

Accord Canada-Saint Vincent et les Grenadines

Demande de prestations de Saint Vincent et les Grenadines

Voici des renseignements importants dont vous devez tenir compte au moment de remplir votre demande.

Veuillez vous assurer de signer la demande. Si vous apposez une marque en guise de signature, (par exemple : « X »), la signature d'un témoin est exigée.

Votre demande doit être accompagnée de tous les documents justificatifs requis. Veuillez soumettre ces documents. Omettre de remplir la demande ou de fournir les documents demandés pourrait retarder le traitement de votre demande.

Lorsqu'il est précisé qu'on exige les documents originaux, il vous faut soumettre les documents originaux avec votre demande. Vous devez conserver, pour vos dossiers, une copie certifiée conforme de tout document original que vous nous envoyez. Certains pays exigent des documents originaux qui ne vous seront pas retournés.

Vous pouvez soumettre l'original ou une photocopie certifiée conforme de tout document lorsque les originaux ne sont pas exigés. Il est préférable d'envoyer des photocopies certifiées de documents plutôt que les originaux. Si vous nous envoyez vos documents originaux, veuillez le faire par courrier recommandé. Nous vous retournerons tous vos originaux. Nous acceptons les photocopies seulement si elles sont lisibles et certifiées conformes aux documents originaux. Le personnel de tout Centre Service Canada photocopiera vos documents et les certifiera sans frais. Si vous ne pouvez visiter un Centre Service Canada, vous pouvez demander à une des personnes suivantes de certifier vos photocopies :

avocat; chef de bande des Premières nations; comptable; directeur d'un établissement financier; employé d'un Centre Service Canada qui agit à titre officiel; employé d'un ministère fédéral ou provincial ou de l'une de ses agences; enseignant; entrepreneur de pompes funèbres; greffier municipal; ingénieur; juge de paix; magistrat; maître de poste; député fédéral ou son personnel; député provincial ou son personnel; ministre du culte; notaire; policier; professionnel de la santé : chiropraticien, dentiste, médecin, pharmacien, psychologue, infirmier autorisé et infirmier praticien; représentant d'une ambassade, d'un consulat ou d'un haut-commissariat; représentant d'un pays avec lequel le Canada a conclu un accord de réciprocité en matière de sécurité sociale; travailleur social.

La personne qui certifie la photocopie doit la comparer à l'original, indiquer son poste ou son titre officiel, écrire son nom en lettres moulées, indiquer son numéro de téléphone, inscrire la date à laquelle elle certifie le document et le signer.

Elle doit aussi inscrire ce qui suit sur la photocopie : **Photocopie conforme au document original, qui n'a pas été modifié d'aucune façon.**

Si le document a des renseignements des deux côtés, les deux côtés doivent être photocopiés et certifiés. Vous ne pouvez pas certifier les photocopies de vos propres documents et vous ne pouvez pas demander à un parent de le faire pour vous.

Retournez votre demande dûment remplie, les formulaires et les documents à l'appui aux :

Opérations internationales
Service Canada
CP 2710 Succursale Main
Edmonton (Alberta) T5J 2G4
CANADA

Avertissement :

Ce formulaire de demande a été élaboré conjointement par des sources externes et Emploi et Développement Social Canada. Le contenu et le langage répondent aux exigences législatives de ces sources externes.

CAN-SVG 3

NATIONAL INSURANCE SERVICES
P.O. Box 305, Administrative Centre

Tel.: (784) 456 1514

Fax: (784) 456 2604

NATIONAL INSURANCE ACT #33 OF 1986
CLAIM FOR INVALIDITY BENEFIT

Warning: Any person who knowingly makes a false statement or false representatives for the purpose of obtaining benefit commits a criminal offence punishable by a fine or imprisonment or both.

To be completed by Applicant

PART A - PERSONAL INFORMATION

Name (in block capitals)

(Surname) (Other Names)

D M Y

Date of birth | | |

[illegible]

My National Insurance number is | | | | | |

My Canadian Social Insurance number is |_|_|_|_|_|_|_|_|_|_|

Postal Address:

(No. and street, Apt. No.)

.....

(City, town or village)

Sex: Male ☐ Female ☐

Marital Status: Married ☐ Single ☐ Widow/Widower ☐ Divorced ☐

Next of Kin

Last Employer(s)

Address

(No. and street, Apt. No.)

.....

(City, town or village)

Have you ever worked or lived in a country other than Saint Vincent and the Grenadines?
 () yes () no. If yes kindly list below

Name of country	Social Insurance number in that country	Residence		Employment	
		Y-M	Y-M	Y-M	Y-M

I have been medically certified as permanently incapable of work. () yes () no

Attached are copies of my birth certificate as proof of age and my marriage certificate as proof of marriage (Delete whichever does not apply).

If you are unable to sign this form it must be witnessed by a Justice of the Peace, Medical Doctor, Senior Civil Servant, Minister of Religion, Member of Parliament, Police Officer (above the rank of Inspector).

Form must be accompanied by a medical certificate.

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

Signature of Claimant:

Date:

D-M-Y

N.B: Please complete fully and send to the National Insurance Services. Failure to apply within 3 months of eligibility may mean loss of some benefit.



MEDICAL REPORT

SECTION A To be completed by Applicant

Given Name and Initial		Family 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	2a. 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 Human Resources and Skills Development Canada programs and services for the Government of Canada.

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

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

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

☐

Family Physician

☐

Specialty

Postal Code

Signature

X

Year

Month

Day

Telephone No.

Please write legibly



QUESTIONNAIRE FOR DISABILITY BENEFITS CANADA PENSION PLAN

1. FIRST NAME AND INITIAL		LAST NAME		CANADIAN 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 _____	
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 Year Month Day _____ _____ _____		Last day on the job Year Month Day _____ _____ _____	
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 Year Month Day _____ _____ _____		b) When did you actually stop working in the business? Year Month Day _____ _____ _____			
c) Why did you stop working in the business? _____ _____ _____					
d) Describe the business operation _____ _____ _____					
e) What was your involvement with the business? _____ _____ _____					

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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:

Year Month Day

Date of disposition

☐ sold ☐ rented ☐ profit sharingIf **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 Year Month Day	Last day on the job Year Month Day
Name and full address of employer				

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

From

To

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

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:

Year Month

☐ 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:☐ Noa) The date you plan to **return** to your former employer/employment

Year Month

b) The date you will **start** a new job.

Year Month

c) The date you plan to start looking for work.

Year Month

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?

From Year Month Day

To Year Month Day

☐ If **yes**, give the dates:
☐ No

From Year Month Day

To Year Month Day

MEDICAL INFORMATION

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

Year Month Day

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?

Year Month

When was your last visit?

Year Month

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?

Year Month

When was your last visit?

Year Month

Were your visits related to your present medical condition?

☐ Yes
☐ No**If yes**, explain the reasons for your visits.

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?

Year Month

When was your last visit?

Year Month

Were your visits related to your present medical condition?

☐ Yes
☐ No**If yes**, explain the reasons for your visits.

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, Apt., P.O. Box, R.R.)

City Province or Territory Country (If other than Canada) Postal Code

Date admitted Year Month Day Date discharged Year Month Day Name of attending physician

Reason for admission and type of treatment

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

City Province or Territory Country (If other than Canada) Postal Code

Date admitted Year Month Day Date discharged Year Month Day 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 **If no**, please explain.
☐ No

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

Year Month Day

Telephone Number

X

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



**RETURN THIS FORM WITH YOUR APPLICATION
AND QUESTIONNAIRE TO SERVICE CANADA**

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 (HRSDC 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
- return this form with your application and questionnaire to **Service Canada**.

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 Human Resources and Skills 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, 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 _____
Year Month Day

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 _____
Year Month Day

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.



**GIVE THIS FORM TO YOUR PHYSICIAN
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.

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Instructions:

- Complete Sections 1 and 2 of this form; and
- Give this form to **your physician** 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	

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- 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 _____
Year Month Day

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 _____
Year Month Day

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.

Canada / Saint Vincent and the Grenadines Agreement

Documents and/or information required to support your application [CAN-SVG 3] for a Saint Vincent and the Grenadines Invalidity Pension

The applicant must submit original or certified copies of the following:

- Birth certificate
- Marriage certificate, if married

The following original documents (if applicable) must accompany the application to Saint Vincent and the Grenadines:

- A sworn affidavit/declaration from a third party attesting to the difference in name: *where there is a difference in name*
- Where the claimant has not applied for a Canada Pension Plan Disability pension, he/she must complete a Questionnaire, Authorization to Disclose Information/Consent for Medical Evaluation and Medical Report

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.