



Avec vous,  
au cœur de votre sécurité

Claim Number

**Student**

To be filled out by the claimant

Student's last name (accident victim or dependant, as applicable)

First name

Address  
Street number Street name

Apartment

P.O. box Municipality

Province or state

Country

Postal code

Accident victim's last name at birth

First name

Date of the accident  
Year Month Day

**Studies**

To be filled out by the educational institution

Name of the educational institution

Address  
Street number Street name

P.O. box Municipality

Province or state

Country

Postal code

Please circle the level at which the student was enrolled at the time of the accident.

Secondary 1 2 3 4 5

University Undergraduate Master's Doctorate

College 1 2 3

**Declaration**

Was the person identified above enrolled at your educational institution at the time of the accident?  Yes  No

If so, indicate the program in which the student was enrolled and check the appropriate box to specify whether the student  Full-time  Part-time had full-time or part-time status.

Start date  
Year Month Day

Scheduled date of completion  
Year Month Day

Number of courses per week: \_\_\_\_\_ Number of hours of instruction per week: \_\_\_\_\_

Signature of the institutional authority

Date  
Year Month Day

**X**

Name of the institutional authority (please print)

Title or position

Telephone

Extension

Seal of the institution



**THERE ARE THREE WAYS TO SUBMIT A DOCUMENT: Through the Reimbursement of Expenses and Document Submission online service: [saaq.gouv.qc.ca/enviordocuments](http://saaq.gouv.qc.ca/enviordocuments)**

**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.*

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