AVANTAGES SOCIAUX
MÉDIC CONSTRUCTION

CLAIM FOR ACCIDENTAL DISMEMBERMENT BENEFITS

POLICYHOLDER'S STATEMENT

1. POLICYHOLDER DETAILS

CCQ client number		Date of birth (YYYY-MM-DD)	
Last name		First name	
No.	Street		Apartment no.
City	Province		Postal code
Phone (daytime)		Mobile phone no.	

2. INFORMATION ON THE INJURIES

Description of the accident

2.1 Date of the accident (YYYY-MM-DD)	Time _____ AM _____ PM

2.2 What type of accident was it? ☐ Workplace accident ☐ Traffic accident ☐ Personal accident ☐ Other, specify: _____

2.3 Place of accident

2.4 Please explain how the accident occurred.

Description of the injuries

2.5 Please provide a brief description of your injuries.

2.6 Did you undergo surgery? ☐ Yes ☐ No

If so, state the nature of the surgery.	If so, state the date of the procedure (YYYY-MM-DD).

Additional information

3. CERTIFICATION

I certify that all information provided in support of my claim for accidental dismemberment benefits is accurate.

Signature _____ Date (YYYY-MM-DD) _____

4. AUTHORIZATION

To ensure that the Commission de la construction du Québec (CCQ) or its agent, Desjardins Financial Security (DFS), has all the information needed to study my claim for accidental dismemberment benefits, I hereby authorize any physician, health professional, health or social services institution, Retraite Québec, 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'actes criminels (IVAC), the Société d'assurance automobile du Québec (SAAQ), the Régie de l'assurance maladie du Québec (RAMQ), my employers, and the disability insurance plan administrators, to provide to the CCQ or DFS any medical, psychosocial or administrative information that may be required to process my claim for accidental dismemberment benefits. Any such information will be used solely for the purpose of processing my accidental dismemberment claim and will be available solely to those persons for whom the information is needed to carry out their duties or mandate, but may be disclosed to other persons if required by law or if specifically authorized by me. Unless I revoke this authorization, it will remain in effect while my accidental dismemberment claim is being processed.

Signature _____ Date (YYYY-MM-DD) _____

Please return this form to the following address:
Commission de la construction du Québec
Section assurance invalidité, Case postale 2515, succursale Chabanel, Montréal (Québec) H2N 0C7

Imprimer

This document is available in the form of adapted media on request.

AVANTAGES SOCIAUX
MÉDIC CONSTRUCTION

CLAIM FOR ACCIDENTAL DISMEMBERMENT BENEFITS

ATTENDING PHYSICIAN'S STATEMENT

1. PATIENT DETAILS

Last name	First name	Date of birth (YYYY-MM-DD)

2. 2. INFORMATION ON THE DISMEMBERMENT OR LOSS OF USE

2.1 Date of the accident (YYYY-MM-DD)

2.2 Did the total and permanent loss occur within 365 days following the accident? ☐ Yes ☐ No

2.3 In the case of a loss of use, is it total and permanent? ☐ Yes ☐ No

2.4 Is it: ☐ a workplace accident? ☐ a traffic accident? ☐ a personal accident? ☐ Other, specify: _____

2.5 Description of the loss

2.6 In the case of a dismemberment or loss of use, specify the level of amputation or percentage of loss of use.

Date (YYYY-MM-DD)

2.7 Is the loss of use a direct result of the accident and independent of any other cause? ☐ Yes ☐ No

If no, please explain:

2.8 Loss of vision diagnosed at last examination, on (YYYY-MM-DD)

a) Visual acuity		b) Acuity with corrective lenses		c) Vision can be fully or partially corrected by:	
Left eye	Right eye	Left eye	Right eye	Left eye ☐ Glasses ☐ Treatment(s) ☐ Operation ☐ No means	Right eye ☐ Glasses ☐ Treatment(s) ☐ Operation ☐ No means

2.9 Other attending physicians

Name	Address	Date (YYYY-MM-DD)
Name	Address	Date (YYYY-MM-DD)

2.10 Hôpitaux ayant traité l'assuré

Name	Address	Date (YYYY-MM-DD)
Name	Address	Date (YYYY-MM-DD)

Comments:

3. ATTENDING PHYSICIAN'S STATEMENT

Physician's name (please print)	First name (please print)

☐ General practitioner ☐ Specialist Specify: _____ Licence no.

Full address		Stamp
Phone	Fax	
Physician's signature		Date (YYYY-MM-DD)