

Treatment Plan (Form AB-2)

Part 7

This form is effective on **November 20, 2004** for accidents that occur on or after **October 1, 2004**.

Part 7: Choice in Following Diagnostic and Treatment Protocols Regulations

Please state whether you choose to be treated within the Diagnostic and Treatment Protocols Regulations:

- I choose to be treated within the Diagnostic and Treatment Protocols Regulation as indicated on Form AB-1 (Notice of Loss and Proof of Claim).
- I choose not to be treated within the Diagnostic and Treatment Protocols Regulation.

I certify that the information provide is true and correct to the best of my knowledge. I confirm that I have consented to the collection, use and disclosure of my personal information for my treatment and care and determination of my eligibility for accident and/or disability income benefits as outline on Form AB-1 (Notice of Loss and Proof of Claim).

I am the claimant, OR I am the Authorized Representative of the claimant.

Name

Date (dd-mm-yyyy)

Signature