Société de l'assurance automobile
Québec

Claim for Compensation — for an Inability to Perform Activities and for Accident-Related Expenses

Claim Number | Page 1/8

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)

Present 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

Daytime telephone (main) | Extension | Daytime telephone (secondary) | Extension

Accident

3

Date and time of 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 accident (municipality)

If outside Québec, indicate the province, state or country

Was a vehicle registered outside Québec involved in the accident? ☐ Yes ☐ No ☐ Don't 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 ☐ Don't 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 ☐ Don't 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 | Telephone

First name

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

DO NOT WRITE HERE

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 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 more than seven days, including the day of 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 Web site, 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 1 888 810-2525.

☐ No

Have the injuries rendered you unable to take care of children or a disabled person? ☐ Yes ▶ ☐ No

Date your disability period began — Year / Month / Day

Date you expect to resume your activities — Year / Month / Day

Resident Status (see the guide)

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

Licence plate number

Did you live outside Québec at any point during the twelve months prior to the accident? ☐ Yes ▶ ☐ No

From — Year / Month / Day — To — Year / Month / Day

Municipality

Province or state/country

If **"Yes"**

- Did you maintain a permanent home in Québec? ☐ Yes ▶ ☐ No

Municipality

- If you stayed longer than six months outside Québec, give the reason(s) for your extended stay:

Were you a Canadian citizen at the time of the accident? ☐ Yes ☐ No ▶

Citizenship

Pension, Benefits, Indemnities, Compensation or Allowance Received from Another Body (see the guide)

11 At the time of the accident, were you receiving a full or reduced pension, or benefits, indemnities, compensation or an allowance from another body (Ministère du Travail, de l'Emploi et de la Solidarité sociale, CNESST, Retraite Québec, etc.)?

☐ Yes ▶ Name of body
☐ No

Reimbursement of Expenses*

12 Were any of the following items damaged in the accident?

☐ Prescription eyeglasses ☐ Contact lenses

☐ Prostheses or orthoses ▶ Specify:

☐ Clothes ▶ Specify:

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.

13 As a result of the accident, have you incurred, or do you expect to incur, expenses for any of the following (see the guide for more information)?

☐ 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**

☐ Medication ▶

☐ Other ▶ Specify:

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** enter 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," go on to Section 15)***

If "Yes," please provide the information requested below. **Keep your bills and receipts for three (3) years so that you can provide them to us upon request.**

Date of travel (Year / Month / Day)	Round trip distance in km (if automobile)	Other means of transportation or parking fees	Amount claimed (parking fees and taxi fares)	Lodging, meals	Medical consultations	
					Location	Reason

Signature of the Claim for Compensation

15 I certify that the information provided on this claim form is accurate. 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 bodies that can provide it to the SAAQ, such as 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, etc.

SIGNATURE OF THE ACCIDENT VICTIM (IF OF FULL AGE) OR HIS OR HER REPRESENTATIVE. NO COMPENSATION CAN BE PAID WITHOUT A SIGNATURE.

Date (Year / Month / Day)

X

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 or mother of a minor ☐ Dative tutor or curator (enclose a copy of the judgment) ☐ Other, specify:

☐ Mr. ☐ Ms. Last name of 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

Daytime telephone (main) | Extension | Daytime telephone (secondary) | Extension

Authorization to Disclose Medical Information (see the guide)

16 Accident victim's last name at birth

First name

Present 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

I hereby authorize the assessing physician and any other health care professionals, the accident victim counsellor and the compensation officer at the Société de l'assurance automobile du Québec to convey medical information regarding my health, where appropriate, to my attending physician or to any other health care professional. I understand that a written summary of any oral communication will be entered into my claim file.

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 full age) or his or her representative

X

Date
Year Month Day

Direct Deposit (see the guide)

17 **ONLY COMPLETE THIS SECTION IF YOU WANT TO REGISTER FOR DIRECT DEPOSIT.**

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

Branch No. | Institution No. | Account No.

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 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 its financial institution and to the one indicated above.

Signature of the accident victim (if of full age) or his or her representative

X

Date
Year Month Day

REMEMBER TO ENCLOSE A CHEQUE MARKED "VOID."
DO NOT STAPLE YOUR CHEQUE TO YOUR CLAIM FOR COMPENSATION.

THERE ARE THREE WAYS TO SUBMIT A DOCUMENT:

Through the Document Submission online service: saaq.gouv.qc.ca
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.

Appendix
Social Situation

A

At the time of the accident, did you have a spouse?[1]
☐ Yes ☐ No ▶ ***(If "No," go on to Section B)***

You were:
☐ Legally married 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 you and your spouse? ☐ Yes ☐ No
- had a child of one spouse been adopted by the other spouse? ☐ Yes ☐ No

If "**Yes**," provide a copy of the adoption order

Spouse's last name at birth

First name

Sex ☐ Female ☐ Male

Date of birth Year Month Day

Health Insurance Number

Was your spouse living at the same address as you at the time of the accident? ☐ Yes ☐ No

Is your spouse disabled? ☐ Yes ☐ No

B

At the time of the accident, did you have a former spouse?[1]
☐ Yes ☐ No ▶ ***(If "No," go on to Section C)***

Were you paying or required to pay spousal support in accordance with a judgment or an agreement?
☐ Yes ▶ Indicate the yearly amount $
☐ No **Attach a copy of the official document stating this amount**

Former spouse's last name at birth

Sex ☐ Female ☐ Male

Date of birth Year Month Day

First name

1. "Spouse" refers to a person of the same or opposite sex.

C

Did you have any dependant(s) at the time of the accident? ☐ Yes ☐ No ▶ ***(If "No," go on to Section D)***

FOR EVERY CHILD OR OTHER DEPENDANT, PLEASE PROVIDE THE INFORMATION REQUESTED BELOW.

1. Last name

Sex ☐ Female ☐ Male

Date of birth Year Month Day

First name

Health Insurance Number

Relationship to you ☐ Biological child ☐ Spouse's child ☐ Other, specify:

Level of education in progress ☐ Elementary ☐ High school ▶ ☐ General ☐ Vocational ☐ CEGEP ☐ University ☐ Does not apply

Gross annual employment income (including social assistance payments, Employment Insurance benefits, etc.) $

Is this person disabled? ☐ Yes ☐ No

Was this person living with you? ☐ Yes ☐ No

2. Last name

Sex ☐ Female ☐ Male

Date of birth Year Month Day

First name

Health Insurance Number

Relationship to you ☐ Biological child ☐ Spouse's child ☐ Other, specify:

Level of education in progress ☐ Elementary ☐ High school ▶ ☐ General ☐ Vocational ☐ CEGEP ☐ University ☐ Does not apply

Gross annual employment income (including social assistance payments, Employment Insurance benefits, etc.) $

Is this person disabled? ☐ Yes ☐ No

Was this person living with you? ☐ Yes ☐ No

3. Last name

Sex ☐ Female ☐ Male

Date of birth Year Month Day

First name

Health Insurance Number

Relationship to you ☐ Biological child ☐ Spouse's child ☐ Other, specify:

Level of education in progress ☐ Elementary ☐ High school ▶ ☐ General ☐ Vocational ☐ CEGEP ☐ University ☐ Does not apply

Gross annual employment income (including social assistance payments, Employment Insurance benefits, etc.) $

Is this person disabled? ☐ Yes ☐ No

Was this person living with you? ☐ Yes ☐ No

C DEPENDENTS (CONTINUED)

4. Last name

Sex ☐ Female ☐ Male

Date of birth Year Month Day

First name

Health Insurance Number

Relationship to you ☐ Biological child ☐ Spouse's child ☐ Other, specify:

Level of education in progress ☐ Elementary ☐ High school ▶ ☐ General ☐ Vocational ☐ CEGEP ☐ University ☐ Does not apply

Gross annual employment income (including social assistance payments, Employment Insurance benefits, etc.) $

Is this person disabled? ☐ Yes ☐ No

Was this person living with you? ☐ Yes ☐ No

5. Last name

Sex ☐ Female ☐ Male

Date of birth Year Month Day

First name

Health Insurance Number

Relationship to you ☐ Biological child ☐ Spouse's child ☐ Other, specify:

Level of education in progress ☐ Elementary ☐ High school ▶ ☐ General ☐ Vocational ☐ CEGEP ☐ University ☐ Does not apply

Gross annual employment income (including social assistance payments, Employment Insurance benefits, etc.) $

Is this person disabled? ☐ Yes ☐ No

Was this person living with you? ☐ Yes ☐ No

6. Last name

Sex ☐ Female ☐ Male

Date of birth Year Month Day

First name

Health Insurance Number

Relationship to you ☐ Biological child ☐ Spouse's child ☐ Other, specify:

Level of education in progress ☐ Elementary ☐ High school ▶ ☐ General ☐ Vocational ☐ CEGEP ☐ University ☐ Does not apply

Gross annual employment income (including social assistance payments, Employment Insurance benefits, etc.) $

Is this person disabled? ☐ Yes ☐ No

Was this person living with you? ☐ Yes ☐ No

IF YOU HAD ANY OTHER DEPENDANTS, PLEASE PROVIDE THE SAME INFORMATION ABOUT THEM ON A SEPARATE SHEET OF PAPER AND ATTACH IT TO THIS FORM. BE SURE TO INDICATE THE CLAIM NUMBER SHOWN ABOVE AT THE TOP OF EACH ADDITIONAL SHEET OF PAPER.

D

Were you employed at the time of the accident? ☐ Yes ☐ No ▶ ***(If "No," go on to Section E)***

PROVIDE THE INFORMATION REQUESTED BELOW FOR EACH POSITION YOU HELD AT THE TIME OF THE ACCIDENT.

Name of employer or business | Telephone

Date hired (Year / Month / Day) | Expected end (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*** filled out **if you were disabled for seven or more days after the accident.**

☐ Self-employed ▶ **If you were disabled for seven or more days after the accident, you must provide the following, for each of the three previous years:**

– If you were resident in Québec

☐ Québec income tax return, AND

☐ Notice of assessment, AND

☐ Form TP-80-V *(Business or Professional Income and Expenses)* or ☐ Statement of income and expenses

– If you were resident in Canada (outside Québec)

☐ Federal income tax return, AND

☐ Notice of assessment, AND

☐ Form T2125 *(Statement of Business or Professional Activities)* or ☐ Statement of income and expenses

– If you were not resident 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 SAME INFORMATION ON A SEPARATE SHEET OF PAPER AND ATTACH IT TO THIS FORM. BE SURE TO INDICATE THE CLAIM NUMBER SHOWN ABOVE AT THE TOP OF EACH ADDITIONAL SHEET OF PAPER. HAVE SCHEDULE 2 FILLED OUT BY EACH EMPLOYER (MAKE PHOTOCOPIES OF SCHEDULE 2 IF NEED BE).

E

At the time of the accident:

Were you registered as a full-time student in an educational program? ☐ Yes ▶ If you were 16 years of age or older, have ***Schedule 4 - Attestation of School Attendance*** filled out. ☐ No

Were you working without pay in a family business? ☐ Yes ☐ No

Were you receiving Employment Insurance benefits or an employment-assistance allowance? ☐ Yes ▶ Have ***Schedule 3 - Confirmation of Employment Insurance Benefits Lost/Confirmation of an Employment-Assistance Allowance Lost*** filled out **if you were disabled for seven or more days after the accident.** ☐ No

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

☐ Yes ▶ Name of employer or business | Telephone

☐ No

Please request a *Confirmation of Hiring* form if you were disabled for seven or more days after the accident.

Appendix
Economic Situation

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F At the time of the accident, were you unable to work for a reason other than the accident? ☐ Yes ☐ No ▶ ***(If "No," go on to Section G)***

You had been unable to work ☐ Temporarily ☐ Permanently Since Year Month Day

Describe your illness or disability prior to the accident.

G At the time of the accident, you were

Your file number:

☐ The recipient of compensation or indemnities from the Commission des normes, de l'équité, de la santé et de la sécurité du travail ▶

☐ The recipient of a disability pension under the Québec Pension Plan

☐ The recipient of a disability pension from another body ▶ Specify:

☐ Not receiving any pension, compensation or indemnities

H **IF YOU HAD NOT HELD FULL-TIME EMPLOYMENT FOR OVER A YEAR WHEN THE ACCIDENT OCCURRED, YOU MUST PROVIDE THE INFORMATION BELOW.**

Education

Please circle 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:

Your main occupation was taking care of a child under 6 years of age without pay? ☐ Yes ▶ ☐ No

From: Year Month To: Year Month

You were unable to hold a job due to illness, an accident, etc.? ☐ Yes ▶ ☐ No

Reason(s)

From: Year Month To: Year Month

From: Year Month To: Year Month

From: Year Month To: Year Month

Do you hold any certificates of qualification or professional licences? ☐ Yes ☐ No If "**Yes**," specify:

Are you a member of a professional corporation? ☐ Yes ☐ No If "**Yes**," specify:

Employment history

Provide information about all the positions you have held over the past five (5) years, or provide information about the last three (3) positions you have held if you did not work during the past five (5) years. **This information is required for us to process your file. Keep all of your supporting documents so that you can provide them to us on request.**

Period worked (starting with moste recent)	Name of employer	Sector of activity	Job title	Number of hours		Gross income
				worked per week	regular full-time work week for this employment at this employer	
From: Year Month To: Year Month						$ ☐ Per hour ☐ Per week
From: Year Month To: Year Month						$ ☐ Per hour ☐ Per week
From: Year Month To Year Month						$ ☐ Per hour ☐ Per week
From: Year Month To: Year Month						$ ☐ Per hour ☐ Per week
From: Year Month To: Year Month						$ ☐ Per hour ☐ Per week