AVANTAGES SOCIAUX
MÉDIC CONSTRUCTION

DECLARATION OF THE INSURED IN A STATE OF PERMANENT TOTAL INVALIDITY

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IMPORTANT You must fill out all sections completely or the form will be returned to you and processing of your application will be delayed.

1. IDENTIFICATION OF THE INSURED

CCQ client number or social insurance number		Date of birth (YYYY-MM-DD)	
Last name		First name	
No.	Street		Apartment no.
City	Province		Postal code
Telephone number		Cell number	

2. INFORMATION REGARDING THE INVALIDITY

2.1 Has your incapacity ended? ☐ Yes ☐ No		If yes, on what date? (YYYY-MM-DD)	
2.2 Has your medical condition improved? ☐ Yes ☐ No		2.3 Has your medical condition deteriorated? ☐ Yes ☐ No	
If you answered yes to 2.2 or 2.3, explain the changes in your state of health			
2.4 Have you tried to return to:	Your job? ☐ Yes ☐ No	Another job or money-making activity? ☐ Yes ☐ No	
If yes, for which period(s)? From (YYYY-MM-DD) to (YYYY-MM-DD)		Hours of work per day	Hours of work per week / Hourly rate
if yes, for which period(s)? From (YYYY-MM-DD) to (YYYY-MM-DD)		Hours of work per day	Hours of work per week / Hourly rate
Detailed description of the money-making activity(ies) executed:			
2.5 If no, do you plan to return to:	Your job? ☐ Yes ☐ No	Another job or money-making activity? ☐ Yes ☐ No	

We hereby inform you that if you are planning to return to work or if you are working in your trade or in any other money-making occupation, whether full time or part time, you are obliged to inform the commission of this immediately.

RESERVED FOR THE CCQ

ID	☐ CT ☐ LT ☐ AI ☐ M038 ☐ M058

This document is available in adapted media upon request.

3. INFORMATION ON INCOME AND BENEFITS

Do you receive invalidity or retirement benefits or have you made an application or do you intend to make an application under:

Please answer each question		Date of request (YYYY-MM-DD)	File or request no.	Request accepted	Request denied	Request under study	In appeal of decision
Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST)	☐ Yes ☐ No			☐	☐	☐	☐
Act respecting occupational accidents or diseases in force in another province or foreign country (ex.: United States)	☐ Yes ☐ No			☐	☐	☐	☐
Crime victims compensation Act (IVAC)	☐ Yes ☐ No			☐	☐	☐	☐
Société de l'assurance automobile de Québec (SAAQ)	☐ Yes ☐ No			☐	☐	☐	☐
Employment insurance act (Employment and Social Development Canada) or similar act in force in a foreign country (ex.: United States)	☐ Yes ☐ No			☐	☐	☐	☐
Retraite Québec	☐ Yes ☐ No			☐	☐	☐	☐
Canada pension plan	☐ Yes ☐ No			☐	☐	☐	☐
Construction industry pension plan	☐ Yes ☐ No			☐	☐	☐	☐
Other group pension plan	☐ Yes ☐ No			☐	☐	☐	☐
Other individual or group disability Insurance plan	☐ Yes ☐ No			☐	☐	☐	☐
Other income (ex.: Employment, Severance pay, etc.) Specify:	☐ Yes ☐ No			☐	☐	☐	☐

If you answered «yes» to one of these questions, it is possible that a reduction of benefits (taking account of your income) or an exclusion will apply in conformity with the regulation respecting complementary social benefits plans in the construction industry.

4. CERTIFICATION

I certify the accuracy of all the information given in support of my application for salary insurance and/or hour credits and/or maintenance of insurance.

Signature _____ Date (YYYY-MM-DD) _____

5. AUTORISATION

I authorize all individuals and companies providing medical services (physicians, hospitals), as well as insurance companies, investigation boards, employers, the medical information bureau, the Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST), the Direction de l'indemnisation des victimes d'acte criminel, the Régie de l'assurance maladie du Québec, the Société de l'assurance automobile du Québec, Retraite Québec and Employment and Social Development Canada, to transmit to the Commission de la construction du Québec (CCQ) or its authorized representatives all information that they possess concerning me with regard to my application for salary insurance and/or hour credits and/or maintenance of insurance.

The information thus transmitted to the CCQ must not be used except to study my application for salary insurance and/or hour credits and/or maintenance of insurance in conformity with the provisions in the regulation respecting complementary social benefits plans in the construction industry. However, this information may be divulged to any individual or company studying this application or to other individuals or companies if the law so requires or if expressly authorize it. The present authorization or a copy of it shall be valid as long as the application is under study.

Signature _____ Date (YYYY-MM-DD) _____

Have you answered all the questions? Did you sign and date sections 4 and 5? If not, the form will be returned to you.

Please send this form and the supporting documentation to the following address:

Commission de la construction du Québec
Section assurance invalidité
Case postale 2515, succursale Chabanel
Montréal (Québec) H2N 0C7

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