

Canada/Antigua and Barbuda Agreement

Applying for an Antigua and Barbuda invalidity benefit

Here is some important information you need to consider when completing your application.

Please ensure you sign the application. If you are signing with a mark, (for example: "X") the signature of a witness is required.

Your application must be supported by documentation. Please submit the documents requested. Failure to complete the application and provide the requested documentation may result in delays in processing your application.

Where original documents are specifically requested, originals must be submitted with your application. You should keep a certified true copy of any originals you send us for your records. Some countries require original documentation which will not be returned to you.

You may submit the original or a photocopy that is certified as true for any of the documents where originals are not required. It is better to send certified copies of documents rather than originals. If you choose to send original documents, send them by registered mail. We will return the original documents to you. We can only accept a photocopy of an original document if it is legible and if it is a certified true copy of the original. Our staff at any Service Canada centre will photocopy your documents and certify them free of charge. If you cannot visit a Service Canada Centre, you can ask one of the following people to certify your photocopy:

Accountant; Chief of First Nations Band; Commissioner for Oaths; Employee of a Service Canada Centre acting in an official capacity; Funeral Director; Justice of the Peace; Lawyer, Magistrate, Notary; Manager of Financial Institution; Medical and Health Practitioners: Chiropractor, Dentist, Doctor, Naturopathic Doctor, Nurse Practitioner, Ophthalmologist, Optometrist, Pharmacist, Psychologist, Registered Nurse; Member of Parliament or their staff; Member of Provincial Legislature or their staff; Minister of Religion; Municipal Clerk; Official of a federal government department or provincial government department, or one of its agencies; Official of an Embassy, Consulate or High Commission; Officials of a country with which Canada has a reciprocal Social Security Agreement; Police Officer; Professional Engineer; Social Worker; Teacher, University Professor.

People who certify photocopies must compare the original document to the photocopy, state their official position or title, sign and print their name, give their telephone number and indicate the date they certified the document.

They must also write the following statement on the photocopy: **This photocopy is a true copy of the original document which has not been altered in any way.**

If a document has information on both sides, both sides must be copied and certified. You cannot certify photocopies of your own documents, and you cannot ask a relative to do it for you.

Return your completed application, forms and supporting documents to:

International Operations
Service Canada
P.O. Box 2710 Station Main
Edmonton AB T5J 2G4
CANADA

Disclaimer:

This application form has been developed by external sources in cooperation with Employment and Social Development Canada. The content and language contained in the form respond to the legislative needs of those external sources.

SOCIAL SECURITY ACT 1972

APPLICATION FOR INVALIDITY BENEFIT

Soc. Sec. No.

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Date of Birth

D	M	Y

TO: The Director
Social Security

Full Name of Insured Person

ADDRESS

I hereby state that I am incapable of work as a result of a disablement which is likely to remain permanent and I am claiming Invalidity Benefit from
(Date)

During the last fifty-two weeks my employers were:—

- (1) NAME ADDRESS.....
- (2) NAMEADDRESS
- (3) NAMEADDRESS
- (4) NAME ADDRESS

PLEASE SUPPLY THE FOLLOWING INFORMATION.

- (1) Have you previously received INVALIDITY BENEFIT from the SOCIAL SECURITY FUND
Yes/No
- (2) Are you receiving any SOCIAL SECURITY BENEFIT?
Yes/No
If so, please state which
- (3) What is your usual Occupation?
- (4) If because of your incapacity that you are unable to cash your cheques personally and you wish that your cheques be made payable to someone else, please give name and address of the person:—
NAME
ADDRESS

I declare that the foregoing statements given in this form are true to the best of my knowledge and belief.

I also authorise the disclosure of the Diagnosis overleaf for the purpose of the Antigua and Barbuda Social Security Invalidity Benefit.

Signature

Date 19

If you are too ill to sign this claim yourself, it may be signed on your behalf by someone who should state that he or she has done so.

IMPORTANT

Please complete fully and send to
the Social Security office immediately.
Delay may mean loss of benefit.

**MEDICAL CERTIFICATE OF PERMANENT
INCAPACITY FOR WORK**

To be completed by a Registered Medical Practitioner

TO: Mr.
 Mrs.
 Miss

I hereby certify that on 19 , I examined
you and found that you are suffering from

.....
(Please Print)

.....
a disablement which is likely to remain permanent. In my opinion you are likely to remain permanently
incapable of work as a result of this disablement.

NAME
(Please Print)
Registered Doctor

ADDRESS

SIGNATURE

.....
.....
.....
Date

Any other Remarks by Doctor

.....
.....
.....

NOTE

For the purpose of the Benefit Regulations "INVALID"
means a person incapable of work as a result of a
specific disease or bodily or mental disablement
which is likely to remain permanent.

Canada/Antigua and Barbuda Agreement

Documents and/or information required to support your application for an Antigua and Barbuda invalidity benefit

Complete the attached forms:

- *Canadian Residence* [SC ISP5013]
- *Medical Report* [ISP 2519], *Questionnaire for Disability Benefits* [ISP 2507], and *Consent for Service Canada to Obtain Personal Information* [ISP-2502B] (only required if you have never applied for a Canada Pension Plan Disability benefit)

Originals or certified copies to be submitted:

- Your birth certificate
- Identification page of your passport
- Marriage certificate, if applicable
- Divorce decree, if applicable
- Document(s) for any name change other than marriage or divorce, if applicable
- Proof of the dates of your entry(ies) to Canada and departure(s) from Canada (such as: Immigration 1000, passport, visa, ship or airline tickets, etc.)

IMPORTANT: If you have already submitted any of the documents required when you applied for a Canada Pension Plan or Old Age Security benefit, you do not need to resubmit them.



CANADIAN RESIDENCE

Canadian Social Insurance Number: _____

☐ Mr. ☐ Mrs.

☐ Ms. ☐ Miss

Given Name and Initial

Family Name

The following information is required to support your application for benefits under a social security agreement. If required, please provide additional information on a separate sheet of paper.

1. If you were born outside of Canada, please provide us with the following information:

Date of arrival in Canada (YYYY-MM-DD): _____

Place of arrival in Canada: _____

2. List all the places where you have lived in Canada after the age of 18 and provide proof of all your entries and departures (Permanent Resident card, Record of Landing (IMM 1000), complete passport, airline tickets, etc.):

From YYYY-MM-DD	To YYYY-MM-DD	City	Province/Territory

3. List all absences from Canada, which were longer than six months, during your Canadian residence listed in number 2 above:

Departure YYYY-MM-DD	Return YYYY-MM-DD	Destination	Reason

Canadian Social Insurance Number: _____

PROTECTED B (when completed)

4. Please give us the names, addresses and telephone numbers of at least two people, not related to you by blood or marriage, who can confirm your Canadian residence:

Name	Address	City	Telephone Number

DECLARATION OF APPLICANT

I declare that this information is true and complete.

NOTE: If you make a false or misleading statement, you may be subject to an administrative monetary penalty and interest, if any, under the *Canada Pension Plan* or the *Old Age Security Act*, or may be charged with an offence. Any benefits you received or obtained to which there was no entitlement would have to be repaid.

Signature

Date (YYYY-MM-DD)

X _____

Telephone number



MEDICAL REPORT

SECTION A - To be completed by Applicant			
First Name and Initial		Last Name	
Home Address (No., Street, Apt. No., P.O. Box, R.R.)		City, Town or Village	
Province or Territory	Country		Postal Code
Telephone number	Date of Birth (Year Month Day)	Canadian Social Insurance Number	
SECTION B - To be completed by Physician			
Please provide factual objective opinions			
1. Height	2 a) How long have you known the patient?	b) When did you start treating the patient for the main medical condition? Year Month	c) Date of last visit Year Month Day
Weight			
3. Diagnosis(es)			
4. Relevant/significant medical history relating to the main medical condition:			

Please write legibly

Service Canada delivers Employment and Social Development Canada
programs and services for the Government of Canada

Canadian Social Insurance Number:

5. Over the past two years, has the patient been admitted to a hospital/institution?☐ Yes **If yes, please list:**☐ No

Name of the Hospital(s)/Institution(s)

The date(s) of admission

Year Month Day

The reason(s) for admission

6A. Is there supporting evidence for the main medical condition? Please attach supporting documentation.

Laboratory Reports

☐ Yes ☐ No

X-ray reports

☐ Yes ☐ No

Consultants' opinions

☐ Yes ☐ No

Other

☐ Yes ☐ No

Documentation to be returned

☐ Yes ☐ No**6B. Please describe relevant physical findings and functional limitations.**

Please write legibly

Canadian Social Insurance Number:

7. Are further consultations or medical investigations planned relating to the main medical condition?

☐ Yes **If yes,** please specify:

☐ No

8. Is the patient currently on medication(s) as a result of the main medical condition?

☐ Yes **If yes,** please indicate dosage and frequency.

☐ No

9. Treatment: List type and response.

Please write legibly

Canadian Social Insurance Number:

FOR OFFICE USE ONLY

☐

A.C.

Initials

Year

Month

Day

10. Prognosis of the main medical condition of this patient:

11. Additional Information

SIGNATURE (Please print or use a stamp)

Physician's Full Name

Address

Postal Code

☐

Family Physician

☐

Nurse Practitioner

☐

Specialty

Signature

X

Year

Month

Day

Telephone No.

Please write legibly



QUESTIONNAIRE FOR DISABILITY BENEFITS CANADA PENSION PLAN

1. FIRST NAME AND INITIAL	LAST NAME	SOCIAL INSURANCE NUMBER
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EDUCATION

2. What was the highest grade you completed in school?	Have you attended college or university? ☐ Yes If yes , indicate number of years and/or diploma/degree obtained. ☐ No	
3. Have you ever been involved in any technical, trade, or on the job training?	☐ Yes If yes , provide the following details: ☐ No	
Dates _____	Type of program _____	Certificate obtained _____

WORK HISTORY (BE SURE TO INCLUDE WORK DONE IN CANADA AND/OR OTHER COUNTRIES)

EMPLOYEE

4. Have you stopped working completely?	Type of Work				
☐ Yes, go to question 5. ☐ No, provide the following information:	☐ Full-time ☐ Part-time ☐ Volunteer ☐ Seasonal				
Number of hours per day _____	Number of days per week _____	If seasonal, explain period(s) of work _____	Salary per hour _____	/or per day _____	/or per year _____
5. If you have stopped working completely, provide the following information:	What kind of work did you do in your most recent job?				
Why did you stop working? _____	Date employment started (YYYY-MM-DD) _____	Last day on the job (YYYY-MM-DD) _____			

6. Name and full address of your present or most recent employer.

SELF - EMPLOYED

7. If you are or were self-employed, provide the following information:	
a) Date business started (YYYY-MM-DD) _____	b) When did you actually stop working in the business? (YYYY-MM-DD) _____
c) Why did you stop working in the business? _____	
d) Describe the business operation _____	
e) What was your involvement with the business? _____	

SELF - EMPLOYED (CONTINUED)

f) Are you involved in the business in any way at the present time?

- ☐ Yes, explain your present involvement.
- ☐ No, provide the following information:

Indicate what disposition has been made for the business:

☐ sold ☐ rented ☐ profit sharing

Date of disposition

(YYYY-MM-DD)

If **no disposition** has been made of the business, how does it operate now and what arrangements are you contemplating in the future?

g) What was the last year that an income tax return on the operation of the business was filed in your name?

h) Will you declare yourself a self-employed person for income tax purposes this year?

☐ Yes ☐ No

OTHER WORK HISTORY**IF THERE IS INSUFFICIENT SPACE TO LIST ALL YOUR OTHER TYPES OF WORK, USE THE SPACE AT THE END OF THIS QUESTIONNAIRE.**8. In the past two years, did you do **any other work** in addition to your main job (such as part-time farming, night or other employment)?

☐ Yes **If yes**, provide the following details:

☐ No

Type of work	Number of hours per day	Number of hours per week	Work started (YYYY-MM-DD)	Last day on the job (YYYY-MM-DD)
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Name and full address of employer

9. Have you done **any other type of work** in the last five years?

- ☐ Yes **If yes**, list the type of work and the dates.
- ☐ No

From

To

Year Month Day

Year Month Day

10. Because of your medical condition, did you have to do a lighter job or a different type of work?

☐ Yes **If yes**, please describe.

☐ No

11. Has your physician told you when you can return to work?

☐ Yes **If yes**, give the date: (YYYY-MM)

☐ No

12. Do you plan to return to work or seek work in the near future?

☐ Yes **If yes**, answer **one** of the following questions:

☐ No

a) The date you plan to **return** to your former employer/employment (YYYY-MM)b) The date you will **start** a new job. (YYYY-MM)

c) The date you plan to start looking for work. (YYYY-MM)

Social Insurance Number:

PROTECTED B (when completed)

OTHER BENEFITS

13. If you are receiving any form of accident or illness/disability benefits, state the name of the insurance company

14. If any of your health problems are covered by Provincial workers' compensation benefits, provide details in each case.

Claim Number

Province or Territory

Year

Injury

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

State type of benefit
you now receive.

Percentage of
pension awarded

15. Have you received regular Employment
Insurance benefits in the last two years?

☐ Yes If yes, give the dates:
☐ No

From (YYYY-MM-DD)

To (YYYY-MM-DD)

From (YYYY-MM-DD)

To (YYYY-MM-DD)

MEDICAL INFORMATION

16. When could you no longer work because of your medical condition?

(YYYY-MM-DD)

17. Height

Weight

☐ Right-handed

☐ Left-handed

18. State the illnesses or impairments that prevent you from working. If you do not know the medical names, describe in your own words.

19. Describe how these illnesses or impairments prevent you from working.

20. If you have other health-related conditions or impairments, please describe them.

21. If you had to stop other activities (such as hobbies, sports or volunteer work), please explain and give dates activities ceased.

22. Explain any difficulties/functional limitations you have with the following:

Sitting/Standing (How long?)	Seeing/Hearing
Walking (How long and how far?)	Speaking
Lifting/Carrying (How much and how far?)	Remembering
Reaching	Concentrating
Bending (How much?)	Sleeping
Personal needs (Eating, washing hair, dressing, etc.)	Breathing
Bowel and bladder habits	Driving a car (How long?)
Household maintenance (Cooking, cleaning, shopping and similar activities)	Using public transportation

Social Insurance Number:

PROTECTED B (when completed)

INFORMATION ABOUT YOUR PHYSICIANS

23. Provide the following information about the physician who will be completing your medical report.

Physician's Full Name				☐ Family Physician		☐ Specialist (Please specify)	
Address					City		
Province or Territory	Country (If other than Canada)	Postal Code	Telephone Number				
When did you first see this physician? (YYYY-MM)			When was your last visit? (YYYY-MM)				

What were the reasons for your visits?

24. List all other physicians you have seen in the last two years (space for two physicians is provided). If there is insufficient space to list all of your physicians, use the space at the end of this questionnaire.

a) Physician's Full Name				Specialty		
Address					City	
Province or Territory	Country (If other than Canada)	Postal Code	Telephone Number			
When did you first see this physician? (YYYY-MM)			When was your last visit? (YYYY-MM)			

Were your visits related to your present medical condition? ☐ Yes **If yes, explain the reasons for your visits.**
☐ No

b) Physician's Full Name				Specialty	
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Address					City	
Province or Territory	Country (If other than Canada)	Postal Code	Telephone Number			
When did you first see this physician? (YYYY-MM)			When was your last visit? (YYYY-MM)			

Were your visits related to your present medical condition? ☐ Yes **If yes, explain the reasons for your visits.**
☐ No

HOSPITALIZATION

25. If you have been admitted to hospital in the last two years, please provide the following information. Space for two hospitals is provided. If there is insufficient space to list all of the hospitals, use the space at the end of this questionnaire.

a) Name of hospital Mailing address (No., Street, P.O. Box, R.R.)

City	Province or Territory	Country (If other than Canada)	Postal Code
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Date admitted (YYYY-MM-DD)	Date discharged (YYYY-MM-DD)	Name of attending physician
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Reason for admission and type of treatment

b) Name of hospital Mailing address (No., Street, P.O. Box, R.R.)

City	Province or Territory	Country (If other than Canada)	Postal Code
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Date admitted (YYYY-MM-DD)	Date discharged (YYYY-MM-DD)	Name of attending physician
----------------------------	------------------------------	-----------------------------

Reason for admission and type of treatment

MEDICATION AND TREATMENT

26. List any medication you now take.

Name of medication	Dosage	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

27. Describe other treatment you receive (such as counselling, physiotherapy).

28. If future treatments or medical tests are planned, please explain, giving dates.

29. List any medical devices you use (such as crutches, cane, artificial limb, splints, braces, wheelchair, hearing aid, heart pacemaker, ostomy apparatus).

VOCATIONAL REHABILITATION

30. If considered suitable, would you consent to a vocational rehabilitation assessment?

☐ Yes☐ No **If no**, please explain.

31. Are you presently or have you ever been involved in a rehabilitation program?

☐ Yes **If yes**, please provide details.☐ No**DECLARATION AND SIGNATURE**

I realize that my personal information is governed by the *Privacy Act* and it can be disclosed where authorized under the Canada Pension Plan.

I agree to notify the Canada Pension Plan of any changes that may affect my eligibility for benefits. This includes: an improvement in my medical condition; a return to work (full, part-time, volunteer, or trial period); attendance at school or university; trade or technical training; or any rehabilitation.

Note: If you make a false or misleading statement, you may be subject to an administrative monetary penalty and interest, if any, under the *Canada Pension Plan*, or may be charged with an offence. Any benefits you received or obtained to which there was no entitlement would have to be repaid.

Signature of Applicant or Representative

Date (YYYY-MM-DD)

Telephone Number

X

Use this space if required. Identify the number of the question the information belongs to.

**GIVE THIS FORM TO YOUR PHYSICIAN OR
NURSE PRACTITIONER WITH THE MEDICAL REPORT**

Consent for Service Canada to Obtain Personal Information

Service Canada is authorized under Section 68 and 69 of the *Canada Pension Plan (CPP) Regulations* to receive personal (medical and non-medical) information about you to decide if you qualify or continue to qualify for CPP disability benefits. Your consent to permit Service Canada to obtain this information is necessary, should Service Canada need this information from persons and organizations listed on the following page.

Protecting your privacy:

Service Canada cannot give your personal information to any person or organization without your written consent, except where authorized by *CPP legislation*. Under the *Privacy Act*, you (or your authorized representative) have the right to request a copy of the information in your file and to request correction(s) to that information. Your personal information is retained in Personal Information Bank (ESDC PPU 146). Instructions for accessing this information are provided in the Info Source, a copy of which is located in Service Canada offices or at: infosource.gc.ca

Instructions:

- Complete Sections 1 and 2 of this form; and
- Give this form to **your physician or nurse practitioner** with the medical report.

Section 1 - Client Information			
☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.		Canadian Social Insurance Number	
First Name and Initial		Last Name	
Mailing address (No., Street, Apt. No., P.O. Box, R.R.)		City, Town or Village	
Province or Territory	Country	Postal Code	
Telephone Number		Fax Number	

Service Canada delivers Employment and Social Development Canada
programs and services for the Government of Canada

Consent to obtain personal information

I give Service Canada my consent to obtain personal information about me that would help decide if I qualify or continue to qualify for Canada Pension Plan disability benefits. For this reason, Service Canada may contact any of the following persons and organizations if necessary:

- medical doctors, nurse practitioners, consultant specialists, or health-care professionals
- medical facilities or hospitals
- educational institutions or other vocational agencies
- my accountant or book-keeper for information on self-employment
- administrators of insurance plans
- federal, provincial, territorial, or municipal government departments and agencies
- employers, former employers
- provincial or territorial workers' compensation boards
- financial institutions - for address updates only

Section 2 - I give my consent or I do not give my consent

☐ I give my consent to Service Canada to obtain medical and other personal information about me from all persons and organizations listed above. I understand that this information may help in determining if I qualify or continue to qualify for Canada Pension Plan disability benefits.

☐ I do not give my consent to Service Canada to obtain medical and other personal information about me from all persons and organizations listed above.

I understand that my refusal means:

- that Service Canada will make a decision based on the available information on my file;
- if I am already receiving disability benefits, Service Canada may stop paying me the benefits; and
- under certain circumstances, Service Canada can require that I provide the necessary information (*CPP Regulations* and Pension Appeals Board Rules of Procedures).

Signature _____ Date of signature _____
(YYYY-MM-DD)

To be completed by witness if signed with a mark "X" or by a representative of the applicant

First Name and Initial

Last Name

Telephone Number

Signature _____ Date of signature _____
(YYYY-MM-DD)

This signed consent is valid for up to **3 years** unless you cancel it in writing. A photocopy or fax of this completed form is as valid as the original.