

SEND THIS FORM TO:

OFFICE OF THE SUPERINTENDENT OF INSURANCE
 Room 402 Terrace Building, 9515 – 107 Street
 Edmonton, Alberta 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 October 1, 2004. 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.gov.ab.ca/publications/insurance/>.

Part 1 Claimant Information	Title (e.g., Mr., Mrs., Ms., Dr.)	Last Name	First Name	
	Address			
	City, Town or County		Province	Postal Code
	Telephone Number (Home) (include Area Code)	Fax Number (Work) (include Area Code)	Date of Motor Vehicle Accident	

Part 2 Insurance Company Information	Insurance Company Name			
	Address			
	City, Town or County		Province	Postal Code
	Telephone Number (Work) (include Area Code)	Fax Number (Work) (include Area Code)	Name of Claims Representative	

Part 3 Certified Examiner Declined by Claimant	Name of 1 st Declined Certified Examiner			
	Address			
	City, Town or County		Province	Postal Code
	Telephone Number (Work) (include Area Code)	Fax Number (Work) (include Area Code)		

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

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 <input type="checkbox"/> the claimant or <input type="checkbox"/> the insurance company		
	<ul style="list-style-type: none"> 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 Representative (please print)	Signature of Requesting Party Representative	Date Signed (MMDDYYYY)