AVANTAGES SOCIAUX
MÉDIC CONSTRUCTION

APPLICATION FOR HOUR CREDITS

USER GUIDE

15

STEPS TO TAKE

You must submit your application for hour credits within one year from the date that the event began.
It is your responsibility to ensure that all information provided is complete and accurate.

Section 1 – *Identification information*. Please fill out the boxes regarding your identification.

Section 2 – *Type of application for hour credits*. You must tick the box that applies to your situation.

Section 3 – *Disability*. You must fill out this section if you are applying for hour credits for disability (accident or illness). Please answer all the questions. Have section 8, 9, or 10 filled out by the agency that is providing your benefits. Fill out sections 6, 7 et 8.

Section 4 – *Preventive cessation of work, maternity leave, paternity leave, and parental leave*. You must fill out this section if you are applying for hour credits for a preventive cessation of work and/or for maternity leave, paternity leave, or parental leave.
For a preventive cessation of work, have the CNESST fill out section 8. Fill out sections 6, 7 and 8.
In the case of a maternity, paternity, or parental leave paid by the Québec Parental Insurance Plan (QPIP), the agency does not have to fill out the form, but **you must attach a copy of the decision and the calculation statement** that you will receive.

Section 5 – *Grievance*. You must fill out this section if you are contesting a dismissal with a grievance presented for arbitration. Fill out sections 6, 7 et 8.

Section 6 – *Detention - Fill out this section. If you are in this situation, attach a letter from the facility confirming the detention period.*

Section 7 – *Certification*. This section **must be signed and dated** for certification of the information provided. Fill out section 8.

Section 8 – *Authorization*. This section **must be signed and dated**. It enables the affected agencies to fill out the section of the form that concerns them. This authorization also enables us to obtain, as needed, extra information needed to process your application. Fill out the employee identification above sections 9 and 10.

Have the form filled out by the agency providing your benefits
Go to the page referring to the organization that compensates you.
Provide the requested identification details. Sign and date the employee authorization. Have the organization complete this section.

Section 9 – *CNESST* (work-related accident, work-related illness, preventive cessation of work, IVAC)

Section 10 – *Employment Insurance*
Send the “Employee’s Declaration”, duly filled out, and the “Declaration by Employment Insurance”.

Section 11 – *SAAQ*

Documents to attach:

Maternity/paternity/parental leave:
- Copy of the decision by the Québec Parental Insurance Plan (QPIP) and the calculation statement

Canadian Benefit for Parents of Young Victims of Crime:
- Copy of the decision confirming the period when payments were made.

Grievance:
- Copy of grievance submitted to arbitration
- Copy of the arbitration ruling or out-of-court settlement
- Letter from employer proving the end of work on the site

Did you remember?
- To fill out the employee’s declaration in the sections appropriate to your situation?
- To sign and date sections 7 and 8?
- Providing the requested identification details. Sign and date the employee authorization of the organization that compensates you?
- To have the appropriate section filled out by the agency providing your benefits?
- To attach all the required documents?

FOR MORE INFORMATION

- On the Web: **ccq.org**
- By phone: CCQ’s Customer Services: **1 888 842-8282**
- You may also consult the pamphlet “Disability Insurance protection and credit hours.”

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

Or go to your regional office to submit your documents.

AVANTAGES SOCIAUX
MÉDIC CONSTRUCTION

APPLICATION FOR HOUR CREDITS

EMPLOYEE'S DECLARATION

15

See user guide on last page.

1. IDENTIFICATION INFORMATION

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 (day)		Cell number	

2. TYPE OF APPLICATION FOR HOUR CREDITS

2.1 ☐ Disability (accident or illness). **Fill out sections 3, 6, 7 and 8.**

2.2 ☐ Preventive cessation of work, maternity leave, paternity leave, and parental leave. **Fill out sections 4, 6, 7 and 8.**

2.3 ☐ Grievance submitted to arbitration. **Fill out sections 5, 6, 7 and 8.**

2.4 ☐ Compassionate care benefits or family caregiver benefit for children or adults. **Fill out sections 6, 7 and 8.**

2.5 ☐ Canadian Benefit for Parents of Young Victims of Crime. **Fill out sections 6, 7 and 8.**

3. DISABILITY

3.1 Last day at work (YYYY-MM-DD):	3.2 First day of disability (YYYY-MM-DD):
3.3 Has your disability ended? ☐ Yes ☐ No	On which date (YYYY-MM-DD)?
3.4 Explain why your disability currently keeps you from working.	
3.5 Since your disability began, have you performed any light work or other tasks? ☐ Yes ☐ No	If so, for which period (AAAA-MM-JJ to AAAA-MM-JJ)?
If yes, specify:	
3.6 Have you returned to your regular job? ☐ Yes ☐ No	If so, when did you return (YYYY-MM-DD)?
3.7 Is it due to an accident? ☐ Yes ☐ No	If yes, specify: ☐ Work-related ☐ Road-related accident ☐ Personal accident
Date of accident (YYYY-MM-DD)	Description:

3.8 Are you receiving benefits or have you submitted a claim to:
(For each agency, answer "no" or "yes" to the question. If yes, indicate the status of your application).

3.8.1 Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST)	☐ Yes ☐ No	If yes: ☐ Under analysis ☐ Accepted ☐ Rejected	If it was rejected, did you contest? ☐ Yes ☐ No
3.8.2 Société de l'assurance automobile du Québec (SAAQ)	☐ Yes ☐ No	If yes: ☐ Under analysis ☐ Accepted ☐ Rejected	If it was rejected, did you contest? ☐ Yes ☐ No
3.8.3 Employment Insurance	☐ Yes ☐ No	If yes: ☐ Under analysis ☐ Accepted ☐ Rejected	If it was rejected, did you contest? ☐ Yes ☐ No
3.8.4 Crime victims compensation Act (IVAC)	☐ Yes ☐ No	If yes: ☐ Under analysis ☐ Accepted ☐ Rejected	If it was rejected, did you contest? ☐ Yes ☐ No

Fill out section 4.

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This document is available in adapted media upon request.

IDENTIFICATION

Last name	First name	CCQ client number or social insurance number

4. PREVENTIVE WITHDRAWAL, MATERNITY, PATERNITY AND PARENTAL LEAVE

4.1 What is the date of delivery (or projected date) (YYYY-MM-DD):

Preventive withdrawal paid by the Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST)

4.2 What was your last day worked (YYYY-MM-DD):	4.3 What is the first day work stopped for preventive cessation of work (YYYY-MM-DD):
4.4 What is the end date (or expected end date) of the preventive withdrawal (YYYY-MM-DD):	**Mandatory : Have the CNESST complete Section 9**

Maternity, paternity and parental leave paid by the Quebec parental insurance plan (QPIP)

4.5 What is the start date of the leave (YYYY-MM-DD):	4.6 What is the date of the last week paid by the QPIP so far (YYYY-MM-DD):
4.7 What is the end date (or expected end date) of the leave (YYYY-MM-DD): ☐ Don't know	**Mandatory: Attach a copy of the decision and the QPIP calculation statement.**

Fill out section 6

5. GRIEVANCE SUBMITTED TO ARBITRATION

Is your work cessation (dismissal) contested by a grievance submitted to arbitration? ☐ Yes ☐ No	If yes, see documents to attach in the user guide. If no, you do not have the right to hour credits.

Fill out section 6

6. DETENTION

6.1 Since your disability began, have you been detained following sentencing for a criminal act? ☐ Yes ☐ No	**If yes, attach a letter from the facility confirming the detention period.**
6.2 Are you awaiting a verdict following a criminal charge? ☐ Yes ☐ No	

Fill out section 7

7. CERTIFICATION

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

Employee's signature _____ Date (YYYY-MM-DD) _____

Fill out section 8

8. EMPLOYEE'S AUTHORIZATION

I authorize all persons providing medical services, healthcare institutions, insurance companies, my current employer and ex-employers, the Commission des normes, de l'équité, de la santé et de la sécurité du travail, the Ministère de l'Emploi et de la Solidarité sociale, the Régie de l'assurance maladie du Québec, the Société d'assurance automobile du Québec, the Retraite Québec, and Employment and Social Development Canada to communicate, through the declaration below or in another way, to the Commission de la construction du Québec (CCQ) or its authorized representatives all the information necessary to process the present application, which is in regard to my work-related benefits and to all disabilities, current or previous, including medical information regarding these disabilities. This authorization is valid for the duration of processing of my application and for as long as I receive benefits from the CCQ.

The information transmitted will be used only for processing the present application and will be accessible only to the employees for whom this information is necessary for them to carry out their duties.

Signature _____ Date (YYYY-MM-DD) _____

If you are compensated by the CNESST, IVAC, employment insurance or the SAAQ, the organization that compensates you must complete the appropriate section.

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

Or go to your regional office to submit your documents.

AVANTAGES SOCIAUX
MÉDIC CONSTRUCTION

APPLICATION FOR HOUR CREDITS

DECLARATION BY THE CNESST/IVAC

15

IDENTIFICATION

Last name	First name	CCQ client number	CNESST/IVAC file number

IMPORTANT: Fill out the identification section, sign and date the employee's authorization, and then have section 9 filled out by the CNESST/IVAC.

EMPLOYEE'S AUTHORIZATION

I authorize all persons providing medical services, healthcare institutions, insurance companies, my current employer and ex-employers, the Commission des normes, de l'équité, de la santé et de la sécurité du travail, the Ministère de l'Emploi et de la Solidarité sociale, the Régie de l'assurance maladie du Québec, the Société d'assurance automobile du Québec, the Retraite Québec, and Employment and Social Development Canada to communicate, through the declaration below or in another way, to the Commission de la construction du Québec (CCQ) or its authorized representatives all the information necessary to process the present application, which is in regard to my work-related benefits and to all disabilities, current or previous, including medical information regarding these disabilities. This authorization is valid for the duration of processing of my application and for as long as I receive benefits from the CCQ.

The information transmitted will be used only for processing the present application and will be accessible only to the employees for whom this information is necessary for them to carry out their duties.

Signature

Date (YYYY-MM-DD)

9. DECLARATION BY THE CNESST/IVAC (OR ANALOGOUS AGENCY IN ANOTHER PROVINCE OR COUNTRY)

9.1 Last name and first name of the worker:	9.2 File number:	9.3 Date of birth (YYYY-MM-DD):
9.4 Date of event (YYYY-MM-JJ):	9.5 Date of recurrence, relapse or aggravation (YYYY-MM-DD):	
9.6 Diagnosis or diagnoses accepted:		
9.7 Diagnosis or diagnoses rejected:		
9.8 Employer obligatory period (YYYY-MM-DD) to (YYYY-MM-DD):		
9.9 Periods in temporary assignment:	from (YYYY-MM-DD) to (YYYY-MM-DD):	
	from (YYYY-MM-DD) to (YYYY-MM-DD):	
9.10 Periods compensated in medical consolidation:	from (YYYY-MM-DD) to (YYYY-MM-DD):	
	from (YYYY-MM-DD) to (YYYY-MM-DD):	
9.11 Periods compensated in rehabilitation:	from (YYYY-MM-DD) to (YYYY-MM-DD):	
	from (YYYY-MM-DD) to (YYYY-MM-DD):	
9.12 If there was a delay between the date of the event and the date that payments began, please specify the reason (unless it was the employer's obligatory period):		
9.13 Date of medical consolidation:	By: ☐ Attending phys. ☐ BEM	
9.14 Has a REM been produced in the last 6 months? ☐ Yes ☐ No	No. Projected date (if known) (YYYY-MM-DD):	
9.15 Date of capacity to perform his or her job:		

Please fill out the back of the form.

This document is available in adapted media upon request.

IDENTIFICATION

Last name	First name	CCQ client number	CNESST/IVAC file number

9. DECLARATION BY THE CNESST/IVAC (OR ANALOGOUS AGENCY IN ANOTHER PROVINCE OR COUNTRY) (CONTINUED)

9.16 Date of capacity to perform a suitable job (YYYY-MM-DD):

9.17 Type of suitable job established:

9.18 Period in complete IRR following a suitable job from (YYYY-MM-DD) to (YYYY-MM-DD):

9.19 Start date of reduced IRR (YYYY-MM-DD):	9.20 Amount of daily reduced IRR ($):
9.21 Is there a decision pending in this file? ☐ Yes ☐ No	If yes since which date (YYYY-MM-DD)?

9.22 Is there a contestation in this file? (eligibility, capacity to perform his or her job, suitable job, right to IRR)		
	Worker: ☐ Yes ☐ No	If yes since which date (YYYY-MM-DD):
	Employer: ☐ Yes ☐ No	If yes since which date (YYYY-MM-DD):

What is the subject of the contestation(s)?

Remember to sign and date your declaration in the "Identity of the CNESST/IVAC representative" section.

Preventive cessation of work

9.23 File number:	9.24 Date of delivery (or projected date) (YYYY-MM-DD):
9.25 Employer obligatory period from (YYYY-MM-DD) to (YYYY-MM-DD):	9.26 Period compensated following a preventive cessation of work from (YYYY-MM-DD) to (YYYY-MM-DD):

Identification of CNESST/IVAC representative

Name of CNESST/IVAC representative	Telephone number (Area code)	Ext.

Signature of CNESST/IVAC representative

Date (YYYY-MM-DD)

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

Or go to your regional office to submit your documents.

AVANTAGES SOCIAUX
MÉDIC CONSTRUCTION

APPLICATION FOR HOUR CREDITS

DECLARATION BY EMPLOYMENT INSURANCE

15

IDENTIFICATION

Last name	First name	Social insurance number

IMPORTANT: Fill out the identification section, sign and date the employee's authorization. Have section 10 filled out by Service Canada, being sure to send the "Employee's Declaration," duly filled out, and the "Declaration by Employment Insurance."

EMPLOYEE'S AUTHORIZATION

I authorize all persons providing medical services, healthcare institutions, insurance companies, my current employer and ex-employers, the Commission des normes, de l'équité, de la santé et de la sécurité du travail, the Ministère de l'Emploi et de la Solidarité sociale, the Régie de l'assurance maladie du Québec, the Société d'assurance automobile du Québec, the Retraite Québec, and Employment and Social Development Canada to communicate, through the declaration below or in another way, to the Commission de la construction du Québec (CCQ) or its authorized representatives all the information necessary to process the present application, which is in regard to my work-related benefits and to all disabilities, current or previous, including medical information regarding these disabilities. This authorization is valid for the duration of processing of my application and for as long as I receive benefits from the CCQ.

The information transmitted will be used only for processing the present application and will be accessible only to the employees for whom this information is necessary for them to carry out their duties.

Signature _____ Date (YYYY-MM-DD) _____

10. DECLARATION BY EMPLOYMENT INSURANCE

Disability

10.1 ☐ Initial application ☐ Application renewal

10.2 Date of start of disability (YYYY-MM-DD)?

10.3 Is the beneficiary eligible for illness benefits? ☐ Yes ☐ No

If yes, indicate the date of eligibility (YYYY-MM-DD):

If no, why?

10.4 If there is a delay between eligibility and start of disability, why?

☐ Submitted late ☐ Income rep ☐ Subsequent application ☐ Other, specify: _____

10.5 Is the beneficiary eligible for 15 weeks of illness benefits? ☐ Yes ☐ No

If no, indicate the maximum number of eligible weeks for illness benefits:

10.6 If the beneficiary is not receiving 15 weeks of illness benefits, why?

☐ No medical certificate ☐ Return to work ☐ Maximum reached on application renewal ☐ Other, specify: _____

10.7 Waiting period: Week 1 (YYYY-MM-DD):

10.8 Start of illness benefits paid or payable (YYYY-MM-DD):

10.9 Until which date is the employee eligible for illness benefits under this application?

10.10 Once illness benefits are exhausted, is the employee eligible for a subsequent illness application? ☐ Yes ☐ No

If no, reasons:

10.11 If it is an application renewal, was the employee receiving benefits on this application before the start of illness benefits? ☐ Yes ☐ No

If yes, period from (YYYY-MM-DD) to (YYYY-MM-DD):

Identification of Employment Insurance representative

Name of Employment Insurance representative	Telephone number (Area code)	Ext.

Signature of Employment Insurance representative _____ Date (YYYY-MM-DD) _____

Please fill out the back of the form.

This document is available in adapted media upon request.

IDENTIFICATION

Last name	First name	Social insurance number

10. DECLARATION BY EMPLOYMENT INSURANCE (CONTINUED)

Parental, maternity, compassionate leave, family caregiver for children or adults

10.12 ☐ Demande initiale ☐ Application renewal	10.13 Date of start of leave (YYYY-MM-DD):
10.14 Is the beneficiary eligible for benefits? ☐ Yes ☐ No	If yes, indicate eligibility date (YYYY-MM-DD):
	If no, why?

10.15 Waiting period: Week 1 (YYYY-MM-DD):

10.16 Period of payable compassionate benefits from (YYYY-MM-DD) to (YYYY-MM-DD):

10.17 Period of payable family caregiver benefits from (YYYY-MM-DD) to (YYYY-MM-DD):	☐ Children ☐ Adults

10.18 Period of payable maternity benefits from (YYYY-MM-DD) to (YYYY-MM-DD):

10.19 Period of payable parental benefits from (YYYY-MM-DD) to (YYYY-MM-DD):

Identification of Employment Insurance representative

Name of Employment Insurance representative	Telephone number (Area code)	Ext.

Signature of Employment Insurance representative

Date (YYYY-MM-DD)

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

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AVANTAGES SOCIAUX
MÉDIC CONSTRUCTION

APPLICATION FOR HOUR CREDITS

DECLARATION BY THE SAAQ

15

IDENTIFICATION

Last name	First name	CCQ client number	SAAQ file number

IMPORTANT: Fill out the identification section, sign and date the employee's authorization, and then have section 11 filled out by the SAAQ.

EMPLOYEE'S AUTHORIZATION

I authorize all persons providing medical services, healthcare institutions, insurance companies, my current employer and ex-employers, the Commission des normes, de l'équité, de la santé et de la sécurité du travail, the Ministère de l'Emploi et de la Solidarité sociale, the Régie de l'assurance maladie du Québec, the Société d'assurance automobile du Québec, the Retraite Québec, and Employment and Social Development Canada to communicate, through the declaration below or in another way, to the Commission de la construction du Québec (CCQ) or its authorized representatives all the information necessary to process the present application, which is in regard to my work-related benefits and to all disabilities, current or previous, including medical information regarding these disabilities. This authorization is valid for the duration of processing of my application and for as long as I receive benefits from the CCQ.

The information transmitted will be used only for processing the present application and will be accessible only to the employees for whom this information is necessary for them to carry out their duties.

Signature

Date (YYYY-MM-DD)

11. DECLARATION BY THE SAAQ (OR ANALOGOUS AGENCY IN ANOTHER PROVINCE OF COUNTRY)

11.1 Last name and first name of the worker	11.2 File number	11.3 Date of birth (YYYY-MM-DD)
11.4 Date of accident (YYYY-MM-JJ):	11.5 Date of recurrence, relapse or aggravation (YYYY-MM-DD):	
11.6 Diagnosis (diagnoses) accepted:		
11.7 Diagnosis (diagnoses) rejected:		
11.8 Exclusion period (e.g., 180 days) from (YYYY-MM-DD) to (YYYY-MM-DD):	Reason:	
11.9 7-day waiting period from (YYYY-MM-DD) to (YYYY-MM-DD):		
11.10 Periods compensated for disability:	From (YYYY-MM-DD) to (YYYY-MM-DD): From (YYYY-MM-DD) to (YYYY-MM-DD):	
11.11 Date of capacity to return to work (YYYY-MM-DD):	11.12 Date of capacity to perform another job (YYYY-MM-DD):	
11.13 Is there an application awaiting decision? ☐ Yes ☐ No	If yes, since which date? (YYYY-MM-DD):	
11.14 Is there a decision in contestation? ☐ Yes ☐ No	If yes, since which date? (YYYY-MM-DD):	
If yes, what is the subject of the contestation(s):		

Identification of SAAQ representative

Name of SAAQ representative	Telephone number (Area code)	Ext.

SAAQ representative's signature

Date (YYYY-MM-DD)

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Commission de la construction du Québec
Section assurance invalidité, Case postale 2515, succursale Chabanel, Montréal (Québec) H2N 0C7
Or go to your regional office to submit your documents.

Imprimer

This document is available in adapted media upon request.