Health Claims for Auto Insurance Processing

HCAI Insurer Enrolment Form

Date: _____

To: Health Claims for Auto Insurance Processing
2235 Sheppard Ave. E, Suite 1100
Toronto, ON M2J 5B5 insurersupport@hcaiinfo.ca

Section "A" Company Information

1. Company Legal Name: _____
2. Street Address: _____
   City/Province: _____
   Postal Code: _____
   Phone: _____
   Fax: _____
3. IBC ID: _____
4. Please Indicate How this Insurer is to be set up in HCAI (one option only)
   Parent Insurer? ○ Child Insurer? ○ Virtual Insurer? ◉
5. Parent Company Name* _____
   **Mandatory if insurer is being set up as a Child Insurer or Virtual Insurer*

Section "B" Business Contact Information

Please assign two individuals who will be the HCAI contacts for all locations. If you are planning to integrate with HCAI, you may wish to make one a technical contact. Please also assign a Chief Privacy Officer to be responsible for managing privacy communications and inquiries on behalf of your organization.

1. **Contact 1**
   First & Last Name: _____
   Phone (with extension): _____
   Email: _____
2. **Contact 2**
   First & Last Name: _____
   Phone (with extension): _____
   Email: _____

3. **Chief Privacy Officer**

Privacy Officer Name: _____

Privacy Officer Phone: _____

Privacy Officer Email: _____

Section "C" System Integration Information

If your organization would like to integrate with HCAI, please indicate which feed/extracts your organization requires (select all that apply):

- Claim-Claimant Feed and Extracts ☐
- Insurer All Data (a.k.a. Insurer) Extract ☐

Section "D" Digital Certificate Owners (*for Insurers who completed Section C)

Please provide the following contact information only if your organization would like to integrate with HCAI via feed and/or extracts. These individuals will receive the test and production digital certificates for your insurer. They will also be sent the annual renewal of your test and production digital certificates.

Please note that these individuals do **not** receive regular communications from the HCAI team.

Digital Certificate Owner #1

Full Name: _____

Title: _____

Email: _____

Phone: _____

Digital Certificate Owner #2

Full Name: _____

Title: _____

Email: _____

Phone: _____

Section "E" System User & Organization Administrator Contact Information

Please assign a contact person to receive the first user ID for the production environment. This User will be given full access to set-up the organizational branches, adjusters and set up User IDs for staff within

the Parent insurer organization and any affiliated Child Insurer Organization. This user must be from the Parent insurer. If this Enrolment Form is for a Child Insurer, this section does not apply.

Title: _____

First & Last Name: _____

Phone: _____

Email: _____

Adjuster ID: _____

Preferred HCAI logon ID: _____

Alternate Logon ID (if 1st choice unavailable): _____

2nd Alternate Logon ID (if 2nd choice unavailable): _____

Section "F" APPLICABLE AUTHORIZING OFFICER OF THE INSURANCE COMPANY

Health Claims for Auto Insurance Processing ("HCAI" or "HCAI Processing") operates the HCAI System in order to facilitate the submission of medical and rehabilitation treatment plans, invoices and other documents by Health Care Provider Facilities ("Facilities") to automobile insurers in Ontario who are required to receive such claims through the central processing agency designated by a Guideline issued by the Superintendent of Financial Services pursuant to the Statutory Accident Benefits Schedule – Accidents On or After November 1, 1996, as amended (the "SABS"). Your organization's rights and obligations in respect of the HCAI System and service, and your relationship with HCAI Processing, will be governed by the HCAI Insurer Terms and Conditions.

Your signature on this form will signify your organization's agreement to the HCAI Insurer Terms and Conditions. Copies of the HCAI Insurer Terms and Conditions are available at www.hcaiinfo.ca and may be modified from time to time in accordance with their terms. It is your responsibility to check for updates from time to time. Any use of the HCAI system by you or your organization, including the retrieval of any new forms by electronic means after the modified HCAI Insurer Terms and Conditions are effective shall constitute your agreement to the revised version of the HCAI Insurer Terms and Conditions.

The information provided by you on this form will be used to support the provision of services provided by HCAI and/or to facilitate your participation in the HCAI System.

It may be necessary for HCAI to collect, retain, use, disclose and share your enrolment information with the following parties: Insurance Bureau of Canada (IBC) and health care facilities, providers and practice management software vendors that are submitters to you of health benefit claims under the SABS. You authorize IBC and these third parties to collect, retain, use, disclose and share the information provided in this form as reasonably required to support the provision of services provided by HCAI Processing and/or to facilitate your participation in the HCAI System. HCAI Processing's privacy statement is available at

www.hcaiinfo.ca. You agree that IBC may be provided with a copy of this form and that IBC shall be entitled to rely upon and enforce your agreement to the HCAI Insurer Terms and Conditions.

The accuracy and completeness of the information you provide is solely your responsibility. HCAI Processing and its contractors accept no liability for damage of any nature or kind whatsoever, caused directly or indirectly by, through or as a result of any error in information you have submitted. You agree that you will not attempt to secure unauthorized access (including, but not limited to, through means such as misrepresenting your identity or misrepresenting your authority to act for or submit/receive information in respect of any other person) to the HCAI system or any HCAI information. HCAI Processing and its contractors may log and monitor access to the registration system to ensure quality and security. Unauthorized activity or access may be subject to prosecution.

If you access the HCAI System electronically then you hereby (1) in accordance with Section 22(3) of the Electronic Commerce Act (Ontario), as amended from time to time, designate the HCAI System for the purpose of receiving (i) information and documents sent to you by health care facilities and providers through the HCAI System or (ii) which relate to communications from HCAI Processing; and (2) consent to the delivery of such information and documents, and any communications from HCAI Processing, by electronic means through the HCAI System. HCAI Insurer Enrolment Form Page 4 of 4

Important: Please complete and sign this enrolment form, and send a scanned copy to insurersupport@hcaiinfo.ca. Retain a copy for your records. Please do not send back the HCAI Insurer Terms and Conditions portion of the document. You will be contacted by mail with confirmation of account activation once your form has been processed.

SIGNATURE OF AUTHORIZING OFFICER

By signing this HCAI Enrolment Form, I agree on behalf of the Company to the provisions set out in this document and the HCAI Insurer Terms and Conditions as amended from time to time in accordance with its terms (the current version of which will be set out at http://www.hcaiinfo.ca). I represent that I am authorized to bind the Company.

Full Legal Name of Insurer: _____

Name of Authorizing Officer: _____

Title of Authorizing Officer: _____

Signature: _____

Date: _____

For Office Use Only: Reviewed and Signed Off by

- ☐ Received – Staff Member: _____ Date: _____
- ☐ Processed – Staff Member: _____ Date: _____