Société de l'assurance automobile Québec

# 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

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

Telephone (home) | Extension | Telephone (other) | Extension

## Accident

**3**

Date and time of 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 was he or she in?

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

**Licence plate number of the vehicle the accident victim was in** | Province, state or country in which the vehicle the accident victim was 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**

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 ☐ Don't 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

**DO NOT WRITE HERE**

**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.***

**DD**

## Injuries

**7** Please describe, in your own words, the injuries the accident victim sustained that led to his or her death as a result of the accident. **(Enclose a document from a physician or coroner describing the cause(s) of death.)**

Please provide the date and time of death: Year | Month | Day | Hour : Minute | ☐ AM ☐ PM

**Enclose the death certificate from 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 ▶ ☐ No

Municipality

- If the accident victim stayed longer than six months outside Québec, give the reason(s) for his or her extended stay:

Was the accident victim a Canadian citizen at the time of the accident? ☐ Yes ☐ No ▶ Citizenship

## Pension, Benefits, Indemnities, Compensation or Allowance Received from Another Body

**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 body (Ministère du Travail, de l'Emploi et de la Solidarité sociale, CNESST, Retraite Québec, etc.)? ☐ Yes ☐ 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** **"SPOUSE" REFERS TO A PERSON OF THE SAME OR OPPOSITE SEX.

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

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

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 his or her 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

Were the accident victim and his or her spouse living together at the time of the accident? ☐ Yes ☐ No

The spouse had been living at the address below since: Year Month

Address
Street number Street name Apartment P.O. Box

Municipality Province or state

Country Postal code

Telephone (home) Telephone (work) Extension Telephone (other)

**12** Is the spouse disabled? ☐ Yes ☐ No If "**Yes,**" submit a 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 SPOUSE" REFERS TO A PERSON 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 ▶ ***Go on 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

First name

Sex ☐ Female ☐ Male

Date of birth Year Month Day

Address
Street number Street name Apartment P.O. Box

Municipality Province or state

Country Postal code

Telephone (home) Telephone (work) Extension Telephone (other)

**14** Is the former spouse disabled? ☐ Yes ☐ No If "**Yes,**" enclose a 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," go on 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 BIRTH CERTIFICATE FROM THE DIRECTEUR DE L'ÉTAT CIVIL BEARING THE NAME OF THE DEPENDANT'S MOTHER AND FATHER.**

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

First name

Health Insurance Number | Relationship to 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 4D – Attestation of School Attendance filled out.***

Gross annual employment income (including 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

Is this person disabled? ☐ Yes ▶ Enclose a medical report attesting to the person's disability ☐ No | Was this person living with the accident victim? ☐ Yes ☐ No ▶ If "**No,**" give 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 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 4D – Attestation of School Attendance filled out.***

Gross annual employment income (including 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

Is this person disabled? ☐ Yes ▶ Enclose a medical report attesting to the person's disability ☐ No | Was this person living with the accident victim? ☐ Yes ☐ No ▶ If "**No,**" give 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 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 4D – Attestation of School Attendance filled out.***

Gross annual employment income (including 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

Is this person disabled? ☐ Yes ▶ Enclose a medical report attesting to the person's disability ☐ No | Was this person living with the accident victim? ☐ Yes ☐ No ▶ If "**No,**" give the dependant's address below

Address Street number Street name Apartment P.O. Box

Municipality Province or state

Country Postal code

## Dependants

### 15 DEPENDANTS (CONTINUED)

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

First name

Health Insurance Number

Relationship to 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 4D – Attestation of School Attendance filled out.***

Gross annual employment income (including 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

Is this person disabled? ☐ Yes ▶ Enclose a medical report attesting to the person's disability ☐ No

Was this person living with the accident victim? ☐ Yes ☐ No ▶ If "**No,**" give 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 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 4D – Attestation of School Attendance filled out.***

Gross annual employment income (including 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

Is this person disabled? ☐ Yes ▶ Enclose a medical report attesting to the person's disability ☐ No

Was this person living with the accident victim? ☐ Yes ☐ No ▶ If "**No,**" give 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 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 4D – Attestation of School Attendance filled out.***

Gross annual employment income (including 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

Is this person disabled? ☐ Yes ▶ Enclose a medical report attesting to the person's disability ☐ No

Was this person living with the accident victim? ☐ Yes ☐ No ▶ If "**No,**" give 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 ATTACH IT TO 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 THE ACCIDENT VICTIM'S BIRTH CERTIFICATE ISSUED BY THE DIRECTEUR DE L'ÉTAT CIVIL AND BEARING THE NAME OF THE ACCIDENT VICTIM'S MOTHER AND FATHER.**

**16** Accident victim's parent*

Sex
☐ Female
☐ Male

☐ Biological or adoptive father/mother
☐ Person acting as a father/mother ▶ since: Year Month Day
☐ No one was acting as a father/mother

If the accident victim's biological parent is deceased, give 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,**" give this person's address below

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

Municipality | Province or state

Country | Postal code

Telephone (home) | Telephone (work) Extension | Telephone (other)

Accident victim's parent*

Sex
☐ Female
☐ Male

☐ Biological or adoptive father/mother
☐ Person acting as a father/mother ▶ since: Year Month Day
☐ No one was acting as a father/mother

If the accident victim's biological parent is deceased, give 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,**" give this person's address below

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

Municipality | Province or state

Country | Postal code

Telephone (home) | Telephone (work) Extension | Telephone (other)

Accident victim's parent*

Sex
☐ Female
☐ Male

☐ Biological or adoptive father/mother
☐ Person acting as a father/mother ▶ since Year Month Day
☐ No one was acting as a father/mother

If the accident victim's biological parent is deceased, give 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,**" give this person's address below

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

Municipality | Province or state

Country | Postal code

Telephone (home) | Telephone (work) Extension | Telephone (other)

* Parents may be of the same or opposite sex.

**IF EITHER THE FATHER OR THE MOTHER HAS BEEN DIVESTED OF PARENTAL AUTHORITY, ENCLOSE A COPY OF THE COURT ORDER.**

## 16 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 THE ACCIDENT VICTIM'S BIRTH CERTIFICATE ISSUED BY THE DIRECTEUR DE L'ÉTAT CIVIL AND BEARING THE NAME OF THE ACCIDENT VICTIM'S MOTHER AND FATHER.**

Accident victim's parent*

Sex
- ☐ Female
- ☐ Male

- ☐ Biological or adoptive father/mother
- ☐ Person acting as a father/mother ▶ since (Year / Month / Day)
- ☐ No one was acting as a father/mother

If the accident victim's biological parent is deceased, give 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,**" give this person's address below

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

Municipality | Province or state

Country | Postal code

Telephone (home) | Telephone (work) | Extension | Telephone (other)

* Parents may be of the same or opposite sex.

**IF EITHER THE FATHER OR THE MOTHER HAS BEEN DIVESTED OF PARENTAL AUTHORITY, ENCLOSE A COPY OF THE COURT ORDER.**

## Signature of the Claim for Death Benefits

## 17

I certify that the information provided on this claim form is accurate. In the event that further information is required in order to establish entitlement to benefits 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 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 or Mother ☐ Administrator of the succession ☐ Notary or attorney ☐ Other, specify:

☐ Mr. ☐ Ms.

Representative's last name

First name

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

Municipality | Province or state

Country | Postal code

Telephone (home) | Telephone (work) | Extension | Telephone (other)

## Direct Deposit

## 18 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 financial 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 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," go on to Section B***

**PROVIDE THE INFORMATION REQUESTED BELOW FOR EACH POSITION 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.

☐ Self-employed ▶ **Please provide the following documents for the three previous years:**

***— If the accident victim was 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 the accident victim was 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 the accident victim was 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).**

**B** At the time of the accident:

Was the accident victim registered as a full-time student in an educational program? ☐ Yes ▶ If the accident victim was 16 years of age or older, have ***Schedule 4D – Attestation of School Attendance*** filled out. ☐ No

Was the accident victim working without pay in a family business? ☐ Yes ☐ No

Was the accident victim 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. ☐ No

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

☐ Yes ▶ Name of employer or business | Telephone

☐ No

**Please request a *Confirmation of Hiring* form.**

# Appendix
## Employment History – Qualifications – Disability

| Claim Number | | Page | 9/9 |
|---|---|---|---|

**C** At the time of the accident, was the accident victim unable to work for a reason other than the accident? ☐ Yes ☐ No ▶ ***If "No," go on 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 body ▶ 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 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 6 years of age without pay? ☐ Yes ▶ ☐ No

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 — Reason(s)

From: Year Month To: Year Month — Reason(s)

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: _____

**Employment history** Provide information about all the positions the accident victim held during the five (5) years preceding the accident, or provide information about the last three (3) positions he or she held if the accident victim did not work during that period. **This information is required for us to process the file. Keep all of the 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: worked per week | Number of hours: regular full-time work week for this employment at this employer | Gross income |
|---|---|---|---|---|---|---|
| From: Year Month<br>To: Year Month | | | | | | $<br>☐ Per hour ☐ Per week |
| From: Year Month<br>To: Year Month | | | | | | $<br>☐ Per hour ☐ Per week |
| From: Year Month<br>To: Year Month | | | | | | $<br>☐ Per hour ☐ Per week |
| From: Year Month<br>To: Year Month | | | | | | $<br>☐ Per hour ☐ Per week |
| From: Year Month<br>To: Year Month | | | | | | $<br>☐ Per hour ☐ Per week |