



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/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/State Country Postal code

Please circle the level of schooling in progress at the time of the accident (or the level at which the student was enrolled)

High School 1 2 3 4 5 University Undergraduate Master's Doctorate

CEGEP 1 2 3

**Declaration**

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

If "Yes," indicate the program in which he or she was enrolled and check the appropriate box to specify whether he or she was enrolled full time or part time  Full time  Part time

Date studies began (or were to begin) Scheduled date of completion  
Year Month Day Year Month Day

Number of courses per week Number of hours of courses per week

Signature of the authorized person Date  
Year Month Day

**X**

Name of the authorized person (please print)

Title or function Telephone Extension

Seal of the institution

**DO NOT WRITE IN THIS SPACE**

**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.