Société de l'assurance automobile Québec

Avec vous, au cœur de votre sécurité

Claim for Compensation for Accident-Related Expenses

Claim number | **Page** 1/4

Accident Victim

1

Québec driver's licence number | Social insurance number | Health insurance number

Last name at birth | Sex ☐ Female ☐ Male

First name | Date of birth Year Month Day

Last name if different from last name at birth

Civil status at the time of the accident ☐ Married or in a civil union ☐ In a de facto union ☐ Single ☐ Widowed ☐ Divorced ☐ Legally separated ☐ Separated (de facto separation)

Language of correspondence ☐ French ☐ English

Accident Victim's Address

2

Street number | Street name | Apartment | P.O. box

Municipality | Province or state

Country | Postal code

Telephone (main) | Extension | Telephone (secondary) | Extension

Accident

3

Date and time of the accident Year Month Day Hour : Minute ☐ AM ☐ PM

You were: ☐ The driver ☐ A passenger ☐ A pedestrian ☐ A cyclist

If you were the driver or a passenger, what type of vehicle were you in?

☐ Car, SUV, minivan ☐ Truck ☐ Bus ☐ Motorcycle ☐ Moped, motorized scooter ☐ Other, specify:

Licence plate number of the vehicle you were in | Province, state or country in which the vehicle you were in was registered

Location of the accident (Municipality) | If outside Québec, indicate the province, state or country

Was a vehicle registered outside Québec involved in the accident? ☐ Yes ☐ No ☐ Do not know

4

Please give a full, detailed account of all the facts relating to the accident. *(If space is insufficient, use a separate sheet.)*

5

Was an accident report drawn up by a police officer? ☐ Yes ▶ Accident report number (if known) ☐ No ☐ Do not know

If the accident occurred **outside Québec**, submit a copy of the accident report, if you have one.

Was a joint report of the accident drawn up? ☐ Yes ***(Enclose a copy.)*** ☐ No ☐ Do not know

If there was no accident report or joint report, was there a witness to the accident to whom we could speak? ☐ Yes ☐ No

Last name of witness

First name | Telephone

6

Did the traffic accident occur:

- while you were working? ☐ Yes ☐ No
- while someone was carrying out a criminal act? ☐ Yes ☐ No
- while assisting a person in distress? ☐ Yes ☐ No

DI

Injuries

7 Did you sustain injuries (physical or psychological) as a result of the accident? ☐ Yes ☐ No
Have you recovered? ☐ Yes ☐ No

Please describe your injuries. If a physician or a specialized nurse practitioner completed the *Initial Report* form, please send it to us.
(If space is insufficient, use a separate sheet.)

8 After the accident, you

☐ consulted a physician?
☐ consulted another health care professional? Specify:

☐ did not consult any health care professionals.
☐ Check this box if you intend to obtain medical follow-up for your injuries. ***(If you think you need to consult a health care professional, do not wait to do so.)***

First medical consultation (Year / Month / Day)
Name of the physician or other health care professional consulted
Name of the health care facility
Municipality

9 Did the injuries sustained in the accident render you unable to perform your usual activities for seven or more days after the accident?

☐ Yes ▶ Complete the appendices (pages 5 to 8). If these appendices are not included with your form, you can either go on our website, open the *Claim for Compensation for an Inability to Perform Activities and for Accident-Related Expenses* form and print the appendices, or call us at 1-800-361-7620.
☐ No

Have the injuries rendered you unable to take care of children or a disabled person?

☐ Yes ▶ Date your disability period began: (Year / Month / Day)
☐ No

Date you expect to resume your activities: (Year / Month / Day)

Resident Status (Consult the guide as needed.)

10 At the time of the accident, did you own a vehicle registered in Québec?
☐ Yes ▶ Licence plate number
☐ No

Did you live outside Québec at any point during the twelve months prior to the accident?
☐ Yes ▶ from (Year / Month / Day) to (Year / Month / Day)
☐ No
Municipality
Province, state or country

If **"Yes"**:

- Did you maintain a permanent home in Québec? ☐ Yes ▶ Municipality ☐ No
- If you stayed longer than six months outside Québec, give the reason(s) for this extended stay:

Did you have Canadian citizenship at the time of the accident?
☐ Yes
☐ No ▶ Citizenship

Pension, Benefits, Indemnities, Compensation or Allowance Received from Another Organization (Consult the guide as needed.)

11 At the time of the accident, were you receiving a full or reduced pension or benefits, indemnities, compensation or an allowance from another organization (examples: ministère de l'Emploi et de la Solidarité sociale, CNESST, Retraite Québec, etc.)? ☐ Yes ▶ Name of the organization ☐ No

Reimbursement of Expenses*

12 ***Enclose your bills or receipts for all expenses you are claiming for the replacement of items damaged in the accident. Be sure to write your claim number on each bill or receipt.***

Were any of the following items damaged in the accident?

☐ Prescription eyeglasses ☐ Contact lenses

☐ Prostheses or orthoses ▶ Specify: _____

☐ Clothes ▶ Specify: _____

13 Check off the expenses you incurred or expect to incur as a result of the accident (consult the guide as needed):

☐ Child care or care of a disabled person
☐ Personal home assistance (housekeeping, meal preparation, personal hygiene)
☐ Availability allowance (if you need to be accompanied when you receive medical treatment or go to medical appointments)
☐ Physical or psychological treatments that you have been **prescribed**
☐ Other ▶ Specify: _____

☐ Medication ▶

Automated reimbursement of the cost of medication directly at the pharmacy

As soon as the eligibility of your *Claim for Compensation* has been established, you can receive your medication at the pharmacy **without having to pay** for it up front.

- ▶ If you wish to take advantage of this service, you must have entered your health insurance number in Section 1.
- ▶ The SAAQ will contact you to let you know how to use this service.

14 Did you incur travel expenses (transportation, lodging, meals) in order to receive treatment or medical care? ☐ Yes ☐ No ▶ ***If "No", proceed to Section 15.***

If "**Yes**", please provide the information requested below.

Keep your bills and receipts for three years so that you can provide them to us upon request.

Trip date Year	Month	Day	**Round-trip distance in km** (if automobile)	**Means of transportation or parking fees**	**Amount claimed** ($)	**Lodging, meals**	**Medical consultation** Location	Reason

Signature of the Claim for Compensation

15 **Note: No compensation can be paid if this claim is not signed.**

Certification

I certify that the information provided on this claim form is accurate and complete.

Signature of the accident victim (if of legal age) or their representative.

X

Date Year Month Day

If you are signing this claim form as the accident victim's authorized representative, please indicate in what capacity you are acting and provide the additional information requested below.

☐ Father, mother or parent of a minor ☐ Dative tutor (*Enclose a copy of the judgment.*) ☐ Other, specify:

☐ Mr. ☐ Ms. | Last name of the representative | First name

Address (if it is different from that of the accident victim) Street number | Street name | Apartment | P.O. box

Municipality | Province or state

Country | Postal code

Telephone (main) | Extension | Telephone (secondary) | Extension

Consent to the Collection and Disclosure of Personal and Medical Information (Consult the guide as needed.)

16 For the purpose of analyzing your compensation claim, the SAAQ requires your consent to the collection and disclosure of your personal information and medical data.

Accident victim's last name at birth

First name

Last name if different from last name at birth

Health insurance number

Authorization to convey medical information to an attending physician or other health care professional

In the event that further information is required in order to establish my entitlement to compensation and determine the amount thereof, I hereby authorize the Société de l'assurance automobile du Québec (SAAQ), in accordance with section 83.17 of the *Automobile Insurance Act*, to obtain any such information from organizations that can provide it to the SAAQ, such as the Retraite Québec, the Commission des normes, de l'équité, de la santé et de la sécurité du travail, the Régie de l'assurance maladie du Québec and the ministère de l'Emploi et de la Solidarité sociale.

This consent is valid until the compensation claim has been processed, unless it is withdrawn in writing.

Under articles 2840 and 2841 of the *Civil Code of Québec*, a photocopy or scanned reproduction of this authorization is as valid as the original.

Signature of the accident victim (if of legal age) or their representative

X

Date Year Month Day

Direct Deposit (Consult the guide as needed.)

17 Only complete this section if you want to register for direct deposit.

Are you the sole holder of this account? ☐ Yes ☐ No

Branch number | Institution number | Account number

These numbers are shown on your cheques. If you do not have any cheques, your institution can provide an equivalent document providing this information.

Name of the financial institution

I authorize the Société de l'assurance automobile du Québec (SAAQ) to deposit into the above-mentioned account the payments it makes to me. I also authorize the SAAQ to convey the information required to make such deposits to the financial institution indicated above.

Signature of the accident victim (if of legal age) or their representative

X

Date Year Month Day

Remember to enclose a cheque marked "VOID". Do not staple your cheque to your *Claim for Compensation*.

Protection of Personal Information

The SAAQ only collects personal information that is necessary for it to exercise its powers and apply the laws it administers. All personal information gathered by authorized personnel is handled confidentially. This information may be shared with its licensing agents and certain government departments or agencies, including those located outside Québec, in accordance with the *Act respecting Access to documents held by public bodies and the Protection of personal information*. It may also be used for statistical, survey, study, audit or investigative purposes. Failure to provide this information can result in a refusal of service. You may consult, correct or obtain a copy of any personal information concerning you.

For more information, consult the Policy on Privacy on the SAAQ's website at saaq.gouv.qc.ca/confidentialite or contact the SAAQ's call centre.

THERE ARE THREE WAYS TO SUBMIT A DOCUMENT: Through the Reimbursement of Expenses and Document

Submission online service: saaq.gouv.qc.ca/envoidocuments
By fax: 1-866-289-7952
By mail: Société de l'assurance automobile du Québec
Case postale 2500, succursale Terminus
Québec (Québec) G1K 8A2

Keep the original or a copy for your files.