. 546/05, s. 16 (3).

(7) The notice under subsection (6) must,

(a) state which assessments or examinations in the application the insurer agrees to pay for;

(b) advise the insured person that the insurer requires the insured person to be examined under section 42, if the insurer has not agreed to pay for all assessments or examinations to which the application relates; and

(c) disclose any conflict of interest that the insurer has relating to any assessment or examination to which the application relates. O. Reg. 546/05, s. 16 (3).

(8) A notice required under subsection (6) may be given verbally if, as soon as practicable afterwards, written confirmation of the notice is given to every person who received verbal notice. O. Reg. 546/05, s. 16 (3).

(9) If the insurer does not refuse the application under subsection (4) but fails to give the notice as required under subsection (6), the insurer shall pay for all assessments and examinations to which the application relates. O. Reg. 281/03, s. 17.

(10) If, in a notice under subsection (6), the insurer discloses a conflict of interest relating to an assessment or examination, the insured person may withdraw the application and submit a new application within two business days after receiving the notice from the insurer. O. Reg. 281/03, s. 17.

(11) Despite subsection (10), the insured person shall not withdraw the application or submit a new application if there is no other person within 50 kilometres of the insured person's residence who is able to conduct the assessment or examination. O. Reg. 281/03, s. 17.

(12) If the application is not withdrawn under subsection (10), the insurer shall pay for all assessments and examinations it agreed to pay for in the notice under subsection (6) and shall make each payment within 30 days after receiving an invoice for the cost of the assessment or examination. O. Reg. 281/03, s. 17.

(13) Within five business days after receiving the report of an examination under section 42, the insurer shall give a copy of the report and the insurer's determination with respect to the application to the insured person and the person who prepared the application. O. Reg. 546/05, s. 16 (4).

(13.1) The determination of the insurer shall specify the assessments or examinations the insurer agrees to pay for, the assessments or examinations the insurer refuses to pay for and the reasons for the insurer's decision. O. Reg. 546/05, s. 16 (4).

(13.2) If an insured person fails or refuses to comply with subsection 42 (10), the insurer may make a determination that the insured person is not entitled to the expenses to which the examination relates. O. Reg. 546/05, s. 16 (4).

(13.3) If an insured person subsequently complies with subsection 42 (10), the insurer shall reconsider the application and make a determination under this section. O. Reg. 546/05, s. 16 (4).

(13.4) If the insurer fails to provide a copy of the report of the examination under section 42 or its determination in respect of the application by the day determined in the following manner, the insurer shall pay for all assessments and examinations to which the application relates:

1. If the attendance of the insured person was not required for the examination under section 42, the day is the 10th business day after the day the material required under subsection 42 (10) was provided.
2. If the attendance of the insured person was required for the examination, the day is the 15th business day after the day the examination was completed or was required under paragraph 2 or 3 of subsection 42 (11) to be completed. O. Reg. 546/05, s. 16 (4).

(13.5) An insurer shall pay for all assessments and examinations that it has agreed to pay for or that it is required under this section to pay for within 30 days after receiving an invoice for the cost of the assessment or examination. O. Reg. 546/05, s. 16 (4).

(14) If, after giving a notice under subsection (6) in which the insurer agrees to pay for an assessment or examination, it comes to the insurer's attention that a person described in subsection (2) or (3) has a conflict of interest relating to the assessment or examination, the insurer may give the insured person notice requiring the insured person, within five business days after receiving the notice, to amend the application so that no conflict of interest will arise. O. Reg. 281/03, s. 17.

(15) If the insured person does not amend the application as required under subsection (14), the insurer is not required to pay for the assessment or examination referred to in that subsection. O. Reg. 281/03, s. 17.

(16) Subsection (14) does not apply if there is no other person within 50 kilometres of the insured person's residence who is able to conduct the assessment or examination to which the conflict of interest relates. O. Reg. 281/03, s. 17.

CONFLICT OF INTEREST

38.3 (1) For the purposes of sections 37.1, 37.3, 38, 38.1 and 38.2,

(a) a person has a conflict of interest relating to the provision of goods or services if,

(i) the person or a related person may receive a financial benefit, directly or indirectly, as a result of the provision, by the related person or another person, of the goods or services, and

(ii) the person who may receive the financial benefit is not the employee of the person who will provide the goods or services and does not have a contract with the person who will provide the goods or services or under which goods or services of that kind are provided; and

(b) an insurer has a conflict of interest relating to the provision of goods or services to an insured person if,

(i) the insurer may receive a financial benefit, directly or indirectly, as a result of the provisions of the goods or services, or

(ii) the goods or services will be provided by a person pursuant to a subsisting arrangement with the insurer under which goods or services referred to in this Regulation are or will be provided at the insurer's expense. O. Reg. 281/03, s. 17; O. Reg. 533/06, s. 10.

(2) A related person, in respect of a person who is not a corporation, is an individual who is,

(a) the spouse of the person;

(b) connected with the person by blood relationship or adoption; or

(c) connected by blood relationship to the spouse of the person. O. Reg. 281/03, s. 17; O. Reg. 314/05, s. 5.

(3) For the purposes of subsection (2),

(a) persons are connected by blood relationship if one is the child or other descendant of the other or is the brother or sister of the other; and

(b) persons are connected by adoption if one has been adopted, either legally or in fact, as the child of the other or as a child of a person who is connected by blood relationship, otherwise than as brother or sister, to the other. O. Reg. 281/03, s. 17.

39. (1) An application for attendant care benefits for an insured person must be in the form of an assessment of attendant care needs for the insured person that is prepared and submitted to the insurer by a member of a health profession who is authorized by law to treat the person's impairment. O. Reg. 546/05, s. 17.

(2) Within 10 business days after receiving the assessment of attendant care needs, the insurer shall give the insured person a notice that,

(a) advises the insured person which, if any, expenses described in the assessment of attendant care needs the insurer agrees to pay; and

(b) advises the insured person that the insurer requires the insured person to be examined under section 42, if the insurer has not agreed to pay all expenses described in the assessment of attendant care needs. O. Reg. 546/05, s. 17.

(3) An insurer may, but is not required to, pay an expense incurred before an assessment of attendant needs that complies with subsection (1) is submitted to the insurer. O. Reg. 546/05, s. 17.

(4) The insurer shall begin payment of attendant care benefits within 10 business days after receiving the assessment of attendant care needs and, pending receipt by the insurer of the report of any examination under section 42 required by the insurer, shall calculate the amount of the benefits based on the assessment of attendant care needs. O. Reg. 546/05, s. 17.

(5) If an insurer wants to determine if an insured person is still entitled to attendant care benefits, wants to determine if the benefits are being paid in the appropriate amount or wants to determine both, the insurer shall give the person a notice requesting that a new assessment of attendant care needs for the insured person that complies with subsection (1) be submitted to the insurer within 10 business days after the insured person receives the notice. O. Reg. 546/05, s. 17.

(6) Subject to subsection (10), a notice under subsection (5) may also advise the insured person that the insurer requires the insured person to be examined under section 42. O. Reg. 546/05, s. 17.

(7) Subject to subsection (10), new assessments of attendant care needs may be submitted to an insurer at any time there are changes that would affect the amount of the benefits. O. Reg. 546/05, s. 17.

(8) If a new assessment of attendant care needs indicates that it is appropriate to increase the amount of the attendant care benefits and the insurer has not already advised the insured person that the insurer requires the insured person to be examined under section 42, the insurer may give a notice to the insured person advising that the insurer requires the insured person to be examined under section 42. O. Reg. 546/05, s. 17.

(9) If a new assessment of attendant care needs is required under subsection (5) or the insurer requires an examination under section 42, the insurer shall, subject to section 18, continue to pay the insured person attendant care benefits at the same rate until the insurer receives the assessment of attendant care needs or the report of the examination, as applicable. O. Reg. 546/05, s. 17.

(10) If more than 104 weeks have elapsed since the accident, the insurer shall not require the insured person to be examined under section 42 to determine the insured person's entitlement to attendant care benefits and the insured person shall not submit nor be required to submit an assessment of attendant care needs to the insurer unless,

(a) the insured person is or may be entitled under section 18 to receive attendant care benefits more than 104 weeks after the accident; and

(b) at least 52 weeks have elapsed since the last examination under section 42. O. Reg. 546/05, s. 17.

(11) Within five business days after receiving the report of an examination under section 42, the insurer shall give a copy of the report and the insurer's determination with respect to the benefit to the insured person and to the member of the health profession who prepared the assessment of attendant care needs. O. Reg. 546/05, s. 17.

(12) The insurer's determination shall specify the benefits and expenses the insurer agrees to pay, the benefits and expenses the insurer refuses to pay and the reasons for the insurer's decision. O. Reg. 546/05, s. 17.

(13) If an insured person fails or refuses to comply with subsection 42 (10), the insurer may,

(a) make a determination that the insured person is not entitled to attendant care benefits; and

(b) refuse to pay attendant care benefits relating to the period after the person failed or refused to comply with subsection 42 (10) and before the insured person submits to the examination and provides the material required by subsection 42 (10). O. Reg. 546/05, s. 17.

(14) If an insured person subsequently complies with subsection 42 (10), the insurer shall,

(a) reconsider the application and make a determination under this section;

(b) subject to the new determination, resume payment of attendant care benefits; and

(c) pay all amounts, if any, that were withheld during the period of non-compliance, if the insured person provides not later than the 10th business day after the failure or refusal to comply, or as soon as practicable after that day, a reasonable explanation for not complying with subsection 42 (10). O. Reg. 546/05, s. 17.

(15) If an insurer determines that an insured person is not entitled, by reason of section 18, to attendant care benefits for expenses incurred more than 104 weeks after the accident, the insurer shall give the insured person a notice of its determination, with reasons, not less than 10 business days before the last payment of attendant care benefits. O. Reg. 546/05, s. 17.

(16) An assessment of attendant care needs under this section in respect of accidents occurring on or after March 31, 2008 shall be in the form of and contain the information required in the "Assessment of Attendant Care Needs" dated March 1, 2008 and available on the website for the Financial Services Commission of Ontario. O. Reg. 63/08, s. 1.

(16.1) REVOKED: O. Reg. 63/08, s. 1.

(17) An assessment of attendant care needs under this section in respect of accidents occurring on or after February 1, 2007 but before March 31, 2008 shall be in the form of and contain the information required in the "Assessment of Attendant Care Needs" dated December 31, 2006 and available on the website for the Financial Services Commission of Ontario. O. Reg. 63/08, s. 1.

(18) An assessment of attendant care needs under this section in respect of accidents occurring on or after March 1, 2006 but before February 1, 2007 shall be in the form of and contain the information required in the "Assessment of Attendant Care Needs" dated December 31, 2005, as it read on March 1, 2006 and available on the website for the Financial Services Commission of Ontario. O. Reg. 63/08, s. 1.

(19) An assessment of attendant care needs under this section in respect of accidents occurring before March 1, 2006 shall be in Form 1, as it read on February 28, 2006 and available on the website for the Financial Services Commission of Ontario. O. Reg. 63/08, s. 1.

DETERMINATION OF CATASTROPHIC IMPAIRMENT

40. (1) An insured person who sustains an impairment as a result of an accident may apply to the insurer for a determination of whether the impairment is a catastrophic impairment. O. Reg. 403/96, s. 40 (1).

(2) Within 30 days after receiving an application under subsection (1), the insurer shall give the insured person,

(a) a notice stating that the insurer has determined that the impairment is a catastrophic impairment; or

(b) a notice advising the insured person that the insurer requires the insured person to be examined under section 42 to assist the insurer in determining if the impairment is a catastrophic impairment. O. Reg. 546/05, s. 18.

(3) If an application is made under this section not more than 104 weeks after the accident and, immediately before the application was made, the insured person was receiving attendant care benefits,

(a) the insurer shall continue to pay attendant care benefits to the insured person during the period before the insurer makes a determination under this section; and

(b) the amount of the attendant care benefits for the period referred to in clause (a) shall be determined on the assumption that the insured person's impairment is a catastrophic impairment. O. Reg. 546/05, s. 18.

(3.1) REVOKED: O. Reg. 546/05, s. 18.

(4) Within five business days after receiving the report of an examination under section 42, the insurer shall give a copy of the report and the insurer's determination of whether the insured person's impairment is a catastrophic impairment to the insured person and to the health practitioner who prepared the application under this section. O. Reg. 546/05, s. 18.

(5) The determination of the insurer shall specify the reasons for the insurer's determination of whether the insured person's impairment is a catastrophic impairment. O. Reg. 546/05, s. 18.

(6) If an insured person fails or refuses to comply with subsection 42 (10), the insurer,

(a) may make a determination that the insured person does not have a catastrophic impairment;

(b) may stop payment of any benefits that are payable only if the insured person has a catastrophic impairment; and

(c) may, in respect of the period after the insured person failed or refused to comply with subsection 42 (10) and before the insured person submits to the examination and provides the material required by subsection 42 (10), refuse to pay a benefit or expense that is payable only if the person has a catastrophic impairment. O. Reg. 546/05, s. 18.

(7) If an insured person subsequently complies with subsection 42 (10), the insurer shall,

(a) reconsider the application and make a determination under this section;

(b) subject to the determination, resume payment of benefits, if benefits were being paid before the examination; and

(c) pay all amounts, if any, that were withheld during the period of non-compliance, if the insurer determines that the insured person sustained a catastrophic impairment and the insured person provides not later than the 10th business day after the failure or refusal to comply, or as soon as practicable after that day, a reasonable explanation for not complying with subsection 42 (10). O. Reg. 546/05, s. 18.

(8) If the insurer fails to provide a copy of the report of the examination under section 42 or its determination in respect of the application by the day determined in the following manner, the insurer shall, for the period commencing on that day and ending on the day the insurer gives the insured person the report or determination, pay all amounts in respect of benefits and goods and services to which the insured person would be entitled if he or she had sustained a catastrophic impairment:

1. If the attendance of the insured person was not required for the examination under section 42, the day is the 15th business day after the day the material required under subsection 42 (10) was provided.
2. If the attendance of the insured person was required for the examination, the day is the 15th business day after the day the examination was completed or was required under paragraph 2 or 3 of subsection 42 (11) to be completed. O. Reg. 546/05, s. 18.

OTHER BENEFITS

41. (1) If a person is entitled to a death benefit, a funeral benefit or a benefit under Part VI, the insurer shall pay the benefit within 30 days after the insurer receives the application for the benefit. O. Reg. 403/96, s. 41 (1).

(2) If the insurer refuses to pay a benefit referred to in subsection (1), the insurer shall give the person notice of the reasons for the refusal within 30 days after the insurer receives the application for the benefit. O. Reg. 403/96, s. 41 (2).

(3) In the case of a benefit described in section 22, subsections (1) and (2) are subject to sections 35 and 37. O. Reg. 546/05, s. 19.

TRANSITIONAL RULES — MARCH 1, 2006

41.1 (1) Subject to subsection (2), sections 34, 35 and 37, as they read on February 28, 2006, continue to apply in respect of a claim by a person for income replacement, non-earner or caregiver benefits if, under subsection 37 (1), as it read on February 28, 2006, the insurer gave or was required to give the person, before March 1, 2006, a notice with respect to the claim. O. Reg. 546/05, s. 20.

(2) If, after February 28, 2006, an insurer wishes to determine if a person continues to be entitled to receive income replacement, non-earner or caregiver benefits, section 37, as it reads after February 28, 2006 applies. O. Reg. 546/05, s. 20.

(3) Subsections 37.2 (2) to (5), as they read on February 28, 2006, continue to apply in respect of a claim by an insured person for ancillary goods or services if, under subsection 37.1 (5) as it read on February 28, 2006, the insurer gave or was required to give the insured person, before March 1, 2006, a notice under section 37.1 as it read on February 28, 2006, stating that the insurer requires the insured person to be assessed by a designated assessment centre in respect of ancillary goods or services for which the insurer will not pay. O. Reg. 546/05, s. 20.

(4) Section 38, as it read on February 28, 2006, continues to apply in respect of a claim for medical and rehabilitation benefits by an insured person if, under subsection 38 (8.1) as it read on February 28, 2006, the insurer gave or was required to give the insured person, before March 1, 2006, a notice referred to in subclause 38 (12) (b) (ii) or (12.1) (b) (ii), as it read on February 28, 2006. O. Reg. 546/05, s. 20.

(5) If, before March 1, 2006, an insured person has submitted an application under subsection 38 (3.1), as it read on February 28, 2006, subsection 38 (18) as it read on that day continues to apply in respect of the application. O. Reg. 546/05, s. 20.

(6) Subsections 38.2 (8) and (13), as they read on February 28, 2006, and subsections 38.2 (9) to (12) and (14) to (16) apply in respect of an application for approval for an assessment or examination if, under subsection 38.2 (6), as it read on February 28, 2006, the insurer gave or was required to give the insured person, before March 1, 2006, a notice under subsection 38.2 (6), as it read on February 28, 2006, requiring the insured person to be assessed by a designated assessment centre. O. Reg. 546/05, s. 20.

(7) Section 39, as it read on February 28, 2006, continues to apply to an application for attendant care benefits by an insured person if, under subsection 39 (4), as it read on February 28, 2006, the insurer gave or was required to give the insured person, before March 1, 2006, a notice under subsection 39 (4), as it read on February 28, 2006, requiring the insured person to be assessed by a designated assessment centre. O. Reg. 546/05, s. 20.

(8) Section 39, as it read on February 28, 2006, continues to apply to an application for an increase in attendant care benefits if, under subsection 39 (7) or (8), as it read on February 28, 2006, an insurer gave or was required to give the insured person, before March 1, 2006, a notice requiring the insured person to be assessed by a designated assessment centre. O. Reg. 546/05, s. 20.

(9) Section 40, as it read on February 28, 2006, continues to apply to an application for a determination of whether an insured person has a catastrophic impairment if, under subsection 40 (2), as it read on February 28, 2006, the insurer gave or was required to give the insured person, before March 1, 2006, a notice under subsection 40 (2), as it read on February 28, 2006, requiring the insured person to be assessed by a designated assessment centre. O. Reg. 546/05, s. 20.

(10) Despite subsections (1) to (9), if a designated assessment of an insured person cannot be conducted or completed on or after March 1, 2006 because there is no designated assessment centre that satisfies the requirements of section 53, the insurer may give the insured person notice under subsection 42 (4), as it reads after February 28, 2006, requiring the insured person to be examined under section 42 in respect of the claim or application, instead of being assessed by a designated

assessment centre, and the provisions of this Regulation, as they read after February 28, 2006, apply in respect of the disposition of the claim or application after the notice is given. O. Reg. 546/05, s. 20.

EXAMINATION REQUIRED BY INSURER

42. (1) For the purposes of assisting an insurer determine if an insured person is or continues to be entitled to a benefit under this Regulation for which an application is made, an insurer may, as often as is reasonably necessary, require an insured person to be examined under this section by one or more persons chosen by the insurer who are members of a health profession or are social workers or who have expertise in vocational rehabilitation. O. Reg. 546/05, s. 21.

(2) Subsection (1) does not apply with respect to,

(a) a benefit to which section 37.1 applies, other than an amount claimed for ancillary goods or services referred to in section 37.2; or

(b) a funeral benefit or death benefit. O. Reg. 546/05, s. 21.

(3) Subject to subsection (7), each of the following examinations under this section shall be limited to an examination of material provided under subsection (10) in respect of the insured person without requiring the attendance of the insured person:

1. An examination for the purposes of section 37.2 to assist the insurer in determining whether to pay for ancillary goods or services claimed by the insured person.
2. An examination after an application is made under section 38 to assist the insurer in determining if the insured person has an impairment to which a *Pre-approved Framework Guideline* applies.
3. An examination for the purposes of section 38 to assist the insurer in determining whether to pay for goods or services contemplated by a treatment plan if the goods and services are substantially similar to goods or services the insurer previously refused to pay for when they were included in a previous treatment plan submitted to the insurer on behalf of the insured person in respect of the same accident.
4. An examination for the purposes of section 38.2 relating to an application for approval of an assessment or examination.
5. An examination for the purposes of section 40 that relates only to the issue of whether the insured person has a brain impairment that results in a score of 9 or less on the Glasgow Coma Scale referred to in subclause 2 (1.2) (e) (i). O. Reg. 546/05, s. 21.

(4) Whenever the insurer requires an insured person to be examined under this section, the insurer shall arrange for the examination at its expense and shall give the insured person a notice setting out,

(a) the reasons for the examination;

(b) the type of examination that will be conducted and whether the attendance of the insured person is required during the examination;

(c) the name of the person or persons who will conduct the examination, the regulated health professions to which they belong and their titles and designations indicating their specialization, if any, in their professions; and

(d) if the attendance of the insured person is required at the examination, the day, time and location of the examination and, if the examination will require more than one day, the same information for the subsequent days. O. Reg. 546/05, s. 21.

(5) If the insurer has already notified the insured person under this Regulation that the insurer requires the insured person to be examined under this section, the insurer shall give the notice required under subsection (4),

(a) not more than two business days after the previous notice was given, if the attendance of the insured person is not required at the examination, unless the examination is for the purposes of assisting the insurer determine if the insured person has a catastrophic impairment; or

(b) not more than five business days after the previous notice was given and, unless the insured person and the insurer mutually agree otherwise, not less than five business days before the examination, if the attendance of the insured person is required at the examination or if the examination is for the purposes of assisting the insurer determine if the insured person has a catastrophic impairment. O. Reg. 546/05, s. 21.

(6) If the insurer is not authorized under another section of this Regulation to give the insured person notice that the insurer requires the insured person to be examined under this section, the insurer shall give the insured person the notice required under subsection (4) not less than five business days before the examination, unless the insured person and insurer mutually agree otherwise. O. Reg. 546/05, s. 21.

(7) If a notice under subsection (4) indicates that the attendance of the insured person is not required for the examination and it is subsequently determined by the person conducting the examination that the insured person should be in attendance and personally examined, the insurer shall give a notice to the insured person within two business days after the day the notice described in subsection (4) is given and at least five business days before the examination,

(a) notifying the insured person of the change in the type of examination;

(b) requiring the attendance of the insured person at the examination; and

(c) setting out the day, time and location of the examination and, if the examination will require more than one day, setting out the same information for the subsequent days. O. Reg. 546/05, s. 21.

(8) A notice under subsection (4) or (7) may be verbal if a written confirmation is given as soon as practicable afterwards. O. Reg. 546/05, s. 21.

(9) The following applies if the attendance of the insured person is required at an examination:

1. The insurer shall make reasonable efforts to schedule the examination for a day and time that are convenient for the insured person.
2. Subject to paragraph 3, the examination must be conducted, unless the insured person otherwise consents, at a location that is not more than,
   i. 30 kilometres from the insured person's residence, if the residence is in the City of Toronto or in The Regional Municipality of Durham, The Regional Municipality of Halton, The Regional Municipality of Peel or The Regional Municipality of York, or
   ii. 50 kilometres from the insured person's residence, if the residence is not in a municipality described in subparagraph i.
3. If, after taking reasonable steps, the insurer is unable to arrange for a qualified person to conduct the examination at a location within the distance required under subparagraph 2 i or ii, as applicable, the insurer may arrange for the examination to be conducted by a qualified person at a location that is reasonable in the circumstances. O. Reg. 546/05, s. 21.

(10) For the purposes of the examination,

(a) the insured person and the insurer shall, within five business days after the day the notice of the examination under subsection (4) or (7) is received by the insured person, provide to the person or persons conducting the examination all reasonably available information and documents that are relevant or necessary for the review of the insured person's medical condition; and

(b) if the attendance of the insured person is required at the examination, the insured person shall attend the examination and submit to all reasonable physical, psychological, mental and functional examinations requested by the person or persons conducting the examination. O. Reg. 546/05, s. 21.

(11) Subject to subsection (12), if the insured person complies with subsection (10), the person or persons conducting the examination shall complete the examination, prepare a report of their findings and provide a copy of the report to the insurer in accordance with the following:

1. If the attendance of the insured person was not required for the examination, the examination must be completed and a copy of the report provided to the insurer,
   i. not more than 10 business days after the day the notice of the examination under subsection (4) was given to the insured person, if the examination relates to whether the insured person has a catastrophic impairment, or
   ii. not more than five business days after the day the notice of the examination under subsection (4) was given to the insured person, in any other case.
2. If the attendance of the insured person was required at the examination and the examination relates to whether the insured person has sustained a catastrophic impairment or, if the insured person has sustained a catastrophic impairment, relates to whether the insured person is entitled to medical benefits, rehabilitation benefits, specified benefits under section 35 or attendant care benefits,
   i. the examination must be completed not more than 30 business days after the day the notice relating to the examination was given under subsection (4) or, if a notice was given under subsection (7), 30 business days after the day that notice was given, and
   ii. a copy of the report of the examination must be given to the insurer not later than 10 business days after the day the examination was completed.
3. If the attendance of the insured person was required at the examination and paragraph 2 does not apply,
   i. the examination must be completed not more than 10 business days after the day the notice relating to the examination was given under subsection (4) or, if a notice was given under subsection (7), 10 business days after the day that notice was given, and
   ii. a copy of the report of the examination must be given to the insurer not later than 10 business days after the day the examination was completed. O. Reg. 546/05, s. 21.

(12) If an insured person who failed or refused to comply with subsection (10) subsequently complies, the following rules apply:

1. If the attendance of the insured person was not required for the examination, the examination must be completed and a copy of the report provided to the insurer,
   i. not more than 10 business days after the day the material required under subsection (10) was provided, if the examination relates to whether the insured person has a catastrophic impairment, or
   ii. not more than five business days after the day the material required under subsection (10) was provided in any other case.
2. If the attendance of the insured person was required for the examination, a copy of the report of the examination must be given to the insurer not later than 10 business days after the day the examination was completed. O. Reg. 546/05, s. 21.

(13) If the examination relates to a claim for attendant care benefits, the report of the examination must include an assessment of attendant care needs. O. Reg. 546/05, s. 21.

ASSESSMENT OR EXAMINATION AFTER DENIAL OF BENEFITS

42.1 (1) In this section,

"original provider" means, in respect of an insured person, the member of a health profession who, in accordance with this Regulation, approved the treatment plan, prepared the assessment of attendant care needs, completed the disability certificate or prepared the application under section 40, as applicable, that was submitted to the insurer with respect to the insured person. O. Reg. 546/05, s. 21.

(2) This section applies in respect of an insured person if the following conditions are satisfied:

1. An examination of the insured person was conducted under section 42 and the insurer gave to the insured person a copy of the report of the examination and the insurer's determination.
2. The insurer's determination is,
   i. that the insured person is not entitled to benefits, if the examination related to a claim for benefits, or
   ii. that the insured person does not have a catastrophic impairment, if the examination related to an application under section 40.
3. The examination under section 42 was not related to,
   i. a claim for ancillary goods or services referred to in section 37.2, or
   ii. an application under section 38.2 for approval for an assessment or examination.
4. The examination under section 42 was not for the purposes of assisting the insurer determine if the insured person has an impairment to which a *Pre-approved Framework Guideline* applies.
5. If the examination under section 42 related to a claim for a specified benefit under section 35, no assessment or examination relating to that benefit has been conducted previously under this section.
6. If the examination under section 42 related to a claim for an attendant care benefits under section 39, no assessment or examination relating to that benefit has been conducted under this section within the previous 12 months.
7. The examination under section 42 was not an examination to which subsection 42 (6) applied. O. Reg. 546/05, s. 21.

(3) The insurer shall pay fees in accordance with this section for an assessment or examination of the insured person and for the preparation of a report of the assessment or examination if the following conditions are satisfied:

1. The assessment or examination and the report of the assessment or examination are limited to the portions of the report of the examination under section 42 with which the insured person does not agree and that are relevant to the denial of the claim or application.
2. The assessment or examination is conducted by one or more members of a health profession who are authorized under this section to conduct the assessment or examination.
3. If the insured person has sustained a catastrophic impairment or the examination under section 42 relates to whether the insured person has sustained a catastrophic impairment, the assessment or examination under this section is conducted and the report provided to the insurer not more than 80 business days after the day the insurer gave the insured person notice of its determination.
4. If the insured person has not sustained a catastrophic impairment and the examination under section 42 does not relate to whether the insured person has sustained a catastrophic impairment, the assessment or examination is conducted and the report is provided to the insurer not more than 40 business days after the day the insurer gave the insured person notice of its determination. O. Reg. 546/05, s. 21.

(4) Subject to paragraph 2 of subsection (3) and subsections (5) and (6), an assessment or examination under this section must be conducted by the original provider or, if the insured person had more than one original provider, the original provider designated by the insured person. O. Reg. 546/05, s. 21.

(5) The assessment or examination under this section may be conducted by any person who is a member of any health profession if,

(a) the original provider is not a member of the same health profession as the person who conducted the examination under section 42; or

(b) the original provider is a member of the same health profession as the person who conducted the examination under section 42, but is not legally authorized to practise in the same specialty. O. Reg. 546/05, s. 21.

(6) If members of two or more health professions conducted the examination under section 42, the assessment or examination under this section may be conducted by one or more persons other than the original provider. O. Reg. 546/05, s. 21.

(7) The assessment or examination under this section shall be limited to an examination of the material provided under subsection 42 (10) to the person who conducted the examination under section 42 if,

(a) the examination under section 42 was conducted by a person who,

(i) is a member of the same health profession as the original provider, and

(ii) is legally authorized to practise in the same specialty as the original provider, if the original provider is legally authorized to practise in a specialty;

(b) the examination under section 42 was limited to an examination of the material provided under subsection 42 (10) to the person who conducted that examination; or

(c) the assessment or examination relates to a claim for medical benefits or rehabilitation benefits and an assessment or examination of the insured person with respect to the same accident has been conducted under this section within the previous 12 months. O. Reg. 546/05, s. 21.

(8) If the insured person does not have a catastrophic impairment and the assessment or examination under this section does not relate to whether the insured person has a catastrophic impairment, the total amount payable for an assessment or examination under this section, for the preparation of the report of the assessment or examination and for any related expenses permitted under section 24 shall not exceed the amount determined as follows:

1. If the assessment or examination is limited to, or required by this section to be limited to, an examination of the material provided under subsection 42 (10), the maximum amount payable is $450.

2. If the assessment or examination is not limited to nor required by this section to be limited to an examination of the material provided under subsection 42 (10), the maximum amount payable is,

i. $900 if the assessment or examination is conducted by one or more members of a health profession and at least one of them is a physician who is legally authorized to practise in a medical specialty other than family medicine, or

ii. $775 if the assessment or examination is conducted by one or more members of a health profession and none of them are physicians described in subparagraph i. O. Reg. 546/05, s. 21.

(9) Amounts payable under this section shall be paid by the insurer within 30 days after receipt of an invoice for the amounts. O. Reg. 546/05, s. 21.

(10) An assessment or examination under this section shall be used only for the purposes of assisting in the resolution of a dispute in accordance with sections 280 to 283 of the Act and the insurer is not required as a result of receiving the report of the assessment or examination to allow any application or pay any benefit that it otherwise would not have allowed or paid. O. Reg. 546/05, s. 21.

DESIGNATED ASSESSMENTS

43. (1) The following rules apply if a designated assessment is required under this Regulation:

1. The insurer shall notify the designated assessment centre within five business days.

2. The insured person and the insurer shall provide the person or persons who will conduct the designated assessment with such information as is reasonably necessary, within the same period of five business days referred to in paragraph 1.

3. The designated assessment centre shall promptly notify the insured person and arrange for the designated assessment.

4. The insured person shall submit to all reasonable physical, psychological, mental and functional examinations requested by the person or persons who conduct the designated assessment. O. Reg. 281/03, s. 21.

(2) The following rules apply if an insured person does not submit to a designated assessment arranged under subsection (1) or fails to comply with paragraph 2 or 4 of subsection (1):

1. The insurer may stop payment of the benefit related to the designated assessment until the insured person submits to the designated assessment and complies with paragraphs 2 and 4 of subsection (1).
2. No benefit is payable for the period after the insured person fails to submit to the designated assessment or fails to comply with paragraph 2 or 4 of subsection (1) and before the insured person subsequently submits to an examination under subsection (1) and complies with paragraphs 2 and 4 of subsection (1). O. Reg. 281/03, s. 21.

(3) If an insured person subsequently submits to a designated assessment and is in compliance with paragraphs 2 and 4 of subsection (1), the insurer,

(a) shall resume payment of the benefit; and

(b) shall pay all amounts that were withheld during the period of non-compliance, if the insured person provides a reasonable explanation for not submitting to the designated assessment or not complying with paragraph 2 or 4 of subsection (1), as the case may be. O. Reg. 281/03, s. 21.

(4) After conducting the designated assessment, the person or persons who conducted the designated assessment shall prepare a report and provide a copy of the report to,

(a) the insurer;

(b) the insured person; and

(c) the insured person's health practitioner. O. Reg. 281/03, s. 21.

(5) Subject to subsection (11), the designated assessment centre shall deliver the report within 14 days after the completion of the designated assessment. O. Reg. 281/03, s. 21.

(6) If the designated assessment is required under section 37 in respect of a claim for an income replacement, non-earner or caregiver benefit, the report of the designated assessment shall include a statement as to whether the insured person continues to have a disability that entitles the insured person to continue to receive the benefit. O. Reg. 281/03, s. 21.

(7) If the designated assessment is required under section 37.2, the report of the designated assessment shall state whether the ancillary goods and services claimed in the treatment confirmation form are reasonable and necessary. O. Reg. 281/03, s. 21.

(8) If the designated assessment is required under section 38, the report of the designated assessment shall,

(a) state whether the goods or services to be provided under the treatment plan are reasonable and necessary and shall include recommendations relating to the future provision of goods and services to the insured person for his or her treatment and rehabilitation, if the purpose of the designated assessment is to determine if the goods and services are reasonable and necessary; and

(b) state whether the impairment comes within a *Pre-approved Framework Guideline*, if the purpose of the designated assessment is to determine if the insured person has an impairment to which a *Pre-approved Framework Guideline* applies. O. Reg. 281/03, s. 21.

(9) In the case of a designated assessment described in clause (8) (b), the report of the designated assessment centre shall also state whether the goods or services to be provided under the treatment plan are reasonable and necessary and shall include recommendations relating to the future provision of goods and services to the insured person for his or her treatment and rehabilitation, if the report states that the impairment does not come within a *Pre-approved Framework Guideline*. O. Reg. 281/03, s. 21.

(10) If the designated assessment is required under section 38.2, the report of the designated assessment shall state whether an expense in respect of an assessment or examination is payable under section 24. O. Reg. 281/03, s. 21.

(11) Despite subsection 53 (9), if the designated assessment is conducted to determine whether there are medical or rehabilitation benefits payable otherwise than under a *Pre-approved Framework Guideline* or the designated assessment is required under section 38.2, the designated assessment centre shall deliver its report to the insured person and the insurer within five business days after the later of,

(a) the day it receives the information required to be provided under paragraph 2 of subsection (1); or

(b) the day any conflict of interest disclosed by the designated assessment centre under section 53 in respect of the designated assessment is resolved under that section. O. Reg. 281/03, s. 21.

(12) If an insurer fails to give a notice required under subsection (1) in accordance with that subsection, the insurer shall pay for the goods and services that are the subject of the designated assessment and that relate to the period commencing on the day the insurer was required to give the notice and ending on the day the insurer gives the notice. O. Reg. 281/03, s. 21.

(13) If the designated assessment is required under section 39 in respect of a claim for an attendant care benefit, the report shall include,

(a) an assessment of attendant care needs; and

(b) recommendations on the future provision of attendant care services to the insured person. O. Reg. 281/03, s. 21; O. Reg. 546/05, s. 22.

(14) If the designated assessment is required under section 40 to determine whether an impairment is a catastrophic impairment, the report shall include a statement of whether, in the opinion of the person or persons who conducted the designated assessment, the impairment is a catastrophic impairment. O. Reg. 281/03, s. 21.

METHOD OF PAYMENT

44. (1) An insurer shall pay a benefit under this Regulation,

(a) by mailing or delivering a cheque payable to the person entitled to the benefit to the address where the person ordinarily resides; or

(b) with the consent of the person entitled to the benefit, by electronic funds transfer to an account in the name of the person. O. Reg. 403/96, s. 44 (1).

(2) Despite subsection (1),

(a) an insurer may arrange to be invoiced directly and to pay directly for goods or services provided in respect of an insured person;

(b) an insurer may pay a benefit into court under section 271 of the *Insurance Act*; or

(c) where the person entitled to the benefit has so directed in writing, an insurer shall pay the benefit directly to the person who submitted an invoice in respect of the benefit to a central processing agency in accordance with subsection 44.1 (1). O. Reg. 403/96, s. 44 (2); O. Reg. 533/06, s. 11.

44.1 (1) Despite any other provision of this Regulation, if a benefit that would otherwise be payable by an insurer is payable in respect of an expense for goods or services specified in a Guideline issued for the purposes of this section, an insurer to whom the Guideline applies shall not pay the benefit unless an invoice for the expense, in the form approved by the Superintendent and including all of the information required by the form,

(a) is delivered to the insurer, if neither of paragraph 2 or 3 of subsection 68 (3.2) applies; or

(b) is deemed to be received by the insurer under subsection 68 (3.3) or (3.4), if paragraph 2 or 3 of subsection 68 (3.2) applies. O. Reg. 533/06, s. 12.

(2) An insurer shall not waive the submission of an invoice for goods or services to which subsection (1) applies. O. Reg. 533/06, s. 12.

(3) If a Guideline issued for the purposes of subsection 68 (3.2) specifies that invoices are to be delivered to a central processing agency on behalf of insurers to whom the Guideline applies, every such insurer that receives an invoice that complies with subsection (1) shall report the following to the central processing agency in the manner and within the time required by the Guideline:

1. The date or dates on which the goods or services referred to in the invoice were delivered or rendered.
2. The names, addresses and professional college registration numbers, if applicable, of each provider of goods or services referred to in the invoice.
3. Particulars of the goods or services referred to in the invoice.
4. Particulars of the injury or injuries in respect of which the goods or services were delivered or rendered.
5. The amount, if any, paid in respect of the goods or services referred to in the invoice by any person other than the insurer.
6. The amount paid by the insurer in respect of the invoice.
7. The amount paid by the insurer in respect of each separately described component of the invoice.
8. The date on which a decision was made on payment or other disposition of the invoice.
9. Any other disposition of the invoice.
10. The information referred to in subsection 32 (2.1).
11. Such additional information as may be specified in the Guideline, if the invoice is in respect of expenses described in a notice given by the insurer under subsection 37.3 (1) or 38.1 (1). O. Reg. 533/06, s. 12.

EXPLANATION OF BENEFIT AMOUNTS

45. When a benefit is first paid or the amount of the benefit is subsequently changed, the insurer shall provide the insured person with a written explanation of how the amount of the benefit was determined. O. Reg. 403/96, s. 45.

OVERDUE PAYMENTS

46. (1) An amount payable in respect of a benefit is overdue if the insurer fails to pay the benefit within the time required under this Part. O. Reg. 403/96, s. 46 (1).

(2) If payment of a benefit under this Regulation is overdue, the insurer shall pay interest on the overdue amount for each day the amount is overdue from the date the amount became overdue at the rate of 2 per cent per month compounded monthly. O. Reg. 403/96, s. 46 (2).

REPAYMENTS TO INSURER

47. (1) A person shall repay to the insurer,

(a) any benefit under this Regulation that is paid to the person as a result of an error on the part of the insurer, the insured person or any other person, or as a result of wilful misrepresentation or fraud;

(b) any income replacement or non-earner benefit that is paid to the person if he or she, or a person in respect of whom the payment was made, was disqualified from payment under Part IX;

(c) any income replacement, non-earner or caregiver benefit or any benefit under Part VI, to the extent of any payments received by the person that are deductible from those benefits under this Regulation;

(d) if, by reason of subsection 41.1 (1), subsection 37 (4), as it read on February 28, 2006, applies, any income replacement benefits, non-earner or caregiver benefits that is paid for the period after the insurer gave notice under subsection 37 (1), as it read on that date, and before the date of the report of the designated assessment centre; or

(e) fees paid by the insurer that are referred to in paragraph 8 of subsection 24 (1) if the insured person fails, without a reasonable explanation, to attend a designated assessment that has been arranged, or cancels a designated assessment without providing such notice as may be specified in the *Pre-assessment Cancellation Fee Schedule* established by the committee referred to in section 52, as it may be amended from time to time, that he or she will not be attending the designated assessment. O. Reg. 403/96, s. 47 (1); O. Reg. 281/03, s. 22; O. Reg. 546/05, s. 23.

(2) If a person is required to repay an amount to an insurer under this section,

(a) the insurer shall give the person notice of the amount that is required to be repaid; and

(b) if the person is receiving an income replacement or caregiver benefit, the insurer may give the person notice that the insurer intends to collect the repayment by deducting up to 20 per cent of the amount of the benefit from each payment of the benefit. O. Reg. 403/96, s. 47 (2).

(3) The obligation to repay a benefit does not apply unless the notice under subsection (2) is given within 12 months after the payment was made. O. Reg. 403/96, s. 47 (3).

(4) Subsection (3) does not apply if the benefit was paid as a result of wilful misrepresentation or fraud. O. Reg. 403/96, s. 47 (4).

(5) An insurer that has given the notice referred to in clause (2) (b) may collect the repayment by deducting up to 20 per cent of the amount of the benefit from each payment of the benefit. O. Reg. 403/96, s. 47 (5).

(6) The insurer may charge interest on an amount repayable under this section from the fifteenth day after notice is given under subsection (2) at the bank rate in effect on that day. O. Reg. 403/96, s. 47 (6).

(7) In subsection (6),

"bank rate" means the bank rate established by the Bank of Canada as the minimum rate at which the Bank of Canada makes short term advances to the banks listed in Schedule I to the *Bank Act* (Canada). O. Reg. 403/96, s. 47 (7).

TERMINATION OF BENEFITS FOR MATERIAL MISREPRESENTATION

48. (1) If an insured person has wilfully misrepresented material facts with respect to an application for a benefit, the insurer may terminate payment of the benefit. O. Reg. 403/96, s. 48 (1).

(2) The insurer shall not terminate payment under subsection (1) unless the insurer provides the insured person with notice of the reasons for terminating payment. O. Reg. 403/96, s. 48 (2).

RIGHT TO DISPUTE

49. If an insurer refuses to pay a benefit under this Regulation or reduces the amount of a benefit that a person is receiving under this Regulation, the insurer shall provide the person with a written notice concerning the person's right to dispute. O. Reg. 281/03, s. 23.

MEDIATION PROCEEDINGS

50. An insured person shall not commence a mediation proceeding under section 280 of the Act unless,

(a) the insured person notified the insurer of the circumstances giving rise to a claim for a benefit and submitted an application for the benefit within the times prescribed by this Regulation; and

(b) the insured person, if he or she was required to undergo a designated assessment under section 43, has undergone the designated assessment and has complied with that section. O. Reg. 546/05, s. 24.

TIME LIMIT FOR PROCEEDINGS

51. (1) A mediation proceeding or evaluation under section 280 or 280.1 of the *Insurance Act* or a court proceeding or arbitration under clause 281 (1) (a) or (b) of the Act in respect of a benefit under this Regulation shall be commenced within two years after the insurer's refusal to pay the amount claimed. O. Reg. 403/96, s. 51 (1).

(2) Despite subsection (1), a court proceeding or arbitration under clause 281 (1) (a) or (b) of the *Insurance Act* may be commenced within 90 days after the mediator reports to the parties under subsection 280 (8) of the Act or within 30 days after the person performing the evaluation provides a report to the parties under section 280.1 of the Act, whichever is later. O. Reg. 403/96, s. 51 (2).

PART XI
DESIGNATED ASSESSMENT CENTRES

ESTABLISHMENT OF DESIGNATED ASSESSMENT CENTRES

52. The committee appointed under section 7 of the *Insurance Act* shall,

(a) REVOKED: O. Reg. 546/05, s. 25.

(b) specify the types of impairments that each designated assessment centre is authorized to assess; and

(c) specify the types of assessments that each designated assessment centre is authorized to conduct. O. Reg. 403/96, s. 52; O. Reg. 546/05, s. 25.

52.1 The committee referred to in section 52 may suspend, revoke or modify a designation under section 52, subject to such terms and conditions as the committee specifies. O. Reg. 281/03, s. 25.

52.2 (1) When required by the committee referred to in section 52, every designated assessment centre shall provide the Superintendent with such information respecting the performance of its functions as the committee may require. O. Reg. 281/03, s. 25.

(2) Information required under subsection (1) shall be provided at such times and in such manner as the committee may determine and direct. O. Reg. 281/03, s. 25.

(3) The Superintendent shall review the information compiled under subsection (1) and may take such action in respect of the information as the Superintendent considers appropriate. O. Reg. 281/03, s. 25.

(4) If a designated assessment centre fails to comply with a request for information under subsection (1), the Superintendent may report the deficiency to the committee referred to in section 52. O. Reg. 281/03, s. 25.

DESIGNATED ASSESSMENT CENTRES

53. (1) A designated assessment shall be conducted by a designated assessment centre selected in accordance with this section. O. Reg. 313/03, s. 1 (1).

(1.1) A designated assessment must be conducted by a designated assessment centre that,

(a) is authorized to assess impairments of the type sustained by the insured person; and

(b) is authorized to conduct the type of designated assessment that is required. O. Reg. 313/03, s. 1 (1).

(1.2) A designated assessment must be conducted by a designated assessment centre that is located within,

(a) 30 kilometres of the insured person's residence, if,

(i) the insured person's residence is located in the City of Toronto or the regional municipality of Durham, Halton, Peel or York, and

(ii) a designated assessment centre that complies with subsection (1.1) is located within 30 kilometres of the insured person's residence; or

(b) 50 kilometres of the insured person's residence, if,

(i) the insured person's residence is not located in the City of Toronto or the regional municipality of Durham, Halton, Peel or York, and

(ii) a designated assessment centre that complies with subsection (1.1) is located within 50 kilometres of the insured person's residence. O. Reg. 313/03, s. 1 (1).

(1.3) Subject to subsections (1.1) and (1.2), the insurer and the insured person may jointly select the designated assessment centre if the selection is made not later than the second business day after the insurer or the insured person, as the case may be, receives notice from the other that a designated assessment is required under this Regulation. O. Reg. 313/03, s. 1 (1).

(1.4) If the insurer and the insured person do not jointly select the designated assessment centre in accordance with subsection (1.3), the Superintendent shall, subject to subsections (1.1) and (1.2), select the designated assessment centre. O. Reg. 313/03, s. 1 (1).

(2) If the designated assessment centre is selected by the Superintendent, the designated assessment centre shall, before conducting the designated assessment, give the insurer and the insured person notice disclosing any conflict of interest that the centre has relating to the designated assessment. O. Reg. 313/03, s. 1 (2).

(3) The designated assessment centre shall give any notice required under subsection (2) in respect of a designated assessment described in subsection 43 (11) within three business days after receipt of the request for the designated assessment. O. Reg. 281/03, s. 26.

(4) If a conflict of interest is disclosed under subsection (2),

(a) the designated assessment centre shall conduct the designated assessment if the insurer and the insured person agree; or

(b) if the insurer and the insured person do not agree, the designated assessment shall be conducted, subject to subsections (1.1), (1.2) and (2), by another designated assessment centre selected by the Superintendent. O. Reg. 281/03, s. 26; O. Reg. 313/03, s. 1 (3).

(5) For the purposes of clause (4) (b), the insurer and the insured person shall be deemed not to agree in the case of a designated assessment described in subsection 43 (11) unless they agree by the end of the third business day after the day the insurer receives the notice under subsection (2) or the insured person receives the notice under subsection (2), whichever day is later. O. Reg. 281/03, s. 26.

(6)-(8) REVOKED: O. Reg. 313/03, s. 1 (4).

(9) Except as otherwise required under subsection 43 (11), a designated assessment centre must begin a designated assessment within 14 days after receiving a request for the designated assessment. O. Reg. 281/03, s. 26.

(10) If a designated assessment centre is unable to begin a designated assessment within 14 days after receiving the request for the assessment, the insured person or the insurer may require that, subject to subsections (1.1), (1.2) and (2), the designated assessment be conducted by another designated assessment centre selected by the Superintendent. O. Reg. 313/03, s. 1 (5).

(10.1) The Superintendent may, with the consent of the Minister, delegate in writing to any person the Superintendent's authority to select designated assessment centres under this section. O. Reg. 313/03, s. 1 (5).

(11) For the purpose of this section, a designated assessment centre has a conflict of interest relating to a designated assessment if,

(a) the insurer, the insured person or a lawyer or other representative acting on behalf of the insurer or the insured person has a financial interest in the designated assessment centre; or

(b) the designated assessment centre, a related person, an assessor or consultant who will carry out all or part of the designated assessment or a facility owned or controlled, directly or indirectly, in whole or in part, by the centre or a related person,

(i) has provided goods or services to the person to be assessed, other than a previous designated assessment,

(ii) prepared or approved a treatment confirmation form under section 37.1, a treatment plan under section 38 or an application for approval of an assessment or examination under section 38.2 for the person to be assessed, or

(iii) is identified by a treatment confirmation form, treatment plan or an application for approval of an assessment or examination as a person who will provide goods or services to the person to be assessed. O. Reg. 281/03, s. 26.

(12) In clause (11) (b),

"related person" means, in respect of a designated assessment centre, an owner, partner or another person who has a financial interest in the designated assessment centre, but does not include a person who has a financial interest in the designated assessment centre by reason only of being a creditor who deals at arm's length with the designated assessment centre. O. Reg. 281/03, s. 26.

54. (1) A designated assessment centre that conducts an assessment under this Regulation of a person who sustains an impairment as a result of an accident shall not, after the assessment, provide any goods or services to the person in respect of the accident. O. Reg. 403/96, s. 54 (1).

(2) Subsection (1) does not apply if,

(a) the insured person and the insurer agree; or

(b) there is no other person within 50 kilometres of the insured person's residence who is able to provide the goods or services. O. Reg. 403/96, s. 54 (2).

(3) Subsection (1) does not prevent the designated assessment centre from conducting another assessment of the person. O. Reg. 403/96, s. 54 (3).

PART XII
RESPONSIBILITY TO OBTAIN TREATMENT, PARTICIPATE IN REHABILITATION AND SEEK EMPLOYMENT

TREATMENT AND REHABILITATION

55. (1) An insured person entitled to an income replacement, non-earner or caregiver benefit shall obtain such treatment and participate in such rehabilitation as is reasonable, available and necessary to,

(a) permit the insured person to engage in employment that satisfies the criteria set out in subsection (2), in the case of an insured person entitled to an income replacement benefit; or

(b) shorten the period during which the benefit is payable, in any other case. O. Reg. 403/96, s. 55 (1).

(2) The criteria referred to in clause (1) (a) are:

1. The insured person,
   i. is able and qualified to perform the essential tasks of the employment, or
   ii. would be able and qualified to perform the essential tasks of the employment if the insured person obtained treatment and participated in rehabilitation that is reasonable, available and necessary to permit the person to engage in the employment.
2. The employment exists in the area in which the insured person lives.
3. It would be reasonable to expect the insured person to engage in the employment having regard to the possibility of deterioration in the insured person's impairment and to the insured person's personal and vocational characteristics. O. Reg. 403/96, s. 55 (2).

(3) Subsection (1) does not apply if compliance with subsection (1) would be detrimental to the insured person's treatment or recovery. O. Reg. 403/96, s. 55 (3).

(4) If an insured person does not comply with subsection (1), the insurer may notify the insured person that the insurer intends to stop payment of the benefit in accordance with subsection (5). O. Reg. 281/03, s. 28.

(5) If at least 10 business days have elapsed after a notice was given under subsection (4) and the insured person has not complied with subsection (1), the insurer may stop payment of the benefit. O. Reg. 281/03, s. 28; O. Reg. 546/05, s. 26.

(6) Section 37 does not apply in respect of a stoppage of benefits, or proposed stoppage of benefits, under this section. O. Reg. 281/03, s. 28.

(7) If, after the stoppage of benefits under subsection (5), the insured person subsequently complies with subsection (1), the insurer shall resume payment of the benefit in respect of periods after the insured person complied. O. Reg. 281/03, s. 28.

EMPLOYMENT

56. (1) An insured person who is entitled to an income replacement benefit shall make reasonable efforts to,

(a) return to the employment in which he or she engaged at the time of the accident; or

(b) obtain employment for which he or she is reasonably suited by education, training or experience. O. Reg. 403/96, s. 56 (1).

(2) Subsection (1) does not apply if,

(a) employment would be detrimental to the insured person's treatment or recovery; or

(b) the insured person is participating in a vocational rehabilitation program. O. Reg. 403/96, s. 56 (2).

(3) If an insured person does not comply with subsection (1), the insurer may notify the insured person that the insurer intends to stop payment of the benefit in accordance with subsection (4). O. Reg. 281/03, s. 29.

(4) If at least 10 business days have elapsed after a notice is given under subsection (3) and the insured person is not in compliance with subsection (1), the insurer may stop payment of the benefit. O. Reg. 281/03, s. 29; O. Reg. 546/05, s. 27.

(5) Section 37 does not apply in respect of a stoppage of benefits, or proposed stoppage of benefits, under this section. O. Reg. 281/03, s. 29.

(6) If, after the stoppage of benefits under subsection (4), the insured person subsequently complies with subsection (1), the insurer shall resume payment of the benefit in respect of periods after the insured person complied. O. Reg. 281/03, s. 29.

PART XIII
INTERACTION WITH OTHER SYSTEMS

ACCIDENTS OUTSIDE ONTARIO

57. (1) If, as a result of an accident in another province or territory of Canada or a jurisdiction in the United States of America, a person insured in that jurisdiction dies or sustains an impairment or incurs an expense described in section 14, 15 or 16, the insurer shall pay, as the person may elect,

(a) benefits provided by this Regulation, other than the benefits referred to in clause (b); or

(b) benefits in the same amounts and subject to the same conditions as if the person was a resident of the jurisdiction in which the accident occurred and was entitled to payments under the law of that jurisdiction. O. Reg. 403/96, s. 57 (1).

(1.1) Subsection (1) does not apply if the person receives benefits under the law of the jurisdiction in which the accident occurred. O. Reg. 462/96, s. 8 (1).

(2) A person who elects to claim a benefit as provided in clause (1) (a) is thereafter eligible only for benefits referred to in that clause. O. Reg. 403/96, s. 57 (2).

(3) A person who elects to claim a benefit as provided in clause (1) (b) is thereafter ineligible for benefits referred to in clause (1) (a). O. Reg. 403/96, s. 57 (3).

(4) For the purpose of this section, a person is insured in the jurisdiction in which the accident occurred if the person, at the time of the accident,

(a) was authorized by law to be or to remain in Canada and was living and ordinarily present in Ontario;

(b) met the criteria prescribed for recovery under the law of the jurisdiction in which the accident occurred;

(c) was not the owner or driver of, or an occupant of an automobile registered in the jurisdiction in which the accident occurred; and

(d) was,

(i) an occupant of the insured automobile,

(ii) the named insured, a person specified in the policy as a driver of the insured automobile, the spouse of the named insured or a dependant of the named insured or spouse, while the occupant of any automobile,

(iii) a person who was not the occupant of an automobile and was struck by the insured automobile,

(iv) the named insured, his or her spouse or a dependant of the named insured or spouse and was struck by any automobile,

(v) if the named insured is a corporation, unincorporated association, partnership or sole proprietorship, a person for whose regular use the insured automobile was supplied, his or her spouse or a dependant of the person or spouse who suffered an impairment,

(A) while the occupant of any automobile,

(B) by any automobile while not the occupant of the automobile, or

(vi) a person struck by an automobile that was driven by a person described in subclause (i), (ii) or (v). O. Reg. 403/96, s. 57 (4); O. Reg. 462/96, s. 8 (2); O. Reg. 114/00, s. 6; O. Reg. 314/05, s. 6.

SOCIAL ASSISTANCE PAYMENTS

58. (1) The insurer shall pay benefits under this Regulation even though the insured person is entitled to, or has received, benefits under an Act administered by the Ministry of Community and Social Services for Ontario or under similar legislation in another jurisdiction. O. Reg. 403/96, s. 58 (1).

(2) For the purpose of subsection (1), a service, benefit or entitlement provided under an Act, the administration of which was transferred from the Ministry of Community and Social Services to the Ministry of Health by order in council, shall be deemed to be provided under an Act administered by the Ministry of Community and Social Services for Ontario so long as the nature of the service, benefit or entitlement remains substantially the same as it was before the transfer. O. Reg. 403/96, s. 58 (2).

WORKERS' COMPENSATION BENEFITS

59. (1) The insurer is not required to pay benefits under this Regulation in respect of any insured person who, as a result of an accident, is entitled to receive benefits under any workers' compensation law or plan. O. Reg. 403/96, s. 59 (1).

(2) Subsection (1) does not apply in respect of an insured person who elects to bring an action referred to in section 30 of the *Workplace Safety and Insurance Act, 1997* so long as the election is not made primarily for the purpose of claiming benefits under this Regulation. O. Reg. 403/96, s. 59 (2); O. Reg. 281/03, s. 30 (1).

(3) If a person is entitled to receive benefits under this Regulation as a result of an election made under section 30 of the *Workplace Safety and Insurance Act, 1997*, no income replacement, caregiver or non-earner benefit is payable to the person in respect of any period of time before the person makes the election. O. Reg. 403/96, s. 59 (3); O. Reg. 462/96, s. 9; O. Reg. 281/03, s. 30 (2).

(4) If a person who would be entitled to benefits under this Regulation in the absence of subsection (1) elects to bring an action referred to in section 30 of the *Workplace Safety and Insurance Act, 1997* and there is a dispute concerning the insurer's liability to pay an expense for a vocational rehabilitation program that the person was attending at the time of the election and continues to attend, the insurer shall pay the expense pending resolution of the dispute. O. Reg. 403/96, s. 59 (4); O. Reg. 281/03, s. 30 (3).

(5) Despite subsection (1), if there is a dispute about whether subsection (1) applies to a person, the insurer shall pay full benefits to the person under this Regulation pending resolution of the dispute if,

(a) the person makes an assignment to the insurer of any benefits under any workers' compensation law or plan to which he or she is or may become entitled as a result of the accident; and

(b) the administrator or board responsible for the administration of the workers' compensation law or plan approves the assignment. O. Reg. 403/96, s. 59 (5).

OTHER COLLATERAL BENEFITS

60. (1) The insurer may deduct the following amounts from the amount payable to an insured person as an income replacement or non-earner benefit:

1. Any temporary disability benefits being received by the insured person in respect of a period following the accident and in respect of an impairment that occurred before the accident.
2. Any other periodic benefit being received by the insured person in respect of a period following the accident and in respect of an impairment that occurred before the accident, if the insured person was receiving the other periodic benefit at the time he or she first qualified for the income replacement or non-earner benefit, and, at that time, the other periodic benefit was a temporary disability benefit. O. Reg. 403/96, s. 60 (1).

(2) Payment of a medical, rehabilitation or attendant care benefit or a benefit under Part VI is not required for that portion of an expense for which payment is reasonably available to the insured person under any insurance plan or law or under any other plan or law. O. Reg. 403/96, s. 60 (2).

(3) In this section,

"temporary disability benefit" means,

(a) an income replacement or non-earner benefit paid under this Regulation, unless the benefit is paid more than 104 weeks after the onset of the disability,

(b) a caregiver benefit paid under this Regulation,

(c) benefits paid under Part II, III or IV or section 32 of Ontario Regulation 776/93,

(d) benefits paid under Part V of Ontario Regulation 776/93, unless the benefits have been paid for more than 104 weeks,

(e) benefits paid under Part IV of Regulation 672 of the Revised Regulations of Ontario, 1990, unless the benefits have been paid for more than 156 weeks,

(f) benefits paid under Part II of Subsection 2 of Schedule C to the *Insurance Act* as it existed before June 22, 1990, unless the benefits have been paid for more than 104 weeks,

(g) benefits paid under section 37, subsection 43 (9) or subsection 147 (2) of the pre-1997 Act, as defined in Part IX of the *Workplace Safety and Insurance Act, 1997,* in respect of injuries that occurred before January 1, 1998, including benefits paid under those provisions as those provisions are deemed to have been amended by Part IX of the *Workplace Safety and Insurance Act, 1997,*

(g.1) benefits paid under subsection 43 (3) of the *Workplace Safety and Insurance Act, 1997* in respect of injuries that occurred after December 31, 1997, or

(h) any other periodic temporary benefit paid under an income continuation benefit plan or law, other than,

(i) benefits under the *Employment Insurance Act* (Canada),

(ii) a non-earner benefit paid under this Regulation more than 104 weeks after the onset of the disability,

(iii) benefits paid under Part V of Ontario Regulation 776/93 for more than 104 weeks,

(iv) benefits paid under Part IV of Regulation 672 of the Revised Regulations of Ontario, 1990 for more than 156 weeks, or

(v) benefits paid under Part II of Subsection 2 of Schedule C to the *Insurance Act* as it existed before June 22, 1990 that have been paid for more than 104 weeks. O. Reg. 403/96, s. 60 (3); O. Reg. 462/96, s. 10; O. Reg. 281/03, s. 31.

PART XIV
INCOME CALCULATION

NET WEEKLY INCOME FORMULA

61. (1) For the purpose of this Regulation, a person's net weekly income from employment shall be determined in accordance with the following formula:

$$A = \frac{B - C - D - E}{52}$$

where,

A = the person's net weekly income from employment,

B = the person's gross annual income from employment,

C = the annual premium payable by the person under the *Employment Insurance Act* (Canada) on the gross annual income from employment,

D = the annual contribution payable by the person under the *Canada Pension Plan* on the gross annual income from employment,

E = the income tax payable by the person under the *Income Tax Act* (Canada) and the *Income Tax Act* (Ontario) on the gross annual income from employment.

O. Reg. 403/96, s. 61 (1).

(2) For the purpose of subsection (1), the person whose net weekly income from employment is to be determined shall be deemed to be a resident of Ontario. O. Reg. 403/96, s. 61 (2).

INCOME FROM SELF-EMPLOYMENT

62. (1) For the purpose of this Regulation, a person's income from self-employment shall be determined in the same manner as the person's profit from the business in which the person was self-employed would be determined under the *Income Tax Act* (Canada) and the *Income Tax Act* (Ontario), but without taking into account,

(a) expenses that are eligible for capital cost allowance or an allowance on eligible capital property;

(b) capital gains or losses; or

(c) losses deductible under section 111 of the *Income Tax Act* (Canada). O. Reg. 403/96, s. 62 (1).

(2) Despite subsection (1), an insurer and a named insured who is self-employed and not otherwise employed may agree in a contract evidenced by a motor vehicle liability policy that, for the purpose of determining benefits under this Regulation in respect of an accident that occurs during the period covered by the contract, the named insured's gross income from self-employment for every week shall be deemed to be the weekly income amount specified in the contract if, at the time of the accident, the person continues to engage in the self-employment in which he or she engaged at the time the contract was entered into and the person is not otherwise employed. O. Reg. 403/96, s. 62 (2).

(3) In specifying a weekly income amount for the purpose of subsection (2), the insurer and insured may use information from any source, including,

(a) personal and corporate income tax returns and assessments;

(b) personal and corporate financial statements; and

(c) published data on the average wage for the industry or occupation in which the insured is self-employed. O. Reg. 403/96, s. 62 (3).

INCOME TAX CALCULATIONS

63. (1) For the purpose of this Regulation, the income tax payable by a person under the *Income Tax Act* (Canada) and the *Income Tax Act* (Ontario) shall be determined having regard to only the following deductions and tax credits that apply to the person under those Acts:

1. Alimony and maintenance payments deduction.
2. Basic personal tax credit.
3. Married person's tax credit or equivalent to married tax credit.
4. Age tax credit.

5. Disability tax credit.

6. Employment insurance premium tax credit.

7. *Canada Pension Plan* tax credit.

8. *Quebec Pension Plan* tax credit. O. Reg. 403/96, s. 63 (1).

(2) If a determination of the income tax payable by a person under the *Income Tax Act* (Canada) and the *Income Tax Act* (Ontario) is necessary to determine the amount of a benefit under this Regulation, the applicant for the benefit shall provide the insurer with such information as is reasonably necessary to enable the insurer to make the determination. O. Reg. 462/96, s. 11.

(3) Failure to comply with subsection (2) does not relieve the insurer from any time limit established by this Regulation for the payment of the benefit, but the insurer shall determine the amount of the benefit on the basis of its best estimate of the income tax payable by the person under the *Income Tax Act* (Canada) and the *Income Tax Act* (Ontario), subject to later adjustment of the amount of the benefit when subsection (2) is complied with. O. Reg. 403/96, s. 63 (3).

SEVERANCE OR TERMINATION PAY

64. For the purpose of this Regulation, payments of severance pay or termination pay shall not be included in a determination of a person's income. O. Reg. 403/96, s. 64.

UNREPORTED INCOME

64.1 (1) If, under the *Income Tax Act* (Canada) or legislation of another jurisdiction that imposes a tax calculated by reference to income, a person is required to report the amount of his or her income, the person's income before an accident that occurs after April 14, 2004 shall be determined for the purposes of this Regulation without reference to any income the person has failed to report contrary to that Act or legislation. O. Reg. 458/03, s. 11.

(2) Where the amount of a person's income before an accident is determined for the purposes of this Regulation in accordance with subsection (1), the amount of the income may be adjusted to reflect any change in the amount of the person's income reported or determined in accordance with the *Income Tax Act* (Canada) or legislation of another jurisdiction that imposes a tax calculated by reference to income. O. Reg. 458/03, s. 11.

PART XV
MISCELLANEOUS

ASSIGNMENT OF BENEFITS

65. (1) The assignment of a benefit under this Regulation, or the assignment of the right to pursue a mediation, arbitration, appeal or variation proceeding under sections 280 to 284 of the Act, is void. O. Reg. 281/03, s. 32 (1).

(2) Subsection (1) does not apply to,

(a) an assignment under section 267.8 of the *Insurance Act*;

(b) an assignment of a benefit to,

(i) the Ministry of Community, Family and Children's Services,

(ii) a delivery agent under the *Ontario Disability Support Program Act, 1997* or the *Ontario Works Act, 1997*, or

(iii) The Minister of Finance under subsection 6.1 (4) of the *Motor Vehicle Accident Claims Act*; or

(c) the assignment of a benefit to the Ministry of Health in respect of a service, benefit or entitlement provided under an Act the administration of which was transferred by order in council from the Ministry of Community and Social Services to the Ministry of Health. O. Reg. 403/96, s. 65 (2); O. Reg. 281/03, s. 32.

COMPANY AUTOMOBILES AND RENTAL AUTOMOBILES

66. (1) An individual who is living and ordinarily present in Ontario shall be deemed for the purpose of this Regulation to be the named insured under the policy insuring an automobile at the time of an accident if, at the time of the accident,

(a) the insured automobile is being made available for the individual's regular use by a corporation, unincorporated association, partnership, sole proprietorship or other entity; or

(b) the insured automobile is being rented by the individual for a period of more than 30 days. O. Reg. 403/96, s. 66 (1); O. Reg. 462/96, s. 12 (1).

(2) An individual who is not living and ordinarily present in Ontario shall be deemed for the purpose of this Regulation to be the named insured under the policy insuring an automobile at the time of an accident if, at the time of the accident,

(a) the insured automobile is being made available for the individual's regular use by a corporation, unincorporated association, partnership, sole proprietorship or other entity; and

(b) the individual, his or her spouse or any dependant of the individual or spouse is an occupant of the insured automobile. O. Reg. 403/96, s. 66 (2); O. Reg. 462/96, s. 12 (2); O. Reg. 114/00, s. 7; O. Reg. 314/05, s. 7.

COPIES OF REGULATION

67. On request, the insurer shall provide a copy of this Regulation without charge to a named insured or a person entitled to benefits under this Regulation. O. Reg. 403/96, s. 67.

NOTICES AND DELIVERY

68. (1) Except as otherwise permitted by this Regulation, all notices required or permitted under this Regulation, other than a notice under subsection 32 (1) or (3.1), shall be in writing. O. Reg. 546/05, s. 28 (1).

(2) Any document, including a notice in writing, required or permitted under this Regulation to be given to a person may be delivered,

(a) by faxing the document to the person or to the solicitor or authorized representative, if any, of the person in accordance with subsection (6);

(b) by leaving a copy of the document with the solicitor or authorized representative, if any, of the person, or with an employee in the office of the solicitor or authorized representative;

(c) by personal delivery to the person;

(d) by letter mail, certified mail or registered mail,

(i) in the case of an insurer, addressed to the insurer or its chief executive officer at the insurer's head office in Ontario as identified in the records of the Superintendent,

(ii) in the case of a person other than an insurer, addressed to the person at his or her last known address; or

(e) by electronic means, if the intended recipient of the document consents to delivery by electronic means. O. Reg. 281/03, s. 33; O. Reg. 533/06, s. 13 (1).

(2.1) For the purposes of clauses (2) (a) and (b), an authorized representative may include, subject to subsection (2.2),

(a) a member of a health profession if the document is a notice under subsection 38 (5) or (8), 38.2 (4) or (6) or 42 (4) or a report prepared under section 42; or

(b) a member of a health profession who is a health practitioner if the document is a notice under subsection 37.1 (4) or (5). O. Reg. 546/05, s. 28 (2).

(2.2) Subsection (2.1) does not apply unless,

(a) the insured person is not represented at the relevant time by a solicitor or another authorized representative;

(b) the insured person gives to the insurer a signed authorization and direction specifying which documents listed in subsection (2.1) that the insurer is authorized and directed to give to the member of the health profession;

(c) the signed authorization and direction is given to the insurer before the document is given to the member of the health profession; and

(d) the member of the health profession has agreed to act in accordance with the authorization and direction. O. Reg. 546/05, s. 28 (2).

(3) Despite clause (2) (d), any notice or other document that must be given within five or fewer business days shall not be delivered by letter mail. O. Reg. 281/03, s. 33; O. Reg. 458/03, s. 12.

(3.1) The functional equivalency rules set out in sections 4 to 13 of the *Electronic Commerce Act, 2000* apply in the case of the delivery of a document by electronic means under clause (2) (e). O. Reg. 533/06, s. 13 (2).

(3.2) Despite subsection (2), but subject to subsection (3.10), the following rules apply in the circumstances specified in a Guideline issued for the purposes of this section to a document that is listed in section 69, is specified in the Guideline and is required under this Regulation to be delivered to an insurer to whom the Guideline applies:

1. Subject to paragraphs 2 and 3, the document and any attachments to it shall be delivered to the insurer only in a manner specified in the Guideline.
2. If the Guideline specifies that a document, exclusive of attachments to it, is to be delivered to a central processing agency on behalf of the insurer,
   i. the document shall be delivered not to the insurer but only to the central processing agency specified in the Guideline and only in a manner specified in the Guideline, and
   ii. attachments to the document shall be delivered not to the central processing agency but only to the insurer in a manner specified in the Guideline.

3. If the Guideline specifies that a document, together with attachments to it, is to be delivered to a central processing agency on behalf of the insurer, the document and the attachments shall be delivered not to the insurer but only to the central processing agency specified in the Guideline and only in a manner specified in the Guideline.

4. A document referred to in paragraph 1, 2 or 3 shall be deemed not to have been received by the insurer to whom it is addressed, if it is delivered to the insurer otherwise than as specified in the Guideline. O. Reg. 533/06, s. 13 (3).

(3.3) A document referred to in paragraph 2 of subsection (3.2) is deemed to be received by the insurer to whom it is addressed on the later of,

(a) the date on which the document, delivered in a manner specified in the Guideline to the central processing agency on behalf of an insurer to whom the Guideline applies, is determined by the central processing agency to be duly completed and to contain all information required by this Regulation to be included in it; and

(b) the date on which the last of any attachments is received by the insurer. O. Reg. 533/06, s. 13 (3).

(3.4) A document referred to in paragraph 3 of subsection (3.2) is deemed to be received by the insurer to whom it is addressed when the document and any attachments to it are delivered in a manner specified in the Guideline to the central processing agency on behalf of an insurer to whom the Guideline applies and the document is determined by the central processing agency to be duly completed and to contain all information required by this Regulation to be included in it. O. Reg. 533/06, s. 13 (3).

(3.5) For the purposes of subsections (3.3) and (3.4), the central processing agency shall be deemed to have determined, on the day the document was delivered to the central processing agency in a manner specified by the Guideline, that the document is duly completed and contains all information required by this Regulation to be included in it unless the central processing agency notifies the sender, in a manner specified in the Guideline and not later than the second business day after the document was delivered to the central processing agency, that the document is not duly completed or does not contain all information required by this Regulation to be included in it. O. Reg. 533/06, s. 13 (3).

(3.6) A notice under subsection (3.5) shall include sufficient particulars to enable the sender to remedy the deficiency. O. Reg. 533/06, s. 13 (3).

(3.7) The central processing agency shall, as soon as practicable, make the contents of the document available to the insurer to whom the document is addressed. O. Reg. 533/06, s. 13 (3).

(3.8) An insurer that is deemed by subsection (3.3) or (3.4) to have received a document, other than an invoice to which subsection 44.1 (1) applies, shall in the manner and within the time required by the Guideline provide the central processing agency with the following information, which may include personal information:

1. Particulars of the goods or services referred to in the document for which the insurer agrees to pay and the amount the insurer agrees to pay in respect of such goods or services.

2. Particulars of the goods or services referred to in the document for which the insurer does not agree to pay. O. Reg. 533/06, s. 13 (3).

(3.9) Following receipt of the last of any attachments to a document in accordance with paragraph 2 of subsection (3.2), an insurer shall notify the central processing agency for the purpose of the application of clause (3.3) (b), in the manner and within the time required by the Guideline. O. Reg. 533/06, s. 13 (3).

(3.10) Subsections (3.2) to (3.9) do not apply to a document if the insurer has waived the requirement that the document be submitted to the insurer in circumstances permitted by this Regulation. O. Reg. 533/06, s. 13 (3).

(3.11) Nothing in this Regulation prohibits any person from delivering a document to which subsection (3.2) applies to the central processing agency on behalf of a person otherwise required to deliver it. O. Reg. 533/06, s. 13 (3).

(4) If an attempt is made to personally deliver a document to a person at his or her place of residence and, for any reason, it is not possible to personally deliver the document to the person, the document may be delivered by leaving a copy, in a sealed envelope addressed to the person, at the person's place of residence with anyone who appears to be an adult member of the same household. O. Reg. 380/03, s. 3.

(5) In the absence of evidence to the contrary, a person is deemed to receive anything delivered by letter mail under clause (2) (d) on the fifth business day after the day the document is mailed in accordance with clause (2) (d). O. Reg. 380/03, s. 3; O. Reg. 458/03, s. 12.

(6) A document that is delivered by fax must include a cover page indicating,

(a) the sender's name, address and telephone number;

(b) the name of the person for whom the document is intended;

(c) the date of the accident to which the document relates;

(d) the name, address and telephone number of the person to whom the document relates;

(e) the date and time the fax is sent;

(f) the total number of pages faxed, including the cover page;

(g) the telephone number from which the document is faxed; and

(h) the name and telephone number of a person to contact in the event of transmission problems with the fax. O. Reg. 281/03, s. 33.

(7) A document delivered in accordance with clause (2) (a), (b), (c) or (e) after 5 p.m. local time of the recipient shall be deemed to be delivered on the next business day. O. Reg. 281/03, s. 33; O. Reg. 533/06, s. 13 (4).

(8) Despite subclause (2) (d) (i) and subsections (5) and (7), if the insurer provides the name and address of a contact person to whom documents are to be delivered, anything delivered to the insurer that is not addressed to the attention of the contact person at that address shall not be considered to have been delivered to the insurer until it is received by the contact person. O. Reg. 281/03, s. 33.

(8.1) Subject to subsection (7), subsection 22 (3) of the *Electronic Commerce Act, 2000* applies to determine when a document delivered in accordance with clause (2) (e) is deemed to be delivered to the recipient. O. Reg. 533/06, s. 13 (5).

(8.2) Where subsection (3.3) or (3.4) applies, the recipient for the purposes of subsection (8.1) is the central processing agency. O. Reg. 533/06, s. 13 (6).

(9) A reference in this Regulation to a number of days between two events shall be read as excluding the day on which the first event happens and including the day on which the second event happens. O. Reg. 281/03, s. 33.

(10) Subject to subsection (11), if any provision of this Regulation requires a person to do anything within a time period expressed in days or business days, the time period is deemed to expire on the last day of the time period at 5 p.m. local time. O. Reg. 281/03, s. 33.

(11) If a time period in which a person is required to do anything expires on a day that is not a business day, the time period is deemed to expire on the next day that is a business day at 5 p.m. local time. O. Reg. 281/03, s. 33.

(12) For the purposes of subsections (10) and (11), if the person delivering a document or notice and the person to whom the document or notice is to be delivered are in different time zones, references to 5 p.m. local time shall be read as references to the time when it is 5 p.m. in one time zone and after 5 p.m. in the other time zone. O. Reg. 281/03, s. 33.

(13) A member of a health profession who receives a document under the authority of subsection (2.1) shall immediately notify the insured person by telephone of the substance of the document and send a copy of the document to the insured person by ordinary mail or fax. O. Reg. 546/05, s. 28 (2).

(14) An insurer shall not deliver documents to a member of a health profession in reliance on an authorization under subsection (2.2) unless the documents are expressly specified in the authorization referred to in that subsection. O. Reg. 546/05, s. 28 (2).

SUBSTITUTE DECISION-MAKERS

68.1 Any consent, notice or other thing to be given by or to an insured person under this Regulation may be given by or to a person exercising a power of decision on behalf of the insured person under the authority of the *Substitute Decisions Act, 1992* or as authorized under the *Health Care Consent Act, 1996*. O. Reg. 546/05, s. 29.

FORMS

69. Each of the following documents shall be in a form approved by the Superintendent:

1. An application form referred to in clause 32 (2) (a).
2. A disability certificate.

2.1 A consent under section 32.1.

2.2 A notice under subsection 35 (3) or (4).

3. A notice under section 36.
4. A notice under subsection 37.1 (5).
5. A treatment confirmation form under section 37.1.

5.1 A notice under subsection 37.2 (2).

6. An application referred to in section 38, including the treatment plan.

6.1 A notice under subsection 38 (8).

7. An application under section 38.2.

7.1 A notice under subsection 38.2 (6).

7.2 A notice under section 39 advising an insured person that the insurer requires him or her to be examined under section 42.

8. An application under subsection 40 (1).

9. A notice under subsection 40 (2).

10. A report of a designated assessment.

10.1 A notice under section 42.

10.2 An invoice in respect of an expense for goods or services specified in a Guideline issued for the purposes of section 44.1.

11. An explanation under section 45.

12. A notice under section 49. O. Reg. 281/03, s. 34; O. Reg. 546/05, s. 30; O. Reg. 533/06, s. 14.

69.1 (1) Any document that is required by section 69 to be in a form approved by the Superintendent and to which subsection 68 (3.2) applies and any other document specified in a Guideline issued for the purposes of this section is duly completed and includes all information required by this Regulation to be included in it if,

(a) every field not identified on the form as an optional field is completed in accordance with subsection (2); and

(b) if any field on the form that is identified as an optional field is completed, it is completed in accordance with subsection (2). O. Reg. 533/06, s. 15.

(2) If the form specifies the manner or the format in which a field is to be completed, completion of the field shall be in that manner and in that format. O. Reg. 533/06, s. 15.

TRANSITION

70. (1) Despite anything else in this Regulation, if a motor vehicle liability policy is in effect on the day this Regulation comes into force, subsections (2) and (3) apply until the earlier of the following:

1. The first expiry date under the motor vehicle liability policy.

2. The date on which the motor vehicle liability policy is terminated by the insurer or the insured. O. Reg. 403/96, s. 70 (1).

(2) The following benefits are deemed to be included in the motor vehicle liability policy, and are applicable to an insured person in respect of the motor vehicle liability policy:

1. The optional income replacement benefit referred to in paragraph 1 of subsection 27 (1) that fixes the amount referred to in subparagraph ii of paragraph 2 of subsection 7 (1) at $1,000.

2. The optional caregiver and dependant care benefit referred to in paragraph 2 of subsection 27 (1).

3. The optional death and funeral benefit referred to in paragraph 4 of subsection 27 (1). O. Reg. 403/96, s. 70 (2).

(3) The sum of the medical, rehabilitation and attendant care benefits paid under the motor vehicle liability policy for any one accident in respect of an insured person who does not sustain a catastrophic impairment as a result of the accident shall not exceed $1,000,000, and the limits set out in clauses 19 (1) (a) and (2) (a) do not apply. O. Reg. 403/96, s. 70 (3).

70.1 Form 1, as it read on September 30, 2003, continues to apply in respect of accidents occurring before October 1, 2003. O. Reg. 281/03, s. 35.

71. OMITTED (PROVIDES FOR COMING INTO FORCE OF PROVISIONS OF THIS REGULATION). O. Reg. 403/96, s. 71.

FORM 1 REVOKED: O. Reg. 546/05, s. 31.

Français

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