



**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  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 \_\_\_\_\_

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  Motorcycle  Other, specify: \_\_\_\_\_  
 Bus  Moped, motorized scooter

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  No  Don't know

Accident report number (if known) \_\_\_\_\_

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**



Injuries

7 Did you sustain injuries (physical or psychological) as a result of the accident? Have you recovered?

Please describe your injuries. If a physician completed the Initial Report form, please send it to us.

Multiple horizontal lines for describing injuries.

(If space is insufficient, use a separate sheet)

8 After the accident, you consulted a physician, another health care professional, or did not consult any health care professionals. Includes fields for medical consultation date and facility name.

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? Includes fields for disability period and resumption date.

Resident Status (see the guide)

10 At the time of the accident, did you own a vehicle registered in Québec? Did you live outside Québec at any point during the twelve months prior to the accident? Includes fields for licence number, residence dates, and 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
- Protheses 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**
- 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** 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			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	
Year	Month	Day					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.**

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 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](http://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.**



<b>A</b> At the time of the accident, did you have a spouse? <sup>1</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No ► (If "No," go on to Section B)	You were: <input type="checkbox"/> Legally married or in a civil union <input type="checkbox"/> In a de facto union ► Since: _____ Year _____ Month _____
At the time of the accident, • had a child been born of this union? <input type="checkbox"/> Yes <input type="checkbox"/> No • was a child to be born of this union? <input type="checkbox"/> Yes <input type="checkbox"/> No • had a child been adopted by you and your spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No • had a child of one spouse been adopted by the other spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse's last name at birth _____ First name _____ Sex <input type="checkbox"/> Female <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Is your spouse disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>B</b> At the time of the accident, did you have a former spouse? <sup>1</sup> <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Former spouse's last name at birth _____ First name _____	Indicate the yearly amount \$ _____ <b>Attach a copy of the official document stating this amount</b> Sex <input type="checkbox"/> Female <input type="checkbox"/> Male Date of birth Year _____ Month _____ Day _____

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

<b>C</b> Did you have any dependant(s) at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No ► (If "No," go on to Section D)	<b>FOR EVERY CHILD OR OTHER DEPENDANT, PLEASE PROVIDE THE INFORMATION REQUESTED BELOW.</b>
<b>1.</b> Last name _____ First name _____ Health Insurance Number _____ Level of education in progress <input type="checkbox"/> Elementary <input type="checkbox"/> High school ► <input type="checkbox"/> General <input type="checkbox"/> Vocational <input type="checkbox"/> CEGEP <input type="checkbox"/> University <input type="checkbox"/> Does not apply Gross annual employment income (including social assistance payments, Employment Insurance benefits, etc.) \$ _____	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male Date of birth Year _____ Month _____ Day _____ Relationship to you <input type="checkbox"/> Biological child <input type="checkbox"/> Spouse's child <input type="checkbox"/> Other, specify: _____ Is this person disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No Was this person living with you? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>2.</b> Last name _____ First name _____ Health Insurance Number _____ Level of education in progress <input type="checkbox"/> Elementary <input type="checkbox"/> High school ► <input type="checkbox"/> General <input type="checkbox"/> Vocational <input type="checkbox"/> CEGEP <input type="checkbox"/> University <input type="checkbox"/> Does not apply Gross annual employment income (including social assistance payments, Employment Insurance benefits, etc.) \$ _____	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male Date of birth Year _____ Month _____ Day _____ Relationship to you <input type="checkbox"/> Biological child <input type="checkbox"/> Spouse's child <input type="checkbox"/> Other, specify: _____ Is this person disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No Was this person living with you? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>3.</b> Last name _____ First name _____ Health Insurance Number _____ Level of education in progress <input type="checkbox"/> Elementary <input type="checkbox"/> High school ► <input type="checkbox"/> General <input type="checkbox"/> Vocational <input type="checkbox"/> CEGEP <input type="checkbox"/> University <input type="checkbox"/> Does not apply Gross annual employment income (including social assistance payments, Employment Insurance benefits, etc.) \$ _____	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male Date of birth Year _____ Month _____ Day _____ Relationship to you <input type="checkbox"/> Biological child <input type="checkbox"/> Spouse's child <input type="checkbox"/> Other, specify: _____ Is this person disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No Was this person living with you? <input type="checkbox"/> Yes <input type="checkbox"/> No



**C DEPENDENTS (CONTINUED)**

4. Last name		Sex	Date of birth		
_____		<input type="checkbox"/> Female <input type="checkbox"/> Male	Year	Month	Day
First name		_____			
Health Insurance Number		Relationship to you			
_____		<input type="checkbox"/> Biological child <input type="checkbox"/> Spouse's child <input type="checkbox"/> Other, specify: _____			
Level of education in progress					
<input type="checkbox"/> Elementary		<input type="checkbox"/> High school		<input type="checkbox"/> General	
		<input type="checkbox"/> Vocational		<input type="checkbox"/> CEGEP	
				<input type="checkbox"/> University	
				<input type="checkbox"/> Does not apply	
Gross annual employment income (including social assistance payments, Employment Insurance benefits, etc.) \$			Is this person disabled?		Was this person living with you?
_____			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Last name		Sex	Date of birth		
_____		<input type="checkbox"/> Female <input type="checkbox"/> Male	Year	Month	Day
First name		_____			
Health Insurance Number		Relationship to you			
_____		<input type="checkbox"/> Biological child <input type="checkbox"/> Spouse's child <input type="checkbox"/> Other, specify: _____			
Level of education in progress					
<input type="checkbox"/> Elementary		<input type="checkbox"/> High school		<input type="checkbox"/> General	
		<input type="checkbox"/> Vocational		<input type="checkbox"/> CEGEP	
				<input type="checkbox"/> University	
				<input type="checkbox"/> Does not apply	
Gross annual employment income (including social assistance payments, Employment Insurance benefits, etc.) \$			Is this person disabled?		Was this person living with you?
_____			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Last name		Sex	Date of birth		
_____		<input type="checkbox"/> Female <input type="checkbox"/> Male	Year	Month	Day
First name		_____			
Health Insurance Number		Relationship to you			
_____		<input type="checkbox"/> Biological child <input type="checkbox"/> Spouse's child <input type="checkbox"/> Other, specify: _____			
Level of education in progress					
<input type="checkbox"/> Elementary		<input type="checkbox"/> High school		<input type="checkbox"/> General	
		<input type="checkbox"/> Vocational		<input type="checkbox"/> CEGEP	
				<input type="checkbox"/> University	
				<input type="checkbox"/> Does not apply	
Gross annual employment income (including social assistance payments, Employment Insurance benefits, etc.) \$			Is this person disabled?		Was this person living with you?
_____			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> 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			Expected end (if applicable)			Type of employment					
Year    Month    Day			Year    Month    Day			<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Temporary <input type="checkbox"/> 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?

<input type="checkbox"/> Yes ►	Name of employer or business	Telephone
<input type="checkbox"/> No		

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



**Claim Number**

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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.

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**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: _____
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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

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

Reason(s)

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 most 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 _____						\$ _____ <input type="checkbox"/> Per hour <input type="checkbox"/> Per week
From: _____ Year _____ Month _____ To: _____ Year _____ Month _____						\$ _____ <input type="checkbox"/> Per hour <input type="checkbox"/> Per week
From: _____ Year _____ Month _____ To: _____ Year _____ Month _____						\$ _____ <input type="checkbox"/> Per hour <input type="checkbox"/> Per week
From: _____ Year _____ Month _____ To: _____ Year _____ Month _____						\$ _____ <input type="checkbox"/> Per hour <input type="checkbox"/> Per week
From: _____ Year _____ Month _____ To: _____ Year _____ Month _____						\$ _____ <input type="checkbox"/> Per hour <input type="checkbox"/> Per week