SEND THIS FORM TO:

OFFICE OF THE SUPERINTENDENT OF INSURANCE
Room 402, Terrace Building, 9515 - 107 St.
Edmonton, AB. T5K 2C3
Fax (780) 420 0752
Phone (780) 427 8322
E-mail: insurance@gov.ab.ca

Application to the Superintendent of Insurance to select a Certified Examiner (Form MI-2)

Use this prescribed form for motor vehicle accidents that occur on or after January 1, 2008. This form is prescribed in accordance with Section 8(4) of the *Minor Injury Regulation* and Section 803 of the *Insurance Act*.

Important Notice: This prescribed form is to be used when the claimant and the insurance company cannot agree on a Certified Examiner to assess the claimant. If you have any questions you can contact the Office of the Superintendent of Insurance at the address listed above. A copy of the *Minor Injury Regulation*, *Insurance Act*, prescribed forms and the Certified Examiner registry is available at http://www.finance.alberta.ca/business/insurance/info_insurers.html.

Part 1 **Claimant Information**					
	Title	Last Name	First Name	Date of Birth (YYYY/MM/DD)	Male ☐ Female ☐
	Address				
	City, Town or County		Province	Postal Code	
	Telephone Number	Fax Number		Date of Motor Vehicle Accident	

Part 1a **Claimant Representative Information**				
	Title	Last Name	First Name	
	Name Of Law Firm			
	Mail Address			
	City, Town or County		Province	Postal Code
	Telephone Number	Fax Number		

Part 2 **Insurance Company Information**				
	Name Of Insurance Company			
	Claims Representative		Claim Number	
	Mail Address			
	City, Town or County		Province	Postal Code
	Telephone Number	Fax Number		

Part 3 **Certified Examiner Declined by Claimant**				
	Name of 1st Declined Certified Examiner			
	Address			
	City, Town or County		Province	Postal Code
	Telephone Number	Fax Number		

Part 4 **Certified Examiner Declined by Insurance Company**	Name of 2nd Declined Certified Examiner			
	Address			
	City, Town or County		Province	Postal Code
	Telephone Number	Fax Number		

Part 5 **Signature of Party Applying to the Superintendent of Insurance to Select a Certified Examiner**	**Please indicate whether this request is being made by or on behalf of** ☐ **the claimant** **or** ☐ **the insurance company**		
	• I desire to have a Certified Examiner assess the claimant for the purpose of giving an opinion as to whether the injury is or is not a minor injury. • The personal information that you provide on this form will be used for the purpose of selecting a certified examiner and informing relevant parties of the selection. It is collected under the authority of section 8(4) of the *Insurance Act, Minor Injury Regulation*, and section 33(c) of the *Freedom of Information and Protection of Privacy Act* (RSA 2000). It is protected by the privacy provisions of the *Freedom of Information and Protection of Privacy Act*. If you have any questions you can contact the Office of the Superintendent of Insurance at the telephone number and address listed at the beginning of this form.		
	Name of Requesting Party *(please print)*	Signature of Requesting Party Representative	Date Signed (MMDDYYYY)