Société de l'assurance automobile Québec

Avec vous, au cœur de votre sécurité

Claim for Death Benefits

Claim number | **Page** 1/9

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 ☐ Widowed ☐ Legally separated ☐ Single ☐ Divorced ☐ 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

The accident victim was: ☐ The driver ☐ A passenger ☐ A pedestrian ☐ A cyclist

If the accident victim was the driver or a passenger, what type of vehicle were they in?

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

Licence plate number of the vehicle occupied by the accident victim

Province, state or country in which the vehicle occupied by the accident victim 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

Give a brief account of the facts relating to the accident.

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.

6

Did the traffic accident occur:

- while the accident victim was working? ☐ Yes ☐ No
- while someone was carrying out a criminal act? ☐ Yes ☐ No
- while assisting a person in distress? ☐ Yes ☐ No

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.

DD

Injuries

7 Please describe, in your own words, the injuries the accident victim sustained in the accident and that led to their death.
Enclose a copy of the document from the physician or coroner describing the cause(s) of death.

Please enter the date and time of death: Year | Month | Day | Hour : Minute ☐ AM ☐ PM **Enclose a copy of the death certificate issued by the funeral home or the Directeur de l'état civil.**

Name of the hospital where the accident victim was taken after the accident

Municipality in which that hospital is located

Resident Status

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

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

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

Pension, Benefits, Indemnities, Compensation or Allowance Received from Another Organization

9 At the time of the accident, was the accident victim (or the person who was supporting the accident victim) receiving a full or reduced pension or benefits, indemnities, compensation or an allowance from another organization (Ministère de l'Emploi et de la Solidarité sociale, CNESST, Retraite Québec, etc.)? ☐ Yes ▶ Name of the organization ☐ No

Availability Allowance and Reimbursement of Expenses

10 **See page 12 of the guide to find out if you or someone else is entitled to an availability allowance or reimbursement**

Are you (or is someone else) claiming an availability allowance or the reimbursement of accident-related expenses? ☐ Yes ▶ ***Enclose supporting documents.*** ☐ No

Accident Victim's Spouse*

11 *** Spouses may be of the same or opposite sex.**

At the time of death, did the accident victim have a spouse?
☐ Yes ☐ No ▶ ***If "No", proceed to Section 13.***

The accident victim was:
☐ Legally married **(enclose a copy of the marriage certificate)** or in a civil union ☐ In a de facto union ▶ Since: Year Month

At the time of the accident,
- had a child been born of this union? ☐ Yes ☐ No
- was a child to be born of this union? ☐ Yes ☐ No
- had a child been adopted by the accident victim and their spouse? ☐ Yes ☐ No
- had a child of one spouse been adopted by the other spouse? ☐ Yes ☐ No

If "**Yes**", enclose a copy of the adoption judgment.

Spouse's last name at birth

First name

Sex ☐ Female ☐ Male

Date of birth Year Month Day

Health insurance number

Were the accident victim and their spouse living together at the time of the accident? Year Month
☐ Yes ☐ No ▶ If "**No**", the spouse had been living at the address below since:

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

Municipality | Province or state

Country | Postal code

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

12 Is the spouse disabled?
☐ Yes ☐ No If "**Yes**", submit a copy of the medical report attesting to the spouse's disability if the accident victim was under 45 years of age.

Accident Victim's Former Spouse*

13 *** Former spouses may be of the same or opposite sex.**

At the time of death, did the accident victim have a former spouse? ☐ Yes ▶ ***Enclose a copy of the official divorce judgment or separation order.***
☐ No ▶ ***Proceed to Section 15.***

At the time of death, was the accident victim paying or required to pay spousal support **(excluding child support)** in accordance with a judgment or an agreement? ☐ Yes ▶ ***Enclose a copy of the official document stating the amount.***
☐ No

Former spouse's last name at birth | Sex ☐ Female ☐ Male

First name | Date of birth Year Month Day

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

Municipality | Province or state

Country | Postal code

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

14 Is the former spouse disabled?
☐ Yes ☐ No If "**Yes**", enclose a copy of the medical report attesting to the former spouse's disability.

Dependants

15 Did the accident victim have any dependants at the time of the accident? ☐ Yes ☐ No ▶ ***If "No", proceed to Section 16.***

For every child or other dependant of the accident victim at the time of the accident, please provide the information requested below and enclose a copy of the dependant's birth certificate issued by the Directeur de l'état civil and bearing the names of the dependant's mother, father or parent.

1. Last name | Sex ☐ Female ☐ Male | Date of birth Year Month Day

First name | Health insurance number

Relationship to the accident victim ☐ Biological child ☐ Spouse's child ☐ Other, specify:

Level of education in progress
☐ Elementary ☐ High School ▶ ☐ General ☐ Vocational ☐ CEGEP ☐ University ▶ For dependants who were 18 years of age or older, have **Schedule 4 D – *Attestation of School Attendance*** filled out.

Gross annual employment income and income from social assistance payments, employment insurance benefits, etc. **$**

Did the accident victim: • provide care for this person? ☐ Yes ☐ No
• have financial responsibility for this person? ☐ Yes ☐ No

Does this person have a disability? ☐ Yes ☐ No ▶ If **"Yes"**, enclose a copy of the medical report attesting to the person's disability.
Was this person living with the accident victim? ☐ Yes ☐ No ▶ If **"No"**, enter the dependant's address below.

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

Municipality | Province or state

Country | Postal code

2. Last name | Sex ☐ Female ☐ Male | Date of birth Year Month Day

First name | Health insurance number

Relationship to the accident victim ☐ Biological child ☐ Spouse's child ☐ Other, specify:

Level of education in progress
☐ Elementary ☐ High School ▶ ☐ General ☐ Vocational ☐ CEGEP ☐ University ▶ For dependants who were 18 years of age or older, have **Schedule 4 D – *Attestation of School Attendance*** filled out.

Gross annual employment income and income from social assistance payments, employment insurance benefits, etc. **$**

Did the accident victim: • provide care for this person? ☐ Yes ☐ No
• have financial responsibility for this person? ☐ Yes ☐ No

Does this person have a disability? ☐ Yes ☐ No ▶ If **"Yes"**, enclose a copy of the medical report attesting to the person's disability.
Was this person living with the accident victim? ☐ Yes ☐ No ▶ If **"No"**, enter the dependant's address below.

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

Municipality | Province or state

Country | Postal code

3. Last name | Sex ☐ Female ☐ Male | Date of birth Year Month Day

First name | Health insurance number

Relationship to the accident victim ☐ Biological child ☐ Spouse's child ☐ Other, specify:

Level of education in progress
☐ Elementary ☐ High School ▶ ☐ General ☐ Vocational ☐ CEGEP ☐ University ▶ For dependants who were 18 years of age or older, have **Schedule 4 D – *Attestation of School Attendance*** filled out.

Gross annual employment income and income from social assistance payments, employment insurance benefits, etc. **$**

Did the accident victim: • provide care for this person? ☐ Yes ☐ No
• have financial responsibility for this person? ☐ Yes ☐ No

Does this person have a disability? ☐ Yes ☐ No ▶ If **"Yes"**, enclose a copy of the medical report attesting to the person's disability.
Was this person living with the accident victim? ☐ Yes ☐ No ▶ If **"No"**, enter the dependant's address below.

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

Municipality | Province or state

Country | Postal code

Dependants (continued)

15

4. Last name | Sex ☐ Female ☐ Male | Date of birth Year Month Day

First name | Health insurance number

Relationship to the accident victim ☐ Biological child ☐ Spouse's child ☐ Other, specify:

Level of education in progress
☐ Elementary ☐ High School ▶ ☐ General ☐ Vocational ☐ CEGEP ☐ University
For dependants who were 18 years of age or older, have **Schedule 4 D – *Attestation of School Attendance*** filled out.

Gross annual employment income and income from social assistance payments, employment insurance benefits, etc. **$**

Did the accident victim:
- provide care for this person? ☐ Yes ☐ No
- have financial responsibility for this person? ☐ Yes ☐ No

Does this person have a disability? ☐ Yes ☐ No ▶ If **"Yes"**, enclose a copy of the medical report attesting to the person's disability.
Was this person living with the accident victim? ☐ Yes ☐ No ▶ If **"No"**, enter the dependant's address below.

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

Municipality | Province or state

Country | Postal code

5. Last name | Sex ☐ Female ☐ Male | Date of birth Year Month Day

First name | Health insurance number

Relationship to the accident victim ☐ Biological child ☐ Spouse's child ☐ Other, specify:

Level of education in progress
☐ Elementary ☐ High School ▶ ☐ General ☐ Vocational ☐ CEGEP ☐ University
For dependants who were 18 years of age or older, have **Schedule 4 D – *Attestation of School Attendance*** filled out.

Gross annual employment income and income from social assistance payments, employment insurance benefits, etc. **$**

Did the accident victim:
- provide care for this person? ☐ Yes ☐ No
- have financial responsibility for this person? ☐ Yes ☐ No

Does this person have a disability? ☐ Yes ☐ No ▶ If **"Yes"**, enclose a copy of the medical report attesting to the person's disability.
Was this person living with the accident victim? ☐ Yes ☐ No ▶ If **"No"**, enter the dependant's address below.

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

Municipality | Province or state

Country | Postal code

6. Last name | Sex ☐ Female ☐ Male | Date of birth Year Month Day

First name | Health insurance number

Relationship to the accident victim ☐ Biological child ☐ Spouse's child ☐ Other, specify:

Level of education in progress
☐ Elementary ☐ High School ▶ ☐ General ☐ Vocational ☐ CEGEP ☐ University
For dependants who were 18 years of age or older, have **Schedule 4 D – *Attestation of School Attendance*** filled out.

Gross annual employment income and income from social assistance payments, employment insurance benefits, etc. **$**

Did the accident victim:
- provide care for this person? ☐ Yes ☐ No
- have financial responsibility for this person? ☐ Yes ☐ No

Does this person have a disability? ☐ Yes ☐ No ▶ If **"Yes"**, enclose a copy of the medical report attesting to the person's disability.
Was this person living with the accident victim? ☐ Yes ☐ No ▶ If **"No"**, enter the dependant's address below.

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

Municipality | Province or state

Country | Postal code

If there were other dependants, please provide the same information about them on a separate sheet of paper and enclose it with this form. Be sure to indicate the claim number shown above at the top of each additional sheet of paper.

Accident Victim's Parents

Provide the information requested below if the accident victim was under 18 years of age when the accident occurred and had no spouse or dependants. Enclose a copy of the accident victim's birth certificate issued by the Directeur de l'état civil and bearing the names of the accident victim's mother, father or parent.

16 Accident victim's parent*

Sex
☐ Female
☐ Male

☐ Biological or adoptive father/mother/parent
☐ Person standing in place of a father/mother/parent ▶ since: Year Month Day
☐ No one standing in place of a father/mother/parent

If the accident victim's biological parent is deceased, enter the date of death and enclose a copy of the death certificate. Year Month Day

Last name

First name

Was this person living with the accident victim? ☐ Yes ☐ No ▶ If **"No"**, enter this person's address below.

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

Municipality | Province or state

Country | Postal code

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

Accident victim's parent*

Sex
☐ Female
☐ Male

☐ Biological or adoptive father/mother/parent
☐ Person standing in place of a father/mother/parent ▶ since: Year Month Day
☐ No one standing in place of a father/mother/parent

If the accident victim's biological parent is deceased, enter the date of death and enclose a copy of the death certificate. Year Month Day

Last name

First name

Was this person living with the accident victim? ☐ Yes ☐ No ▶ If **"No"**, enter this person's address below.

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

Municipality | Province or state

Country | Postal code

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

Accident victim's parent*

Sex
☐ Female
☐ Male

☐ Biological or adoptive father/mother/parent
☐ Person standing in place of a father/mother/parent ▶ since: Year Month Day
☐ No one standing in place of a father/mother/parent

If the accident victim's biological parent is deceased, enter the date of death and enclose a copy of the death certificate. Year Month Day

Last name

First name

Was this person living with the accident victim? ☐ Yes ☐ No ▶ If **"No"**, enter this person's address below.

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

Municipality | Province or state

Country | Postal code

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

*Parents may be of the same or opposite sex.

If one of the parents has been divested of parental authority, enclose a copy of the court order.

Accident Victim's Parents (continued)

Provide the information requested below if the accident victim was under 18 years of age when the accident occurred and had no spouse or dependants. Enclose a copy of the accident victim's birth certificate issued by the Directeur de l'état civil and bearing the names of the accident victim's mother, father or parent.

16 Accident victim's parent*

Sex
☐ Female
☐ Male

☐ Biological or adoptive father/mother/parent
☐ Person standing in place of a father/mother/parent ▶ since: Year Month Day
☐ No one standing in place of a father/mother/parent

If the accident victim's biological parent is deceased, enter the date of death and enclose a copy of the death certificate. Year Month Day

Last name

First name

Was this person living with the accident victim? ☐ Yes ☐ No ▶ If **"No"**, enter this person's address below.

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

Municipality | Province or state

Country | Postal code

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

*Parents may be of the same or opposite sex.

If one of the parents has been divested of parental authority, enclose a copy of the court order.

Signature of the Claim for Death Benefits

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

Signature of the accident victim's representative
X
Date Year Month Day

Please indicate in what capacity you are acting and provide the additional information requested below.

☐ Spouse ☐ Father/mother/parent ☐ Administrator of the succession ☐ Notary ☐ Attorney ☐ Other, specify:

☐ Mr. ☐ Ms. | Representative's last name | 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 | Telephone (other)

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.

Direct Deposit (Consult the guide as needed.)

18 **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 person claiming death benefits
X
Date Year Month Day

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

See part 3 of the guide to find out if you must provide the information requested below.

A Was the accident victim employed at the time of the accident? ☐ Yes ☐ No ▶ ***If "No", proceed to Section B.***

Provide the information requested below for each position held at the time of the accident.

Name of the employer or business | Telephone

Start date (Year, Month, Day) | Scheduled end date (if applicable) (Year, Month, Day) | Type of employment: ☐ Full-time ☐ Part-time ☐ Temporary ☐ Other, specify: | Number of hours worked per week:

Job title

Employment status ☐ Salaried ▶ Have **Schedule 2 – *Attestation of Income by the Employer*** and **Schedule 6 – *Job Description*** filled out.
☐ Self-employed ▶ **Please provide the following documents for the three previous years:**

– if the accident victim resided in Québec:

- their Québec income tax return,
- their notice of assessment,
- form TP-80-V (*Business or Professional Income and Expenses*) **or** a statement of income and expenses;

– if the accident victim resided in Canada (outside Québec)**:**

- their federal income tax return,
- their notice of assessment,
- form T2125 (*Statement of Business or Professional Activities*) **or** a statement of income and expenses;

– if the accident victim did not reside in Canada:

- any official document attesting to self-employment income that is required by the fiscal authority of the country or territory concerned (equivalent to Revenu Québec or the Canada Revenue Agency).

If space is insufficient, please provide the additional information on a separate sheet of paper and enclose it with this form.
Be sure to indicate the claim number shown above at the top of each additional sheet of paper.
Have Schedule 2 and Schedule 6 filled out by each employer (make photocopies of Schedule 2 and Schedule 6 if need be).

B At the time of the accident:

- Was the accident victim registered as a full-time student in an educational program? ☐ Yes ☐ No ▶ If the accident victim was 16 years of age or older, have **Schedule 4 D – *Attestation of School Attendance*** filled out.
- Was the accident victim working without pay in a family business? ☐ Yes ☐ No

At the time of the accident, had an employer guaranteed the accident victim employment?

☐ Yes ▶ Name of the employer or business | Telephone
☐ No

Please request a *Confirmation of Hiring* form.

C At the time of the accident, was the accident victim already unable to work? ☐ Yes ☐ No ▶ ***If "No", proceed to Section D.***

The accident victim was unable to work: ☐ Temporarily? ☐ Permanently? ▶ Since: Year Month Day

Describe the accident victim's illness or disability prior to the accident.

D At the time of the accident, the accident victim was:

☐ the recipient of compensation or indemnities from the Commission des normes, de l'équité, de la santé et de la sécurité du travail. ▶ File number: _____

☐ the recipient of a disability pension from Retraite Québec.

☐ the recipient of a disability pension from another organization. ▶ Specify: _____

☐ not receiving any pension, compensation or indemnities.

E **If the accident victim had not held full-time employment for over a year when the accident occurred, you must provide the information requested below.**

Education

Please circle the last level completed.

Elementary 1 2 3 4 5 6 7
High School 1 2 3 4 5
CEGEP 1 2 3
University Undergraduate Master's Doctorate

Date full-time studies ended: Year Month

Diploma(s) obtained and field(s) of study: _____

In the five years before the accident, were there periods when:

- the accident victim's main occupation was taking care of a child under six years of age without pay? ☐ Yes ☐ No ▶ from: Year Month to: Year Month
- the accident victim was unable to hold a job due to illness, an accident, etc.? ☐ Yes ☐ No ▶ from: Year Month to: Year Month Reason(s)

from: Year Month to: Year Month

from: Year Month to: Year Month

- Did the accident victim hold any certificates of qualification or professional licences? ☐ Yes ☐ No If "**Yes**", specify: _____
- Was the accident victim a member of a professional corporation? ☐ Yes ☐ No If "**Yes**", specify: _____