



Please refer to the guide when completing this application form. The guide contains useful information and assistance for completing this form. Please type your answers or print them in ink in legible handwriting. A separate application must be filed for each person seeking compensation.

We may award compensation only if the deceased person died as a result of a violent crime in the Province of Ontario, or while making an arrest or assisting a peace officer with his/her law enforcement duties, or while trying to prevent a crime. Please see the guide for more information about who may be eligible for compensation.

Please provide all of the requested information to ensure that your application is processed as quickly as possible. Our contact centre is available to assist you should you have any questions not answered in the guide. Please read the form carefully so you complete only the sections that apply to you.

Send your completed application form to the Board with as much supporting documentation as possible. If you have a death certificate, police records (occurrence report, crown synopsis, record of arrest), Court records (Information/Indictment), victim impact statement, power of attorney, medical or therapy records that support your injury for a mental or nervous shock claim, invoices and/or original receipts, include these documents with your application. If you do not have these documents, do not wait to mail the application form. Gather the documents and then mail them to us once they become available.

Please only send copies of supporting documents. Do not send originals.

If there is not enough space in certain parts of the application form, use Part 14, the Additional Information section, or additional sheets of paper. Remember to include your name on completed attachments and identify the section of the application form the additional information pertains to.

It is important that we receive your application form within two years of the death. We can extend the two-year limitation when it is warranted, but you will have to request such an extension and explain your reason(s) for the delay in Part 6 of the application.

It is essential that you let us know whenever your address or phone number changes. If we are unable to reach you by phone or mail, your application may be dismissed.

Mail, fax or email your completed application form and supporting documents to the addresses or numbers below. For more information about the Criminal Injuries Compensation Board and the application process, please visit our website. Website: www.sjto.gov.on.ca/cicb

Criminal Injuries Compensation Board
655 Bay Street, 14th Floor
Toronto ON M7A 2A3
Tel: 416 326-2900 (within the Greater Toronto Area)
Toll Free: 1 800 372-7463
Fax: 416 326-2883, Toll Free: 1 844 249-1619
Email: info.cicb@ontario.ca

The Victim Support Line (VSL), through FindHelp, provides a province-wide, toll-free telephone information line providing access to information for victims, in the language of their choice, 24 hours a day, seven days a week. If you would like to find out about services in your area, or would like to inquire about organizations that might be willing to assist with the completion of your application, call the Victim Support Line at 1 888 579-2888 (if you live in the Greater Toronto Area, call 416 314-2447) and choose option 1.

Warning: While we have a variety of security measures in place, it is important to remember that email is not secure. We cannot guarantee the privacy or confidentiality of any information that is sent over the Internet by email as it may not be free from interception by third parties.

Part 1: Claimant Information

The claimant can be any one of the following:

- a person claiming funeral costs and/or other expenses as a result of the death,
- a person who was being supported financially by the deceased person prior to his/her death,
- a person who is caring for one or more children of the deceased person,
- a person who witnessed or came upon the scene of the crime and meets the criteria for a finding of mental or nervous shock.

A date of birth is needed to avoid confusion with other claimants who have the same or similar names. As we may need to contact you during business hours, a daytime number would be helpful. If you are filing this application on behalf of someone else, put his/her information in Part 1 and your information in Part 2.

| | | | | | |
|--------------------|------------|----------------------------|--|--------------------|-------------------------|
| Last Name | | | First Name | | Middle Initial |
| Last Name at Birth | | Date of Birth (yyyy/mm/dd) | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans <input type="checkbox"/> Other, please specify: | | |
| Unit No. | Street No. | Street Name | | PO Box | Postal Code |
| City/Town | | | Province | Home Telephone No. | |
| Email Address | | | Driver's Licence Number | | Alternate Telephone No. |

Do you have any concerns with the Board leaving messages regarding this claim at either of the above phone numbers?

☐ No ☐ Yes - (if so please explain)

What is your preferred method of communication with the Board? (if you check email, you are consenting to the delivery of personal information and documents by email) ☐ Mail ☐ Email ☐ Telephone

Will you require an interpreter at a hearing?

☐ No ☐ Yes (specify a language)

Have you filed an application with the Board before?

☐ No ☐ Yes (specify the year)

Would you like to permit someone else to speak with the Board on your behalf? If so, provide name.

Name (first and last)

Telephone No.

Is the Board authorized to release reports to the individual named?

☐ Yes ☐ No

Is the named individual authorized to update your contact information with the Board?

☐ Yes ☐ No

Is the named individual authorized to request duplicate letters from the Board?

☐ Yes ☐ No

What was your relationship to the deceased person?

Did you reside with the deceased person?

☐ No ☐ Yes

Part 2: Applicant Information (if applicable)

Complete this part only if you are not the claimant, but you are acting on his/her behalf.

You may be the applicant for a claimant if:

- you are a parent or legal guardian of a claimant who is a minor (under the age of 18); or
- you have the legal authority to make decisions for a claimant because he/she cannot make decisions for himself/herself (e.g. due to mental/physical incapacity). Please provide a copy of the power of attorney.

| | | | | | |
|--------------------------------------|------------|-------------|--|--------------------|-------------------------|
| Last Name | | | First Name | | Middle Initial |
| Your Relationship to the Claimant | | | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans <input type="checkbox"/> Other, please specify: | | |
| Name of Organization (if applicable) | | | | | |
| Unit No. | Street No. | Street Name | | PO Box | Postal Code |
| City/Town | | | Province | Home Telephone No. | |
| Email Address | | | Driver's Licence Number | | Alternate Telephone No. |

Do you have any concerns with the Board leaving messages regarding this claim at either of the above phone numbers?

☐ No ☐ Yes - (if so please explain)

Will you require an interpreter at a hearing?

☐ No ☐ Yes (specify a language)

What is your preferred method of communication with the Board? (if you check email, you are consenting to the delivery of personal information and documents by email) ☐ Mail ☐ Email ☐ Telephone

Part 3: Deceased Person Information

The deceased person is the individual who died during the crime. A date of birth is needed to avoid confusion with others having the same or similar names. A copy of the death certificate or other documents verifying the death must be included with your application.

| | | | |
|---|--|----------------------------|----------------------------|
| Last Name | | First Name | Middle Initial |
| Last Name at Birth | | Any other Name(s) | |
| Gender | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans | Date of Birth (yyyy/mm/dd) | Date of Death (yyyy/mm/dd) |
| <input type="checkbox"/> Other, please specify: | | | |

Part 4: Legal Representation (for the purpose of this application only)

Complete this part only if you have retained a lawyer, agent or paralegal to assist you with your claim before the Board. If you have retained legal representation for another purpose, such as a criminal or civil proceeding, do not complete this part. **If you complete this part, you are authorizing the Board to release information about your claim to your legal representative and all further communication will be made with your legal representative.**

| | | | | |
|----------------------------------|------------|-----------------------------------|---------------|-------------|
| Legal Representative's Last Name | | Legal Representative's First Name | | |
| Name of Law Firm/Legal Clinic | | | | |
| Unit No. | Street No. | Street Name | PO Box | Rural Route |
| City/Town | | Province | Postal Code | Country |
| Telephone No. | | Fax No. | Email Address | |

Part 5: Types of Compensation

This part must be completed to let us know the type of compensation you are seeking. We may award compensation only if the death occurred as a result of a violent crime in the Province of Ontario, while making an arrest or assisting a peace officer with his/her law enforcement duties, or while trying to prevent a crime. Be sure to include all original receipts and supporting documents with your application form.

Please check the appropriate box(es)

- ☐ Funeral and Burial expenses (see Part 9)
- ☐ Bereavement Counselling (see Part 10)
- ☐ Loss of Financial Support (see Part 11)
- ☐ Mental or Nervous Shock (see Part 12)
- ☐ Other expenses/financial losses (see Part 9)
(please specify):

Part 6: Request for Extension If Death Occurred More than Two Years Ago

If you are applying for compensation for a death that occurred more than two years ago, you must first request an extension of the two-year limitation period. Please check "Yes" and explain your reason(s) for the delay in filing. Be sure to complete the rest of the application form. If this application relates to a claimant who is under the age of 20, an extension of the limitation period for filing is not required. In that case, please check "No" and move on to Part 7 of the application. The Board will render its decision on the extension based on written information you provide including the information you have given in the application form.

Did the death occur more than two years ago?

- ☐ No - Proceed to Part 7
- ☐ Yes - Please explain below why you did not submit your application within two years of the death

Part 7: Compensation from Other Sources

Have you received (or will you receive) compensation from any other source in respect of this death? (e.g. Canada Pension Plan benefits, WSIB benefits, life insurance proceeds, estate proceeds, etc.)

- ☐ No
- ☐ Yes - Provide details, specify amount and whether it has been paid:

Have you received any services through the Victim Quick Response Program (VQRP) in respect of this death? (e.g. funeral expenses, counselling, emergency expenses)

- ☐ No
- ☐ Yes - Provide details:

To your knowledge, did any of the deceased person's survivors receive benefits for the funeral expenses?

- ☐ No ☐ Yes (if so, please provide the following information)

| Name of Benefit Provider | Details of Coverage | Name of Beneficiary (who received the funds?) | Amount |
|--------------------------|---------------------|--|--------|
| | | | |
| | | | |

Have you commenced a civil court action against the (alleged) offender?

- ☐ No - Advise whether you intend to do so in the future?
- ☐ Yes - Provide the following information below:

| Court File No. | Court Location | Amount awarded in civil action | Amount you have already received |
|----------------|----------------|--------------------------------|----------------------------------|
| | | | |

Part 8: Details of the Crime

We understand recounting the details of the crime may be difficult. This information is needed so that we can properly assess your claim. If you cannot provide full details, you may record details that have been provided to you by someone else such as a police officer. Documents are key to our assessment of your application. **We are obligated, by law, to make a reasonable attempt to locate and notify the (alleged) offender(s) of your application. If you have concerns about our notification of an (alleged) offender or any disclosure of personal information to the (alleged) offender, you must tell us during the application process.**

| | | | |
|---|---|---|--|
| Date of the crime/incident (yyyy/mm/dd) | Where did the crime/incident occur? (e.g. home, on the street, school, etc) | Provide specific address where the crime/incident occurred (Note: it must have occurred in Ontario to be eligible for compensation) | |
| Time of the crime/incident <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | | Street Address | |
| | | City/Town | |
| | | Province | |

| Date the incident was reported to the police (yyyy/mm/dd) | Name of Police Service(s) and Division Number | Name of Police Officer(s) and Badge Number(s) | Occurrence Number |
|---|--|--|--------------------------|
| | | | |

Were charges laid by the police?

☐ No ☐ Don't Know ☐ Yes - if Yes, what were those charges?

Do you know the outcome of those charges?

☐ No ☐ Yes - if Yes, please indicate ☐ Conviction ☐ Withdrawn
☐ Acquittal ☐ Absolute/Conditional Discharge

Is the police investigation or criminal proceeding ongoing?

☐ No ☐ Yes

(Alleged) Offender Information:

| Name of (Alleged) Offender (first and last name) | Date of Birth (yyyy/mm/dd) | Address | Relationship to Deceased Person (e.g. stranger, friend, spouse, etc.) |
|--|--------------------------------------|----------------|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Details of the Crime:

In the space below, please describe what happened in your own words. If you require additional space, please use the **Additional Information Section (Part 14)**.

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Part 9: Funeral and Related Expense Information (if applicable)

This part should be completed only if you are seeking compensation for funeral and/or burial expenses or other expenses that resulted from the death. You must attach all of the original receipts (or bills if unpaid) to your application. If you are claiming costs for bereavement counselling please see Part 10 below.

| | | |
|--|---------------------------------|--|
| What was the total cost of the funeral? | What amount did you pay? | What amount remains unpaid, if any? |
| \$ | \$ | \$ |

If you did not pay for the funeral, or only paid for part of it, did anyone else contribute? ☐ No ☐ Yes

| Name of Service Provider (e.g. funeral home, cemetery, etc.) | Amount | Has this amount been paid? | Name and address of person who paid for this cost (if applicable) |
|---|--------|---|--|
| | \$ | <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| | \$ | <input type="checkbox"/> No <input type="checkbox"/> Yes | |

Did you (or will you) incur any other expenses or financial losses as a result of the death?

☐ No ☐ Yes - Provide details:

Part 10: Bereavement Counselling (if applicable)

Complete this part only if you are claiming compensation for bereavement counselling as a result of this death. This may include expenses for therapy sessions, native spiritual healing practices, or similar initiatives. If you witnessed or came upon the scene of the crime please see Part 12 as you may be eligible for a "mental or nervous shock claim" instead. Please refer to the guide for additional information.

Are you claiming expenses for bereavement counselling?

☐ No - Proceed to Part 11 ☐ Yes - Provide details below:

Psychiatrist/Psychologist/Counsellor/Therapist

| | | | | | | |
|----------------------------|-----------------------------------|-------------|-------------------------|---------------------|--|-----------------|
| Name of Treatment Provider | | | Name of Practice/Clinic | | Telephone No. | |
| Unit No. | Street No. | Street Name | | PO Box | Rural Route | |
| City/Town | | | Province | Postal Code | Country | |
| Estimated number of visits | | | | Treatment Date(s) ► | From (yyyy/mm/dd) | To (yyyy/mm/dd) |
| What is the hourly rate? | Amount that you have paid to date | | Outstanding balance | | Are you still in treatment? | |
| \$ | \$ | | \$ | | <input type="checkbox"/> No <input type="checkbox"/> Yes | |

Is this expense covered through other sources?

☐ No ☐ Yes - Provide details below:

Part 11: Loss of Financial Support (if applicable)

Complete this part only if you are claiming financial support for yourself or any other dependants of the deceased person. In order to be eligible for this type of compensation, you must be able to establish that you and/or the dependants were being financially supported by the deceased person immediately prior to his/her death. Please refer to the guide for additional information.

Was the deceased person employed at the time of his/her death?

- ☐ No
☐ Yes - Provide details below:

| | | | | | |
|------------------|------------|-------------|-------------|---------------|--|
| Name of Employer | | | | Telephone No. | |
| Unit No. | Street No. | Street Name | PO Box | Rural Route | |
| City/Town | | Province | Postal Code | Country | |

If the deceased person was not employed, what was his/her source of income at the time of his/her death?

Was the deceased person financially supporting you at the time of his/her death?

- ☐ No ☐ Yes - What amount did you receive each month? \$ _____

Are you receiving Canada Pension Plan survivor's pension or WSIB benefits as a result of this death?

- ☐ No ☐ Yes - What are your monthly payments? \$ _____

Dependent Children

Do you have guardianship of any children who were being financially supported by the deceased person at the time of his/her death?

- ☐ No ☐ Yes - Provide details below:

| Child's Last Name | Child's First Name | Child's Date of Birth (yyyy/mm/dd) | Your Relationship to the Child | Child's Relationship to the Deceased Person |
|-------------------|--------------------|---------------------------------------|-----------------------------------|--|
| | | | | |
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To your knowledge, are the children receiving any other funds or benefits as a result of this death? (e.g. Canada Pension Plan children/ orphan benefits, WSIB benefits, estate proceeds, life insurance proceeds).

- ☐ No ☐ Yes - Provide details and specify the amount(s) of their monthly payments:

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Part 12: Mental or Nervous Shock Claim (if applicable)

Complete this part only if you are seeking compensation for the injury known as mental or nervous shock. This is a legal term that describes situations where someone has a significant psychological injury caused by witnessing or coming upon the scene of the crime that resulted in the death. This is not the same as shock, grief, sorrow and extreme sadness associated with the loss of a loved one, even under tragic and unexpected circumstances. Evidence of psychological injury is critical to the Board's assessment. Please refer to the guide for additional information.

Please check the appropriate box(es) for the type of compensation you are seeking in respect of your claim for mental or nervous shock

- | | |
|---|--|
| <input type="checkbox"/> Medical expenses | <input type="checkbox"/> Pain and suffering award |
| <input type="checkbox"/> Treatment expenses | <input type="checkbox"/> Loss of wages/income |
| <input type="checkbox"/> Travel to treatment expenses | <input type="checkbox"/> Other expenses/financial losses (please specify): |
- _____

Please describe what you saw when you witnessed the crime or came upon the scene of the crime.

Details of Injury

In the space below, please list your psychological injuries, the type of treatment you received, if any, details of your recovery and your current condition. If you require additional space, please use the Additional Information section (Part 14).

Details of Treatment

Please provide information about the professionals who treated you as a direct result of your injury for mental or nervous shock. If you require additional space, please use the Additional Information section (Part 14).

Psychiatrist/Psychologist/Counsellor/Therapist

| | | | | | | |
|------------------------------------|------------|---------------------|-------------------------|-----------------|---|--|
| Name of Primary Treatment Provider | | | Name of Practice/Clinic | | Telephone No. | |
| Unit No. | Street No. | Street Name | | PO Box | Rural Route | |
| City/Town | | | Province | Postal Code | Country | |
| Estimated number of visits | | Treatment Date(s) ► | From (yyyy/mm/dd) | To (yyyy/mm/dd) | Are you still in treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes | |

Psychiatrist/Psychologist/Counsellor/Therapist

| | | | | | | |
|----------------------------------|------------|---------------------|-------------------------|-----------------|---|--|
| Name of Other Treatment Provider | | | Name of Practice/Clinic | | Telephone No. | |
| Unit No. | Street No. | Street Name | | PO Box | Rural Route | |
| City/Town | | | Province | Postal Code | Country | |
| Estimated number of visits | | Treatment Date(s) ► | From (yyyy/mm/dd) | To (yyyy/mm/dd) | Are you still in treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes | |

Part 13: Other People Who May Apply for Compensation

Please provide the following information as we will give consideration to the total number of potential family members who could apply to assess the amount of financial compensation available to each of them. We will assess compensation for bereavement counselling for family members after claims for funeral expenses and loss of support for the dependants of the deceased person have been assessed and paid out.

Please provide details for anyone else you believe may apply to the Board for compensation with respect to this crime. If you require additional space, please use the Additional Information section (Part 14).

| Name (first and last name) | Address | Telephone Number | Relationship to Deceased Person (e.g. spouse, child, mother, etc.) |
|--------------------------------------|----------------|-----------------------------|--|
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Part 14: Additional Information (if applicable)

This image shows a full page of blank, lined paper. It features approximately 20 evenly spaced horizontal grey lines across the entire width of the page, providing a guide for writing. The background is a solid off-white color. There are no margins, text, or other markings present.

Part 15: Agreement and Authorization for Release of Information

Please read this part carefully. There are certain conditions that apply when a person makes an application for and receives compensation. It is important that you are aware of these conditions. Your signature below shows that you have read, understood and agreed to what is listed below.

1. For the purpose of this application, **I The Undersigned**, hereby consent and authorize:
 - all hospitals, treatment facilities, health and medical practitioners from whom I received treatment, or that will be providing future treatment, to provide the Board at its request with information as to my injuries and treatment and to provide the Board with relevant information regarding the deceased person;
 - the Police to provide the Board at its request with relevant information;
 - correctional facilities, law enforcement and security agencies for public and private institutions/organizations to provide the Board at its request with relevant information;
 - the Workplace Safety and Insurance Board, Canada Employment Insurance Commission, Canada Revenue Agency, Canada Pension Plan and/or any other authority from which I may receive payments from Provincial or Federal funds to provide the Board at its request with relevant information;
 - my employer(s), my union, Canada Revenue Agency and any other authority to provide the Board at its request with information as to my earnings, income, and any benefits received or receivable;
 - all accident, sickness, or life insurance companies, or private pension schemes from which I have received or will receive payments, or other benefits, to provide the Board at its request with relevant information;
 - the Victim Quick Response Program to provide the Board with information regarding services reimbursed through its program.
2. **I Understand that:** (a) the Board may notify the authorities mentioned above that I have submitted an application and may also inform them of the Board's decision; (b) any information submitted to the Board is subject to the *Freedom of Information and Protection of Privacy Act* and the *Statutory Powers Procedure Act*; (c) it is my responsibility to inform the Board of any change in my address and that my claim may be dismissed following a period of time if the Board is unable to contact me; (d) my failure to cooperate with law enforcement (police, Crown, criminal court) may result in the denial of my claim; (e) if the deceased victim's behaviour contributed directly or indirectly to the circumstances that resulted in his/her death, this may result in the denial of my claim or affect the amount of compensation I receive; (f) payment by the **Board** is a payment of last resort and as such, I hereby agree, within a reasonable time period, to notify the Board in the event that benefits and/or other funds become available to me as compensation for this injury or death.
3. **I Agree to:** (a) give the Board all necessary assistance with respect to the above-noted matters; (b) notify the Board of any change in circumstances that may affect the assessment of my compensation; (c) repay the Board if payments are received from the (alleged) offender (restitution or civil action), insurance, WSIB, or any other government or private agency as compensation for this injury or death after receipt of payment from the Board.
4. **I Certify that:** all the above statements contained in my application are true to the best of my knowledge and belief. If you have any questions, please contact this office at 416 326-2900 or toll free at 1 800 372-7463 or visit our website at www.sjto.gov.on.ca/cicb for additional information.

The personal information on this form is collected under the authority of the *Compensation for Victims of Crime Act*, R.S.O. 1990, c.C.24. The principle purpose for which this information will be used is to make a determination of eligibility for an amount of compensation. Please be advised that any information submitted to the Board is subject to the *Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. F.31 and the *Statutory Powers Procedure Act*, R.S.O. 1990, c. S.22. Any questions regarding the collection of personal information should be directed to the Freedom of Information Coordinator, at the Criminal Injuries Compensation Board, 655 Bay Street, 14th Floor, Toronto, ON M7A 2A3, Telephone: 416 326-2900 or Toll Free: 1 800 372-7463.

Submission Options: Choose one of the following options to submit this form

Option 1 - Email

☐ By checking this box and typing my name below, I certify that all information on this form is true and correct. I also agree that the checkbox and my name typed below are to be used as my electronic signature.

| Last Name | First Name | Middle Initial |
|-----------|------------|----------------|
| | | |

Option 2 - Fax/Mail - If you are submitting the completed form by fax or mail, please sign and date below.

| Signature | Date (yyyy/mm/dd) |
|-----------|-------------------|
| X | |