

Claim number
_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Under section 69 of the *Automobile Insurance Act*, an indemnity may be refused or its payment **discontinued or suspended** by decision of the **Société de l'assurance automobile du Québec (SAAQ)**, when the claimant files false or untruthful information, or refuses or neglects to supply the information required for the application of the Act.

### Accident victim information

Last and first name									
Address (Number, street, apartment, municipality)									
P. O. Box	Province	Postal Code	Telephone Area Code						
_ _ _ _	_ _	_ _ _ _	_ _ _ _						
What is the victim's present civil status?									
<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Legally separated	<input type="checkbox"/> Common law union						
<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> De facto separation	<input type="checkbox"/> Member of a religious order						
▶ If the victim presently has a spouse, please provide the following information:			Since the: <table style="display: inline-table; border-collapse: collapse;"><tr><td style="text-align: center;">Year</td><td style="text-align: center;">Month</td><td style="text-align: center;">Day</td></tr><tr><td> _ _ </td><td> _ </td><td> _ </td></tr></table>	Year	Month	Day	_ _	_	_
Year	Month	Day							
_ _	_	_							
Spouse's last name	Spouse's first name	Spouse's health insurance number							
_ _ _ _ _ _ _	_ _ _ _ _ _ _	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _							
Last name at birth if different from above	Spouse's social insurance number	Date of birth							
_ _ _ _ _ _ _	_ _ _ _ _ _ _ _ _ _ _	Year      Month      Day							
_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _									
Spouse's present address if different from the victim's									
_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _									

### Additional information

Is the victim presently paying alimony?	<input type="checkbox"/> Yes	<input type="checkbox"/> No							
▶ If yes, please give the following details:									
Since:	<table style="display: inline-table; border-collapse: collapse;"><tr><td style="text-align: center;">Year</td><td style="text-align: center;">Month</td><td style="text-align: center;">Day</td></tr><tr><td> _ _ </td><td> _ </td><td> _ </td></tr></table>	Year	Month	Day	_ _	_	_	Annual amount currently paid: \$ <table style="display: inline-table; border-collapse: collapse;"><tr><td> _ _ _ _ _ _ _ _ _ _ _ _ </td></tr></table>	_ _ _ _ _ _ _ _ _ _ _ _
Year	Month	Day							
_ _	_	_							
_ _ _ _ _ _ _ _ _ _ _ _									
Note: Attach the judgment granting alimony if it has not already been forwarded to the <b>SAAQ</b> .									

Note: If there has been any change concerning a victim's dependants, it is important that this form be filled out and returned to the SAAQ so the victim's income replacement indemnity may be increased, where this is warranted.

*Specify information about dependants overleaf.*

**Send to:** Société de l'assurance automobile du Québec, Case postale 2500, succ. Terminus, Québec (Québec) G1K 8A2  
**By fax:** 1 866 289-7952

1 <sup>st</sup> Dependant			
Last name	First name	Date of birth Year      Month      Day	Health insurance number
During the last twelve months, was that person in full-time attendance at:			
A) An elementary or secondary school? <input type="checkbox"/> Yes <input type="checkbox"/> No		▶ If yes, specify its name: _____	
B) A post-secondary institution (CEGEP, college, university or other)? If yes, specify the name of the institution attended in each semester:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
_____	_____	_____	
Winter (January to April)	Summer (May to August)	Fall (September to December)	

2 <sup>nd</sup> Dependant			
Last name	First name	Date of birth Year      Month      Day	Health insurance number
During the last twelve months, was that person in full-time attendance at:			
A) An elementary or secondary school? <input type="checkbox"/> Yes <input type="checkbox"/> No		▶ If yes, specify its name: _____	
B) A post-secondary institution (CEGEP, college, university or other)? If yes, specify the name of the institution attended in each semester:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
_____	_____	_____	
Winter (January to April)	Summer (May to August)	Fall (September to December)	

3 <sup>rd</sup> Dependant			
Last name	First name	Date of birth Year      Month      Day	Health insurance number
During the last twelve months, was that person in full-time attendance at:			
A) An elementary or secondary school? <input type="checkbox"/> Yes <input type="checkbox"/> No		▶ If yes, specify its name: _____	
B) A post-secondary institution (CEGEP, college, university or other)? If yes, specify the name of the institution attended in each semester:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
_____	_____	_____	
Winter (January to April)	Summer (May to August)	Fall (September to December)	

4 <sup>th</sup> Dependant			
Last name	First name	Date of birth Year      Month      Day	Health insurance number
During the last twelve months, was that person in full-time attendance at:			
A) An elementary or secondary school? <input type="checkbox"/> Yes <input type="checkbox"/> No		▶ If yes, specify its name: _____	
B) A post-secondary institution (CEGEP, college, university or other)? If yes, specify the name of the institution attended in each semester:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
_____	_____	_____	
Winter (January to April)	Summer (May to August)	Fall (September to December)	

I certify that to the best of my knowledge the information given above is true and complete.	
_____	_____
Signature of accident victim or agent	Date
	Year      Month      Day
	_____

Please return this form duly **completed and signed** as soon as possible in the enclosed return envelope.