Canada/Croatia Agreement

Applying for a Croatian disability pension

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.

HRVATSKI ZAVOD ZA MIROVINSKO OSIGURANJE
SREDIŠNJA SLUŽBA
✉ 10000 ZAGREB, Ul. A. Mihanovića 3 ☎Telefon 385/1/45 95 500 Telefaks 385/1/45 95 066

CAN/HR 3

Zahtjev za invalidsku mirovinu
Demande de pension d'invalidité
Application for disability benefits

Mjesto za potvrdu i napomene tijela za vezu
Espace pour attestations et remarques de l'institution de sécurité sociale
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Datum podnošenja zahtjeva:
Date du dépôt de la demande:
Claim submitted on:

Molimo pišite čitko
Prière d'écrire lisiblement
Please print!
Pitanja s alternativnim odgovorom označite ☒
Pour les questions posant une alternative, marquer d'une croix ce qui convient ☒
Mark questions with alternative answer with ☒

OB (osobni broj) u Hrvatskoj /__/__/__/__/__/__/__/__/__/__/__/
Numéro personnel d'identification de la Croatie
Croatian Personal Identification Number

JMBG (jedinstveni matični broj građana) u Hrvatskoj /__/__/__/__/__/__/__/__/__/__/__/__/__/
Numéro d'enregistrement des citoyens de la Croatie
Croatian Citizen's Registration Number

Kanadski broj socijalnog osiguranja |__/__/__|__/__/__|__/__/__|
Numéro d'assurance sociale canadien
Canadian Social Insurance Number

A. Osobni podaci o osiguraniku
A. Identité de l'assuré
A. Personal information about the contributor

Za osiguranice udane ili udovice navedite djevojačko prezime
Pour les assurées mariées ou veuves, indiquer le nom de jeune fille
1. Prezime — For female contributor(married or widowed) indicate family name at birth
Nom
Family name ……

Navedite sva imena i podvucite uobičajeno ime — SPOL/SEXE/ SEX
Indiquer tous les prénoms et souligner le prénom usuel — ženski/fém. /female ☐ muški/masc./male ☐
Indicate all names and underline common name

2. Ime
Prénoms
Name …..……..……..……..……

3. Datum i mjesto rođenja
Date et lieu de naissance
Date and place of birth ……..…

4. Ime oca
Prénoms du père ……..……..……...
Father's name
Ime i djevojačko prezime majke
Prénoms et nom de jeune fille de la mère
Mother's given name and family name at birth ……..……..…

5. Bračno stanje État civil Marital status	Neoženjen célibataire Single	Oženjen marié(e) Married	Udovac veuf(veuve) Widowed	Razveden divorcé(e) Divorced
označite x ili navedite datum Marquer d'une croix ce qui convient et indiquer la date Mark with x and indicate date	☐	☐	☐	☐
	Od kada? Depuis quand? Since when?	.....	.....	.....

6. Državljanstvo
Nationalité
Nationality .....

Mjesto za potvrdu i napomene tijela za vezu
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7. Adresa
Adresse
Address

Poštanski broj, mjesto, ulica i broj, država
Code postal, ville, rue et numéro, pays
Postal code, city, street and no., country

.....

.....

8. Za osobe pod skrbništvom
Pour les personnes sous tutelle
For persons under guardianship

Prezime,ime i adresa skrbnika
Nom et adresse du tuteur
Family name, name and address of guardian

.....

.....

.....

B. Podaci o obrazovanju osiguranika
B. Indications concernant les études de l'assuré
B. Information about contributor's education

1. Profesija za koju je osposobljen
Profession apprise
Profession

Vrsta stručne izobrazbe (školovanje, učenje zanata, ubrzana stručna izobrazba u poduzeću itd.) Genre de formation profesionnelle (études, apprentissage, formation accélérée dans l'exploitation, etc.) Type of education (schooling, apprenticeship, trade training)	Naziv i adresa škole ili prezime, ime i adresa obrtnika kod koga je učio zanat Nom et adresse de l'école ou nom et adresse du maître d'apprentissage Name and address of school or full name and address of artisan where apprenticeship was served	od du from	do au to
.....			
.....			
.....			
.....			

C Podaci o promjeni zdravstvenog stanja
C. Indications concernant l'atteinte à la santé
C. Information about a change in the medical condition

1.a. Od čega je uzrokovana:
L'atteinte à la santé a-t-elle été causée par un(e):
What was the cause of the change in medical condition:

Bolest ☐	Ozljeda izvan rada ☐	Ozljeda na radu ☐	Profesionalna bolest ☐
Maladie	Accident	Accident de travail	Maladie professionnelle
Disease	Accident	Work accident	Professional disease

b. Podaci o promjeni
Précisions concernant le genre de l'atteinte
Precise information about the change

……

……

……

c. Od kada postoji promjena?
Depuis quand l'atteinte existe-t-elle?
Since when does the change exist?

……

……

d. Je li ozljedu uzrokovala treća osoba? da/oui/yes ☐ ne/non/no ☐
L'atteinte a-t-elle été causée par un tiers?
Was the injury caused by a third person?

Ako da, navedite ime i adresu treće osobe.
Si oui, indiquer le nom et l'adresse du tiers.
If yes, indicate name and address of third person.

……

……

……

2. Tko je osiguranika liječio? (Prezime i ime obiteljskog liječnika)
Qui a traité médicalement l'assuré pour cette atteinte? (nom du médecin de famille)
Who treated the contributor? (full name of family doctor)

Prezime, ime i adresa liječnika ili zdravstvene ustanove Nom et adresse du médecin ou de l'établissement hospitalier Full name and address of the medical doctor or hospital	od - do (mjesec i godina) De quand à quand? (mois et année) from - to (month and year)	Od koje bolesti? Pour quelles affections? For which disease

……

……

……

3. Naknadne napomene:
Remarques complémentaires:
Further notes:

……

……

……

D. Opći podaci
D. Indications générales
D. General information

1. Je li već osiguranik podnio zahtjev za davanja iz kanadskog invalidskog osiguranja?
Une demande de pension d'invalidité du Régime du pensions du Canada en faveur de l'assuré a-t-elle été présentée?
Has the contributor requested a Canada Pension Plan disability pension?

da/oui/yes ☐ ne/non/no ☐

……

……

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2. Isplaćuje li se već davanje (mirovina ili drugo) iz kanadskog osiguranja za slučaj starosti-smrti ili invalidskog osiguranja:
   Des prestations de la Sécurité de la vieillesse du Canada ou une prestation de retraite, d'invalidité ou de survivants du Régime de pensions du Canada sont-elles versées :
   Are Canadian Old Age Security benefits or Canada Pension Plan retirement, disability or survivors benefits being paid to the:

   a. za osiguranika? da/oui/yes ☐ ne/non/no ☐
   à l'assuré?
   contributor?

   b. Ako se isplaćuje, od kada?
   Si oui, depuis quelle date?
   If yes, since when?

   ……..

   ……..

3. Navedite točan datum prestanka zaposlenja u Kanadi
   Indiquer la date exacte de cessation du travail au Canada
   Indicate precise date on which employment ceased in Canada

……

……

4. Prima li osiguranik već davanje iz hrvatskog osiguranja?
   L'assuré reçoit-il déjà une prestation de l'assurance croate?
   Does the contributor already receive a Croatian insurance benefit?

   da/oui/yes ☐ ne/non/no ☐

……

Ako da, od kada?
Si oui, depuis quand?
If yes, since when?

……

……

……

Od kojeg tijela?
De quel organisme?
From which institution?

……

……

……

5. Gdje i kada je osiguranik bio zaposlen u Hrvatskoj?
   Où et pendant combien de temps l'assuré a-t-il exercé une activité lucrative en Croatie?
   Where and when has the contributor been employed in Croatia?

Mjesto zaposlenja Lieu de travail Place of work	Prezime, ime i adresa poslodavca (za osobe koje su obavljale samostalnu djelatnost-vrstu djelatnosti) Nom et adresse de l'employeur (pour les personnes ayant exercé une activité indépendante: genre d'activité) Full name and address of employer (for self-employed: type of business)	od du from	do au to

……

……

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……

……

……

……

……

Mjesto za potvrdu i napomene tijela za vezu
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For use by the social security institution only

6. Želite li isplatu mirovine:
   Désirez-vous le versement de vos prestations
   Do you want the payment of your benefits to be sent

   a) putem banke / par intermédiaire d'une banque / to a bank account ☐

   b) na kućnu adresu / directement à votre domicile / to your home address ☐

-ako želite isplatu putem banke, navedite nazivi adresu i broj Vašeg računa banke:
-si vous désirez le versement par intermediaire d'une banque indiquez le nom et l'adresse de la banque et votre numéro de compte:
-if you want your payment to be sent to your bank account, indicate the name and address of the bank and number of your bank account:

……..

……..

7. Popis priloženih dokumenata:
   Liste des annexes:
   List of enclosed documents:
   a) Radna knjižica i sve potvrde o radu osiguranika u Hrvatskoj
      Livret de travail et tous les certificats concernant le travail de l'assuré en Croatie
      Contributor's working book and all certificates relating to work in Croatia

      Broj priloženih dokumenata: ……...…
      Nombre de documents joints:
      Number of enclosed documents:

…….

…..……..……..……...…

   b) Obavezno treba priložiti raspoloživu medicinsku dokumentaciju za osiguranika
      Joindre obligatoirement la documentation médicale concernant l'assuré
      Medical evidence for the contributor must be enclosed

      Broj priloženih dokumenata: ……..
      Nombre de documents joints:
      Number of enclosed documents:

……..…

……

   c) Ostali dokumenti ……..
      Pièces d'identité officielles
      Official identification documents

……

……..……

……

Potpisani tvrdi da je potpuno i istinito odgovorio na sva pitanja.
Le(la) soussigné(e) certifie avoir répondu à toutes les questions de manière complète et conforme à la vérité.
The undersigned, claims to have answered all the questions completely and truthfully.

Datum ……
Date, le
Date

Potpis osiguranika ili njegova zastupnika
Prezime i ime
Signature de l'assuré ou de son représentant
Nom et prénoms
Signature of contributor or his/her representative
Family name and name

……..……

……..……

Mjesto za potvrdu i napomene tijela za vezu
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Adresa zastupnika ako osiguranik sam ne potpisuje
Adresse du représentant si l'assuré ne signe pas lui/elle -même
Address of representative if contributor does not sign himself/herself

……...……

……...……

Dolje potpisano tijelo za vezu sukladno odredbi članka 4. Administrativnog sporazuma potvrđuje valjanost priloženih službenih dokumenata.
L'institution de sécurité sociale, en application du paragraphe 4 de l'Arrangement administratif, confirme la validité des pièces officielles ci-jointes.
The undersigned social security institution, in accordance with paragraph 4 of the Administrative Arrangement, confirms the validity of the enclosed official documents.

…….…….
……..
……..
……..
……..

Mjesto i datum
Lieu et date
Place and date

..……..

Pečat i potpis
Signature et cachet
Stamp and signature

…….

Canada/Croatia Agreement

Documents and/or information required to support your application [CAN/HR 3] for a Croatian disability pension

You must complete the attached forms if you haven't already applied for a Canada Pension Plan disability benefit:

- ***Questionnaire for Disability Benefits*** **[ISP-5050-IO]**
- ***Consent for Service Canada to Obtain Personal Information*** **[ISP-5051-IO]**
- ***Medical Report*** **[ISP-5052-IO]**

You must submit originals or certified true copies of the following documents:

- Your birth certificate
- Proof of your nationality (e.g., current passport, citizenship certificate, etc.)
- Proof of employment in Croatia (e.g., workbooks, documents issued by employers, 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 must still resubmit them.

QUESTIONNAIRE FOR DISABILITY BENEFITS CANADA PENSION PLAN

Privacy Notice Statement

The personal information you provide is collected by Employment and Social Development Canada (ESDC) under the authority of the *Canada Pension Plan* and/or the *Old Age Security Act* to support your application for benefits under an agreement between Canada and another country. We use this information to send your application and supporting documents to the responsible institution in that country so they can assess your eligibility.

The Social Insurance Number (SIN) is collected and used in accordance with the Treasury Board Secretariat *Directive on the Social Insurance Number* which you can access by searching "Directive on the Social Insurance Number TBS" on Canada.ca to confirm your identity and accurately match your information to your records for the administration of Canada Pension Plan and/or Old Age Security programs.

Providing the requested information is voluntary; however, if you do not provide the information, ESDC will be unable to process your request or facilitate your access to a foreign benefit under a social security agreement.

ESDC may share your personal information with the competent institution in the agreement country when an agreement is in force. Once disclosed, the foreign institution will handle your information in accordance with its laws and policies. ESDC may also use your personal information for policy analysis, research and/or evaluation purposes. Full details about these uses and disclosures are described in Personal Information Banks: Old Age Security (ESDC PPU 116), Canada Pension Plan - Record of Earnings (ESDC PPU 140), Canada Pension Plan Program (ESDC PPU 146), and Social Insurance Number Register (ESDC PPU 390). Instructions for accessing this information are available in the Government of Canada publication Info Source available online at canada.ca/infosource-ESDC or at any Service Canada Centre.

You have the right to the protection of, access to, and correction of your personal information, under the *Privacy Act*. You also have the right to file a complaint with the Privacy Commissioner of Canada about how ESDC handles your personal information online at priv.gc.ca/en/report-a-concern or by calling 1-800-282-1376.

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.

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

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

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

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

EMPLOYEE

4. Have you stopped working completely?

◯ Yes, go to question 5.
◯ No, provide the following information:

Type of Work

☐ 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)

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)

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

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

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

Date admitted (YYYY-MM-DD)	Date discharged (YYYY-MM-DD)	Name of attending physician

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

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

SIGNATURE

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.

Consent for Service Canada to Obtain Personal Information

Service Canada is authorized under sections 44, 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. Service Canada is also authorized under sections 55.3 and 60 (8) to (11) of the CPP to receive personal (medical and non-medical) information about you to help in the assessment of incapacity.

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:

The personal information you provide is collected by Employment and Social Development Canada (ESDC) under the authority of the *Canada Pension Plan* and/or the *Old Age Security Act* to support your application for benefits under an agreement between Canada and another country. We use this information to send your application and supporting documents to the responsible institution in that country so they can assess your eligibility.

The Social Insurance Number (SIN) is collected and used in accordance with the Treasury Board Secretariat Directive on the Social Insurance Number which you can access by searching “Directive on the Social Insurance Number TBS” on Canada.ca to confirm your identity and accurately match your information to your records for the administration of Canada Pension Plan and/or Old Age Security programs.

Providing the requested information is voluntary; however, if you do not provide the information, ESDC will be unable to process your request or facilitate your access to a foreign benefit under a social security agreement.

ESDC may share your personal information with the competent institution in the agreement country when an agreement is in force. Once disclosed, the foreign institution will handle your information in accordance with its laws and policies. ESDC may also use your personal information for policy analysis, research and/or evaluation purposes. Full details about these uses and disclosures are described in Personal Information Banks: Old Age Security (ESDC PPU 116), Canada Pension Plan - Record of Earnings (ESDC PPU 140), Canada Pension Plan Program (ESDC PPU 146), and Social Insurance Number Register (ESDC PPU 390). Instructions for accessing this information are available in the Government of Canada publication Info Source available online at canada.ca/infosource-ESDC or at any Service Canada Centre.

You have the right to the protection of, access to, and correction of your personal information, under the *Privacy Act*. You also have the right to file a complaint with the Privacy Commissioner of Canada about how ESDC handles your personal information online at priv.gc.ca/en/report-a-concern or by calling 1-800-282-1376.

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.

Instructions:

- complete Sections 1 and 2 of this form; and
- return this form to **Service Canada**.

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

Section 1 - Information about you

Optional: ◯ Mr. ◯ Mrs. ◯ Miss ◯ Ms.		Canadian Social Insurance Number
First name	Middle name	Last name(s)
Mailing address (no., street, apt, PO Box, RR)		City, town or village
Province or Territory	Country	Postal code
Telephone number	Alternate telephone number	

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

Consent to obtain personal information

I give Service Canada my consent to obtain personal information about me that would help determine if I qualify or continue to qualify for CPP disability benefits or help in the assessment of incapacity as under the CPP. 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 (long-term care facilities or retirement homes, medical records storage facilities)
- voluntary organizations
- federal, provincial, territorial, or municipal government departments and agencies
- employers, former employers
- provincial or territorial workers' compensation boards
- financial institutions - for address updates only
- employees - for cases of self-employed persons

Note: Failure to select an option below could cause a delay in processing your application or determining your benefit amounts.

◯ **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 determine if I qualify or continue to qualify for CPP 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 if I do not give my consent, Service Canada:

- will make a decision based on the available information on my file;
- may stop paying me the benefits if I am already receiving them; and
- can require that I provide the necessary information.

Signature of applicant / authorized representative **Date** (YYYY-MM-DD)

X _____ _____

Section 2 - I give my consent or I do not give my consent (continued) **To be completed by a witness only if the applicant signs with a mark (e.g. X).**	
I have read the contents of this section to the applicant, who appeared to fully understand them and who made their mark in my presence.	
First name of witness (print) Middle name Last name(s)	Telephone number
Signature of witness **X**	**Date** (YYYY-MM-DD)

This signed consent is valid for up to **3 years** unless you cancel it in writing. Service Canada requires your original signature, but we as well as the third party may accept a photocopy or fax of this completed form as it is as valid as the original when requesting personal information from the persons and organizations listed above.

MEDICAL REPORT

Privacy Notice Statement

The personal information you provide is collected by Employment and Social Development Canada (ESDC) under the authority of the *Canada Pension Plan* and/or the *Old Age Security Act* to support your application for benefits under an agreement between Canada and another country. We use this information to send your application and supporting documents to the responsible institution in that country so they can assess your eligibility.

The Social Insurance Number (SIN) is collected and used in accordance with the Treasury Board Secretariat *Directive on the Social Insurance Number* which you can access by searching "Directive on the Social Insurance Number TBS" on Canada.ca to confirm your identity and accurately match your information to your records for the administration of Canada Pension Plan and/or Old Age Security programs.

Providing the requested information is voluntary; however, if you do not provide the information, ESDC will be unable to process your request or facilitate your access to a foreign benefit under a social security agreement.

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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.

Canadian Social Insurance Number:

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 (YYYY-MM-DD)	Canadian Social Insurance Number

SECTION B - To be completed by Physician

Please provide factual objective opinions

1. Height Weight	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

3. Diagnosis(es)

4. Relevant/significant medical history relating to the main medical condition:

Please write legibly

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
◯ No

If yes, please Specify:

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

◯ Yes
◯ No

If yes, please indicate dosage and frequency.

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