Société de l'assurance automobile Québec

Training and Work Experience

Erase

You are filling out this form further to: ☐ an accident **or** ☐ a relapse

Date of the accident or relapse, as applicable
Y Y Y Y M M D D

Accident Victim		Claim Number
Last name	First name	

1. Accident victim's training

End of full-time studies — Year / Month / Day

Diploma or certificate

Branch of study

Level of schooling completed (check the box and circle the number of years):

☐ Elementary 1 2 3 4 5 6 7
☐ Secondary 1 2 3 4 5
☐ College 1 2 3
☐ University 1 2 3 4 5 or more: _____

Specify: _____

Did the accident victim hold a professional licence or certificate of qualification?

☐ Yes ☐ No If **yes**, specify the type: _____

Professionnal licence no.: _____ Qualification certificate no.: _____

Date of issue: Year / Month / Day

Date of issue: Year / Month / Day

Was the accident victim a member of a professional corporation?

☐ Yes ☐ No

If **yes**, specify: _____

2. Accident victim's employment at the time of the accident or relapse, as applicable

Principal employer

Name or business name

Street number / Street name

Municipality / Postal code

Start of employment: Year / Month / Day

Projected end of employment: Year / Month / Day

Sector of activity

Nature of employment

Brief job description

Type of employment:

1 ☐ full time
2 ☐ part time
3 ☐ temporary
4 ☐ other, specify: _____

Type of remuneration:

1 ☐ wage or salary
2 ☐ self-employed earnings
3 ☐ no remuneration (worked without pay in a family business)
4 ☐ other, specify: _____

Number of hours:

worked per week _____ h

regular, full-time work week for this employment _____ h

Gross income:

☐ per hour
☐ per week $ _____

Other employer (if applicable)

Name or business name

Street number / Street name

Municipality / Postal code

Start of employment: Year / Month / Day

Projected end of employment: Year / Month / Day

Sector of activity

Nature of employment

Brief job description

Type of employment:

1 ☐ full time
2 ☐ part time
3 ☐ temporary
4 ☐ other, specify: _____

Type of remuneration:

1 ☐ wage or salary
2 ☐ self-employed earnings
3 ☐ no remuneration (worked without pay in a family business)
4 ☐ other, specify: _____

Number of hours:

worked per week _____ h

regular, full-time work week for this employment _____ h

Gross income:

☐ per hour
☐ per week $ _____

IMPORTANT: For type 2 remuneration

— Please provide a copy of the last three (3) financial statements and the last three (3) federal and Québec income tax returns.

Employment Insurance

At the time of the accident or relapse, as applicable, was the accident victim receiving Employment Insurance benefits? ☐ Yes ☐ No

If **yes**, please indicate:

Date benefits began: Year / Month / Day

Projected end of benefits: Year / Month / Day

Gross weekly benefits: $

THERE ARE THREE WAYS TO SUBMIT A DOCUMENT:

Through the Document Submission online service: www.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.

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Accident Victim		Claim Number
Last name	First name	

3. Accident victim's previous employment

Provide information about the employment held by the accident victim over the past five (5) years, or provide information about the last three (3) positions held if the accident victim did not work during the past five (5) years. This information is required to determine the amount of any compensation to which the accident victim may be entitled.

1 Full time 2 Part time 3 Temporary 4 Other, specify: _____

Date	Name and address of employer (beginning with the most recent)	Sector of activity	Nature of employment	Type of employment (1 to 4)	Number of hours		Gross income
					Worked per week	Reg. work week for this employment	
From Year Month Day to Year Month Day				No.			☐ hourly ☐ weekly $_____
From Year Month Day to Year Month Day				No.			☐ hourly ☐ weekly $_____
From Year Month Day to Year Month Day				No.			☐ hourly ☐ weekly $_____
From Year Month Day to Year Month Day				No.			☐ hourly ☐ weekly $_____
From Year Month Day to Year Month Day				N°			☐ hourly ☐ weekly $_____
From Year Month Day to Year Month Day				No.			☐ hourly ☐ weekly $_____

Over the past five (5) years, have there been periods when the accident victim was unable to hold a job due to illness, an accident at work, etc.? ☐ Yes ☐ No If **yes,** specify:

Period of time	Reasons
From Year Month Day to Year Month Day	
From Year Month Day to Year Month Day	
From Year Month Day to Year Month Day	

Among the former jobs listed above, were there any that the accident victim could no longer hold on a regular, full-time basis before the accident or relapse, as applicable?

☐ No ☐ Yes, specify: _____

I declare in good faith that the information provided is accurate.

X _____ Year Month Day

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

Keep all of your supporting documents so that you can provide them to us on request.