

Choice of plan

Basic Plan Special Plan

The choice of plan applies to both parents and is irrevocable.

Document intended to help you prepare your application for adoption benefits
Self-employed worker
Québec Parental Insurance Plan

Unofficial document
DO NOT MAIL

Administration by a third party

Are you completing this application for a person who is unable to manage his or her affairs? Yes No

➤ If **yes**, please provide the following information:

In what capacity are you completing this application? _____

Last name according to birth certificate				First name			
Mailing address		Number	Apartment	Street	Post office box	Municipality	
		Province	Country		Postal code	Telephone <small>Area code</small>	

Information on the parent applicant

Last name according to birth certificate				First name					
Date of birth		Year	Month	Day	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social insurance number	Desired language of correspondence	<input type="checkbox"/> French <input type="checkbox"/> English
Home address		Number	Apartment	Street	Post office box	Municipality		Postal code	Telephone <small>Area code</small>
Mailing address <small>(only if different from your home address)</small>		Number	Apartment	Street	Post office box	Municipality		Postal code	Telephone <small>Area code</small>
How would you like us to contact you?				<input type="checkbox"/> By mail or <input type="checkbox"/> By email		Email			
On the start date of your benefit period, were you a resident of Québec? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If you have had another social insurance number in the last three years, please indicate: _____									

Information on the other parent

Last name according to birth certificate				First name					
Date of birth		Year	Month	Day	Sex	<input type="checkbox"/> male <input type="checkbox"/> female	Social insurance number		
If you cannot provide a social insurance number, please indicate why: _____									
If you cannot provide any information on the other parent, please indicate why: _____									
If the other parent has had another social insurance number in the last three years, please indicate: _____									

Information on adoption benefits

Desired benefits start date: _____				Desired number of weeks of adoption benefits (<i>maximum 37</i>): _____						
Breakdown of benefit periods										
Type of benefit		Number of weeks desired			Start date (Sunday)			End date (Saturday)		
Adoption					Year	Month	Day	Year	Month	Day
<i>Note—You can change the breakdown of the benefit periods if necessary.</i>										
Has the child/Have the children with respect to whom you are filing this application been born? <input type="checkbox"/> Yes <input type="checkbox"/> No										
➤ If yes , was the child/were the children born in Québec? <input type="checkbox"/> Yes <input type="checkbox"/> No										
The child(ren) with respect to whom you are filing this application usually lives/live with:										
<input type="checkbox"/> Both parents <input type="checkbox"/> The mother <input type="checkbox"/> The father <input type="checkbox"/> In joint custody <input type="checkbox"/> Other, specify: _____										

Child registration

Identify the child(ren) with respect to whom you are filing this application:			
Last name according to birth certificate	First name	Sex	Date of birth
		<input type="checkbox"/> Male <input type="checkbox"/> Female	Year Month Day
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	

Remuneration end date

If you have received employment income (salary), on what date did you stop working? Year | Month | Day

Note—Paid vacation days, for instance, are considered days worked.

Do you have more than one employment record in the last 52 weeks? Yes No ➤ If **yes**, how many?

Have you reduced your operations as a self-employed worker by at least 40%? Yes No ➤ If **yes**, since what date? Year | Month | Day

Additional information

- Were you a resident of Québec on December 31 of this calendar year preceding the start of your benefit period? Yes No
- In the previous calendar year, did you have:
 - only business income? Yes No
 - business and employment income (salary)? Yes No

➤ If you answered **no** to both questions, skip to question 3.

➤ If you answered **yes**:

 - What was the net business income that you declared to Revenu Québec for the previous calendar year or what is your estimated business income if you have not filed an income tax return? \$
 - What was the net employment income (salary) that you declared to Revenu Québec for the previous calendar year or what is your estimated employment income if you have not filed an income tax return? \$

Skip to question 4.
- In this calendar year, did you or will you have:
 - only business income? Yes No
 - employment income (salary) only or employment income (salary) and business income? Yes No

➤ If you answered **yes**:

 - What do you expect your net business income to be for this year? \$
 - What do you expect your employment income (salary) to be for this year? \$
- In this calendar year, did you or will you have remuneration as a family-type resource or intermediate resource only, or remuneration as a family-type resource or intermediate resource in addition to business income or employment income (salary)? Yes No
- Have you had employment income (salary) in the last 52 weeks? Yes No
 - If you answered **yes**:
During the periods covered by the employment record(s) issued in the 52 weeks preceding the desired benefit start date, were there any full weeks (Sunday to Saturday) in which, although employed, you did not work and were not paid? Yes No
 - If **yes**, please complete the table below, starting with the most recent week.

Periods	From Sunday			to Saturday		
	Year	Month	Day	Year	Month	Day
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

We will calculate your benefit as stipulated by law and the regulation. If you have had employment income (salary) in the last 52 weeks, we will make another calculation based on this income. We will allocate you the benefit that is most beneficial to you.

Additional information (continued)

6. From January 1 of the previous calendar year to today, please indicate in the table below the reason or reasons for which it was impossible for you to have business income or employment income (salary).

Reason		Period from			to		
		Year	Month	Day	Year	Month	Day
You received employment insurance benefits (maternity/parental benefits for another birth or adoption, or regular benefits, sickness benefits or compassionate care benefits).	<input type="checkbox"/> Yes <input type="checkbox"/> No						
You received parental insurance under the QPIP for another birth or adoption.	<input type="checkbox"/> Yes <input type="checkbox"/> No						
You received indemnities from the Société de l'assurance automobile du Québec (SAAQ).	<input type="checkbox"/> Yes <input type="checkbox"/> No						
You received indemnities from the CSST (precautionary cessation of work, work accident, occupational disease, other).	<input type="checkbox"/> Yes <input type="checkbox"/> No						
You received indemnities (other than those from the CSST) under a provincial law for a precautionary cessation of work, work accident, occupational disease, civic duty or as a victim of a criminal act.	<input type="checkbox"/> Yes <input type="checkbox"/> No						
You were unable to work due to illness, injury, quarantine or pregnancy for another reason than those mentioned above.	<input type="checkbox"/> Yes <input type="checkbox"/> No						
You received employment-assistance allowances from Emploi-Québec.	<input type="checkbox"/> Yes <input type="checkbox"/> No						
You were detained in a detention centre.	<input type="checkbox"/> Yes <input type="checkbox"/> No						
You were taking a course recommended by employment insurance or one of its service providers.	<input type="checkbox"/> Yes <input type="checkbox"/> No						
You were on strike or in a lockout.	<input type="checkbox"/> Yes <input type="checkbox"/> No						
Did you have enough space to enter the periods? <input type="checkbox"/> Yes <input type="checkbox"/> No ➤ If no, you must indicate any additional periods below.							

7. Since the desired benefits start date,
a) excluding the arrival of the child(ren) for whom you are requesting benefits, have you been unable to work for any other reason? Yes No

➤ If yes, please complete the table below.

Situations		Period from			to		
		Year	Month	Day	Year	Month	Day
Have you received compassionate care or illness benefits from employment insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
Have you cared for or supported a seriously ill family member without receiving employment insurance benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
Have you been ill for a reason unrelated to your pregnancy without receiving employment insurance benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
b) has the child (or have the children) for whom you are submitting this application been hospitalized for at least one full week (period running from Sunday to Saturday)?	<input type="checkbox"/> Yes <input type="checkbox"/> No						

Have you listed all your periods? Yes No ➤ If no, you must indicate any additional periods below.

8. Since the desired benefit start date, have you received:

Note—Paid vacation days, for instance, are considered days worked.

		Period from Sunday to Saturday						Gross amount	Net amount	Will you continued to receive this same amount without interruption?	End date, if known (Saturday)		
		Year	Month	Day	Year	Month	Day				Year	Month	Day
Employment income?								\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Indemnities from the Société de l'assurance automobile du Québec (SAAQ)?	<input type="checkbox"/> Yes <input type="checkbox"/> No							\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Indemnities from the Commission de la santé et de la sécurité du travail (CSST) for precautionary cessation of work?	<input type="checkbox"/> Yes <input type="checkbox"/> No							\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Other indemnities from the CSST?	<input type="checkbox"/> Yes <input type="checkbox"/> No							\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, specify:								\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Other income?	<input type="checkbox"/> Yes <input type="checkbox"/> No							\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, specify:								\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No			
								\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No			
								\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No			

Supplement for low-income families

Was your net family income for the reference year in which your benefit application was made under \$25,921? Yes No

► If **no**, skip to the next step.

Do you live with your spouse? Yes ► Is this spouse the other parent? Yes No ► If **no**, please answer the following questions.

No

Information identifying a spouse living with you who is not the other parent

Last name according to birth certificate

First name

Date of birth

Year

Month

Day

Social insurance number

Other social insurance number, if applicable

If you cannot provide your spouse's social insurance number, please indicate why:

To whom must the supplement be paid if you and the other parent receive benefits at the same time? To me To the other parent

If the spouse has had another social insurance number in the last three years, please indicate:

Do you have joint custody of the child/children? Yes No

Source deductions

Are you a status Indian? Yes No ► If **yes**, would you like total exemption from income tax source deductions from your benefits? Yes No

What is the applicable tax credit for source deductions made for your benefit? Basic amount Amount transferred from spouse

If you wish, you may also enter additional source deduction amounts, **from each payment of two weeks of benefits**, to be broken down as follows:

► Provincial tax: \$ _____

► Federal tax: \$ _____

Direct deposit

Would you like to have your benefits directly deposited? Yes No ► If **yes**, please give the required information about your financial institution.

Financial institution information

Branch number

Financial institution number

Account number at the financial institution

Request for access to interactive voice response system

An interactive voice response system allows you to obtain information on or make certain changes to your file.

Would you like to use this service? Yes No ► If **yes**, we will send you your user ID and password.

OPTIONAL ► May we contact you to conduct surveys to improve our customer service? Yes No