Canada/Slovenia Agreement

Applying for a Slovenian 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.

AGREEMENT ON SOCIAL SECURITY BETWEEN THE GOVERNMENTS OF CANADA AND THE REPUBLIC OF SLOVENIA

SPORAZUM O SOCIALNI VARNOSTI MED VLADO KANADE IN VLADO REPUBLIKE SLOVENIJE

SLOVENIAN DISABILITY PENSION CLAIM
ZAHTEVEK ZA SLOVENSKO INVALIDSKO POKOJNINO

1. Personal details of the insured (1)
Osebni podatki zavarovanca/ke

1.1 Canadian Social Insurance Number
Zavarovalna številka v Kanadi

Slovenian Pension Number
Pokojninska številka v Sloveniji

1.2 Surname _____
Priimek

Surname at birth _____
Priimek ob rojstvu

1.3 Given name _____
Ime

1.4 Date of birth (day, month, year) _____
Datum rojstva (dan, mesec, leto)

1.5 Place of birth (city/town and country) _____
Kraj rojstva (mesto, država)

1.6 National Identification Number /__/__/__/__/__/__/__/__/__/__/__/__/__/
Enotna matična številka občana - EMŠO

1.7 Sex ☐ male *moški* ☐ female *ženska*
Spol

1.8 Marital status ☐ single *samski/a* ☐ married *poročen/a* ☐ divorced *razvezan/a* ☐ widow/er *ovdovel/a*
Osebno stanje

since (day, month, year) _____
od (dan, mesec, leto)

1.9 Nationality _____
Državljanstvo

1.10 Present address _____
Sedanje prebivališče

_____

/number, street, city/town, postal code, country/
/poštna številka, kraj, ulica, hišna številka, država/

2. Personal details of the spouse
Osebni podatki zakonca

2.1 Surname _____
Priimek

Surname at birth _____
Priimek ob rojstvu

2.2 Given name _____
Ime

2.3 Date of birth (day, month, year) _____
Rojstni datum (dan, mesec, leto)

2.4 Place of birth (city/town and country) _____
Kraj rojstva (mesto, država)

2.5 Present address
Sedanje prebivališče _____

/number, street, city/town, postal code, country/
/poštna številka, kraj, ulica, hišna številka, država/

3. Is someone acting on behalf of the insured? (1)
Ali zastopa zavarovanca/ko v tem postopku druga oseba?

☐ Yes *Da* ☐ No *Ne*

If yes: *Če da:*

Surname and given name _____
Priimek in ime

In the capacity of
V svojstvu kot

☐ legal representative* *zakoniti zastopnik/ca*
☐ guardian* *skrbnik/ca*
☐ authorized person *pooblaščenec/ka*

Since (day, month, year) _____
Od (dan, mesec, leto)

Address
Naslov _____

/number, street, city/town, postal code, country/
/poštna številka, kraj, ulica, hišna številka, država/

*Please enclose proof.
Prosimo, da predložite potrdilo.

4. Other details (1)
Drugi podatki

4.1 Is the insured still employed or self-employed (even if he/she is not working at this time due to his/her incapacity to work)?
Ali je zavarovanec/ka še zaposlen/a oz. če opravlja samostojno dejavnost (tudi če trenutno zaradi nezmožnosti za delo dejavnosti ne opravlja)?

☐ Yes *Da* ☐ No *Ne* | **If yes:** *Če da:* Is he/she planning to stop working? *Ali je predvideno prenehanje ?*

☐ Yes *Da* ☐ No *Ne* | **If yes:** *Če da:* When? (day, month, year) _____ *Kdaj? (dan, mesec, leto)*

Is the insured incapable of working at this time due to an illness?
Ali obstaja trenutna nezmožnost za delo zaradi bolezni?

☐ Yes *Da* ☐ No *Ne* | **If yes:** *Če da:* Since (day, month, year) _____ *Od (dan, mesec, leto)*

4.2 If the insured is no longer contributing to the Canada or Quebec Pension Plan, please state
Če zavarovanec/ka ne plačuje več prispevkov v kanadski ali quebeški pokojninski sistem, prosimo navedite

Date of cessation of contributions (day, month, year) * _____
datum prenehanja (dan, mesec, leto)

*Please provide confirmation of the date of insurance cessation.
Prosimo, predložite potrdilo o prenehanju zavarovanja.

4.3 Is the insured presently contributing to a pension scheme of a third country?
Ali zavarovanec/ka trenutno plačuje prispevke v pokojninsko zavarovanje tretje države?

☐ Yes *Da* ☐ No *Ne* | **If yes:** *Če da:* Which country? _____ *Katere države?*

4.4 Was the insured employed in a third country?
Ali je bil/a zavarovanec/ka zaposlen/a v tretji državi?

☐ Yes *Da* ☐ No *Ne* | **If yes:** *Če da:* In which country? _____ *V kateri državi?*

4.5 Where and when was the insured employed in Slovenia?
Kje in kdaj je bil/a zavarovanec/ka zaposlen/a v Sloveniji?

Place of employment *Kraj zaposlitve*	Employer's name and address *Naziv in naslov delodajalca*	Period *Obdobje* from *od*	to *do*

4.6 The following certificates supporting employment periods specified in Section 4.5 are enclosed:
Priložena so naslednja dokazila za zaposlitve navedene pod točko 4.5:

_____

_____

4.7 Description of the work the insured performed with his/her last employer in Slovenia (please state what kind of jobs were performed).
Opis dela, ki ga je zavarovanec/ka opravljal/a pri zadnjem delodajalcu v Sloveniji (navedite kakšne vrste opravil ste opravljali).

_____

_____

4.8 Education level of the insured in Slovenia in the last year of insurance with the Slovenian insurance agency
Dejanska strokovna izobrazba, ki jo je zavarovanec/ka imel/a v zadnjem letu zavarovanja pri slovenskem nosilcu

_____

/Please give the name of the institution in which the education was attained and enclose a certified copy of the final school report/
/Navedite naziv šole v kateri je bila ta izobrazba pridobljena, ter priložite overjeno fotokopijo zaključnega spričevala!/

5. Particulars on the changes in the insured's medical condition (1)
Podatki o spremembi zdravstvenega stanja

5.1 The change in medical condition was due to
Vzrok spremembe zdravstvenega stanja

☐ non-occupational disease *bolezen* ☐ non-occupational injury *poškodba izven dela* ☐ occupational injury *poškodba pri delu* ☐ occupational disease *poklicna bolezen*

Date of onset of the change in medical condition (day, month, year) _____
Datum spremembe zdravstvenega stanja (dan, mesec, leto)

5.2 Was the injury caused by a third party?
Ali je poškodbo povzročila tretja oseba?

☐ Yes *Da* ☐ No *Ne* | **If yes:** *Če da:* Give the name and address of the person responsible? *Navesti priimek, ime in naslov povzročitelja?*

_____

5.3 Medical documentation for the insured must be enclosed
Obvezno je potrebno priložiti razpoložljivo medicinsko dokumentacijo za zavarovanca/ko

List documentation enclosed: _____
Priložena dokumentacija:

_____

_____

6. Social Security benefits granted by Canada or a third country (1)
Dajatve, ki so jih priznali nosilci zavarovanja v Kanadi ali v tretji državi

6.1 Is the insured receiving a benefit from a Canadian or another foreign pension scheme?
Ali prejema zavarovanec/ka dajatev iz kanadskega ali drugega tujega pokojninskega zavarovanja?

☐ Yes *Da* ☐ No *Ne*

If yes: *Če da:*

Specify benefit type and country _____
Vrsta dajatve in država

Received since (day, month, year) _____
Od kdaj prejema (dan, mesec, leto)

Address of Social Security Institution(s) _____
Naslov nosilca zavarovanja

_____

7. Benefits granted by Slovenian insurer (1)
Dajatve s strani nosilca zavarovanja v Sloveniji

7.1 Has the insured submitted a pension claim to a Slovenian pension scheme?
Ali je zavarovanec/ka vložil/a zahtevek za priznanje pravice do pokojnine iz slovenskega pokojninskega zavarovanja?

☐ Yes *Da* ☐ No *Ne*

If yes: *Če da:*

Specify insurance agency _____
Navedite nosilca zavarovanja

Reference number _____
Številka zadeve

7.2 Has a pension been granted?
Ali je bila pravica do pokojnine priznana?

☐ Yes *Da* ☐ No *Ne*

If yes: *Če da:*

Since when? (day, month, year) _____
Od kdaj? (dan, mesec, leto)

8. Declaration of the insured
Izjava zavarovanca/ke

Note: **According to Slovenian legislation providing false or misleading information is considered a criminal offence.**
Opozorilo: ***Po slovenskih pravnih predpisih je dajanje napačnih oziroma zavajajočih podatkov kaznivo dejanje.***

The undersigned declares that the answers to all questions are complete and truthful. The benefits which have been unjustly granted to me on the basis of incomplete or inaccurate information must be returned.
Podpisani/a izjavljam, da sem na vsa vprašanja v celoti in po resnici odgovoril/a. Dajatve, ki so mi bile priznane na podlagi nepopolnih in netočnih podatkov, moram vrniti.

I hereby authorize the Department of Human Resources Development of Canada to disclose to the Institute of Pension and Disability Insurance of Slovenia all the information and documentation in its possession which relates or could relate to this claim for benefits.
Pooblaščam Department of Human Resources Development of Canada , da pošlje Zavodu za pokojninsko in invalidsko zavarovanje Slovenije vse podatke in dokumentacijo s katero razpolaga in ki se nanaša na zahtevek za dajatev.

Date: _____
Datum:

Signature of the insured _____
Podpis zavarovanca/ke

NOTE: **A mark instead of a signature is acceptable on condition that it has been made in the presence of a responsible person, who must complete the following statement:**
VAŽNO: ***Podpis s križcem se prizna, če je bil narejen v prisotnosti odgovorne osebe, ki mora izpolniti naslednjo izjavo:***

9. **Witness's statement (only when the insured has made a mark instead of signing)**
Izjava priče (zahteva se le, če se zavarovanec/ka podpiše s križcem)

I have read the contents of this claim to the insured, who appeared to fully understand and made a mark in my presence.
Vsebino zahtevka sem prebral/a, zavarovancu/ki za katerega menim, da jo je v celoti razumel/a in ki se je v moji prisotnosti podpisal/a s križcem.

Witness's signature *Podpis priče*	Witness's surname and given name (please print) *Priimek in ime priče (s tiskanimi črkami)*	Witness's address *Naslov priče*

10. **If someone has been authorized to act on behalf of the insured, the following authorization must be completed**
Če ima zavarovanec/ka pooblaščenca, izpolnite pooblastilo

The insured hereby authorizes (name and address)
Zavarovanec/ka pooblašča (ime in naslov)

_____

to represent him/her, have access to all information/documentation and act on his/her behalf.
In addition he/she shall receive any decisions and submit documents required for the processing of this claim.
da ga/jo zastopa, ima vpogled v spis, ukrepa v njegovem/njenem imenu ter da sprejme odločbo in predloži dokazila in / ali dokumentacijo, ki se zahteva za obravnavo tega zahtevka.

Date: _____
Datum:

Signature of the insured *Podpis zavarovanca/ke*	Signature of the authorized person *Podpis pooblaščene osebe*

11. To be completed by the Canadian liaison agency
Opombe kanadskega organa za zvezo

This is to certify that the information provided in Section 1 has been verified.
The following documents are enclosed:
Kanadski organ za zvezo, pri katerem je zahtevek vložen potrjuje, da so bili podatki, ki so v tem zahtevku navedeni pod točko 1 preverjeni. Pošiljamo Vam:

with Section 3 _____
k točki 3

with Section 4.2 _____
k točki 4.2

with Section 4.6 _____
k točki 4.6

with Section 4.8 _____
k točki 4.8

with Section 5.3
k točki 5.3

_____

_____

/other notes/
/morebitne druge opombe/

Official stamp and signature on behalf of the Canadian liaison agency:
Pečat in podpis kanadskega organa za zvezo:

_____

Place and date: _____
Kraj in datum:

Instructions
Navodila

(1) Please tick the appropriate box.
Ustrezni okvirček označite s križcem

INSTRUCTIONS FOR COMPLETING THE CAN/SI 1.3 CLAIM FORM

The CAN/SI 1.3 form "Disability Pension Claim " should be completed by a person who lives in Canada and claims a disability pension from the Slovenian pension and disability scheme.

We ask you to give precise answers to all the questions and enclose the required supporting documentation and certificates. You are requested to complete the form in block letters or type the answers.

Section 1

All the data stated under this section refer to the person who is applying for a disability pension from the Slovenian pension and disability scheme. You are requested to enclose corresponding documentation (birth certificate, nationality certificate) with the personal data of the mentioned person. If applicable, the competent Canadian agency will make certified photocopies of the documents and return them to you.

1.1 Please state your Canadian Social Insurance Number and Slovenian Pension Number. In case these numbers have not been assigned to you yet, or you do not know them, your identification will be determined on the basis of the particulars stated in sections **1.2** to **1.9**.

1.2 Please state your present surname and your surname at birth. The latter is required for identification in case the surname was changed due to marriage or for another reason.

1.3 Please state your given name. If you have several names, please give all of them and underline the one which is most frequently used.

1.4 Please state your date of birth and enclose your birth or baptismal certificate.

1.5 Please give precise data on your place and country of birth.

1.6 Please enter your National Identification Number (EMŠO), which is a thirteen-digit number, consisting of your date of birth, a country's code number, a serial number indicating sex (from 0 to 499 for men and from 500 to 999 for women) and a control number according to module **11**. The EMŠO number can be found in a Slovenian passport, a Slovenian ID card, and some other identification documents.

In addition to other particulars, your National Identification Number will help us to identify you and obtain all the data necessary in the pension procedure.

1.7 Please tick the appropriate box indicating your sex.

1.8 Please state your marital status, specifying the effective date of this status.

1.9 Please state your nationality. In case you are of Slovenian nationality, please enclose a corresponding nationality certificate. In addition to periods completed in Slovenia, the insurance periods completed by a Slovene citizen in the republics of the former Yugoslavia until 31/03/1992 might be taken into account as Slovenian periods until the conclusion of an agreement on social security with the new states.

1.10 Please state your present address. You will receive your mail in relation to your pension claim at this address.

Section 2

All the data stated in this section refer to the spouse of the person mentioned in section **1**. Although these data are not necessary and do not affect the disability pension claim decision whatsoever, they may be useful and helpful to the insurance agency (e.g. in trying to contact the spouse of the deceased insured person, etc.).

The same instructions apply for the completion of individual headings under this section as under section **1**, therefore the instructions to section **1** should correspondingly be observed.

Section 3

This section should only be completed in case the applicant for a Slovenian disability pension - that is the person mentioned in section **1** - has a legal representative, a guardian or another authorized person. If this is the case, please enter his/her surname, given name and address under the corresponding heading, and tick the appropriate box indicating the representative's status. If the person is a legal representative or a guardian, please enclose a supporting document; if the person is another authorized person, section **10** should be completed.

Section 4

The information required under this section is very important in rendering a decision regarding the pension claim, therefore precise answers are requested.

4.1; 4.2; 4.3
Under Slovenian legislation, one of the conditions for pension entitlement is the cessation of employment. Therefore, a person who is employed, self-employed or contributing to an insurance scheme, either in Slovenia or in another foreign country, cannot become entitled to a Slovenian pension. In this regard, information on whether you are still employed, self-employed or contributing to a pension scheme, either in Slovenia, Canada or a third country, is required. If you are, when do you expect the cessation of your employment, self-employment or pension insurance contributions to be? If you are not employed, self-employed or insured anymore, please give the date of employment or insurance cessation.

4.4 Entitlement to benefits under the Agreement on Social Security between Canada and Slovenia could, under special conditions, depend on insurance periods completed in a third country. It is therefore important that the answers under section **4.4** be as accurate as possible so that you get all the benefits you may be entitled to.

4.5 The basic condition for entitlement to Slovenian pension and disability benefits is the completion of a prescribed period of insurance under Slovenian legislation. The insurance period completed also affects the pension rate. Therefore precise answers to the questions under section **4.5** are of extreme importance. There is a precondition for Slovenian insurance periods to be correctly established.

4.6 Under this section you are asked to list all the documents you are providing to support the employment in Slovenia which you have already stated under section **4.5**. This documentation is required to establish your Slovenian insurance period.

4.7 In addition to medical documentation, the Slovenian Board of Examiners, in order to assess the medical condition of the person mentioned in section **1**, requires as much information as possible on the job or the work the person performed during the last employment in Slovenia. Therefore, you are required to give a detailed description of the jobs you performed, and the equipment used for performing the jobs. The working conditions in which you worked, as well as psychological-physical demands, should also be described.

4.8 This section should only be completed in cases when a person claiming a Slovenian disability pension - person mentioned in section **1** - has not completed at least one year of insurance periods in Slovenia after 01/01/1966, the wages of which would serve as a basis for the assessment of one's pension basis (i.e. at least 6 months of insurance in a calendar year).
In these cases - different from a general principle according to which a pension is assessed from a pension basis established on the basis of an eighteen-year wage average or pensionable insurance bases after 01/01/1970, and in some cases after 01/01/1966 - a pension is assessed from a pension basis in the amount of the average scheduled wage rate, which would be established for that person with respect to one's education level in the last year of the membership in the insurance scheme under the service contract or a general contract for the last calendar year before the year in which a pension is claimed. Therefore corresponding data with supporting certificates - a school report on one's education level, referring to the situation in the last year of their membership within the Slovenian pension scheme, are required.

Section 5

The questions under this section refer to the changes in medical condition of the person mentioned under section **1**.

5.1 Please tick the appropriate box and provide the date of onset of the change in medical condition.

5.2 If the injury was caused by a third party, please state the surname, given name and address of the person who caused the injury.

5.3 Under this section we only wish to point out that medical documentation must be provided with the claim for a Slovenian disability pension. In case the person mentioned in section **1** has already submitted a claim for a Canada Pension Plan disability pension, the Canadian liaison agency will supply documentation on the applicant's disability and health condition from their files. If the person in section **1** has not applied for a Canada Pension Plan disability pension, the applicant will - at the request of the Canadian liaison agency - have to complete and provide the following forms: "Medical Questionnaire", "Authorization to Disclose Information" / "Consent for Medical Evaluation" and "Medical Report".

Section 6

Under this section, the data on the pension benefits which the person mentioned in section **1** is already receiving from Canada or another foreign pension scheme should be stated. This information is not necessary for the decision regarding a disability pension but, in cases when other information is incomplete, it can be useful to the competent insurance agency in trying to obtain the necessary documentation.

Section 7

The data required under this section are requested so that double pension files are avoided. In Slovenia all pension procedures for one insured person are contained under one pension number, which is assigned to a claimant when he/she applies for a benefit for the first time.

Section 8

With your signature you confirm that the information provided in the claim is correct. Your signature also authorizes Human Resources Development Canada to disclose all the information and documentation in its possession which could relate to the entitlement to the Slovenian benefit being claimed from the Institute of Pension and Disability Insurance of Slovenia.

Section 9

A witness's statement is only required if the person mentioned in section **1**, claiming a disability pension, makes a mark in section **8** instead of signing the claim.

Section 10

The authorization should only be completed if an authorized person is acting on behalf of the person mentioned in section **1**, who is applying for a disability pension.

Section 11

This section is to be completed and verified by the Canadian liaison agency.

NAVODILA ZA IZPOLNJEVANJE OBRAZCA CAN/SI 1.3

Obrazec CAN/SI 1.3 "Zahtevek za invalidsko pokojnino" mora izpolniti oseba, ki živi v Kanadi in želi pridobiti pravico do invalidske pokojnine iz slovenskega pokojninskega in invalidskega zavarovanja.

Prosimo, da na vsa vprašanja natančno odgovorite, ter priložite zahtevano dokumentacijo in potrdila. Obrazec izpolnite s tiskanimi črkami ali s pisalnim strojem.

Točka 1

Vsi podatki, navedeni pod to točko se nanašajo na osebo, ki želi pridobiti pravico do invalidske pokojnine iz slovenskega pokojninskega in invalidskega zavarovanja. Prosimo Vas, da priložite ustrezne dokumente (rojstni list, potrdilo o državljanstvu) iz katerih so razvidni osebni podatki navedene osebe. Pristojni kanadski organ bo po potrebi naredil overjene fotokopije dokumentov, ter Vam jih nato vrnil.

1.1 Navedite kanadsko zavarovalno številko in pokojninsko številko v Sloveniji. V kolikor še nimate navedenih številk, oziroma jih ne poznate, Vas bomo poizkušali identificirati na podlagi podatkov pod točkami **1.2** do **1.9.**

1.2 Vpišite sedanji priimek in priimek ob rojstvu. Priimek ob rojstvu potrebujemo za identifikacijo, če je bil priimek spremenjen zaradi sklenitve zakonske zveze ali iz drugega razloga.

1.3 Vpišite ime. V primeru, da imate več imen, navedite vsa imena, ter podčrtajte ime, ki ga najpogosteje uporabljate.

1.4 Navedite datum rojstva ter predložite svoj rojstni ali krstni list.

1.5 Navedite natančne podatke o kraju ter državi rojstva.

1.6 Vpišite enotno matično številko občana - EMŠO. To je trinajstmestna številka, ki je sestavljena iz datuma rojstva osebe, številke oznake države, številke, ki označuje spol (od 000 do 499 za moške in od 500 do 999 za ženske) ter kontrolne številke po modulu **11**. EMŠO je vpisana v slovenskem potnem listu, slovenski osebni izkaznici, ter v nekaterih drugih identifikacijskih dokumentih.

Navedena številka nam bo, poleg ostalih podatkov, lahko v pomoč za Vašo identifikacijo ter za kompletiranje podatkov potrebnih v upokojitvenem postopku.

1.7 Označite odgovarjajoč okvirček za spol.

1.8 Označite osebno stanje ter navedite pravno veljavni datum nastanka tega stanja.

1.9 Navedite državljanstvo ter v primeru, da ste slovenski državljan priložite potrdilo o državljanstvu, saj se Vam kot slovenskemu državljanu lahko, poleg dobe dopolnjene v Sloveniji, doba dopolnjena do 31.3.1992 v republikah na območju nekdanje SFRJ do sklenitve sporazumov o socialni varnosti z novo nastalimi republikami, šteje kot slovenska doba.

1.10 Navedite svoj sedanji naslov. Na ta naslov Vam bomo pošiljali pošto v zvezi z Vašim zahtevkom za pokojnino.

Točka 2

Vsi podatki navedeni pod to točko se nanašajo na zakonca osebe iz točke **1**. Ti podatki niso nujno potrebni in ne vplivajo na odločitev o zahtevku za invalidsko pokojnino, so pa nosilcu zavarovanja v določenih primerih potrebni ter v pomoč (tako na primer za vzpostavitev kontakta s preživelim zakoncem v primeru smrti zavarovanca in podobno).

Za izpolnjevanje posameznih rubrik pod to točko veljajo enaka navodila kot pod točko **1**, zato ustrezno upoštevajte navodila k točki **1**;

Točka 3

To točko je potrebno izpolniti samo v primeru, če ima oseba, ki vlaga zahtevek za slovensko invalidsko pokojnino, torej oseba navedena v točki **1** zakonitega zastopnika, skrbnika ali pooblaščenca. V primeru, da ga ima, v ustrezno rubriko vpišite priimek, ime in naslov tega zastopnika ter označite ustrezen okvirček, ki označuje svojstvo zastopnika. V primeru, da gre za zakonitega zastopnika ali skrbnika priložite ustrezno dokazilo, v primeru, da gre za pooblaščenca, pa je potrebno izpolniti točko **10**.

Točka 4

Podatke za katere Vas prosimo v tej točki so zelo pomembni pri odločanju o zahtevku za priznanje pravice do pokojnine zato prosimo, da na vsa vprašanja natančno odgovorite.

4.1; 4.2; 4.3
Po slovenski zakonodaji je eden izmed pogojev za pridobitev pravice do pokojnine tudi prenehanje zavarovanja, kar pomeni, da oseba, ki je, bodisi v Sloveniji ali v kateri drugi državi, še zaposlena ali še opravlja samostojno dejavnost, oziroma je še pokojninsko zavarovana iz kakšnega drugega naslova, ne more pridobiti pravice do slovenske pokojnine. Glede na navedeno potrebujemo podatke o tem, če ste še zaposleni, samozaposleni, oziroma pokojninsko zavarovani, bodisi v Sloveniji, Kanadi ali tretji državi ter če ste še, kdaj predvidevate, da Vam bo prenehala zaposlitev, samozaposlitev, oziroma zavarovanje, oziroma v primeru, da Vam je delovno razmerje oz. zavarovanje že prenehalo, datum prenehanja zaposlitve, samozaposlitve, oziroma zavarovanja.

4.4 Za pridobitev pravic do dajatev po sporazumu med Kanado in Slovenijo je ob določenih pogojih možno upoštevati tudi obdobja zavarovanja v tretji državi. Pomembno je torej, da na vprašanje pod točko **4.4** natančno odgovorite ter tako zagotovite, da boste prejeli vse dajatve, do katerih ste upravičeni.

4.5 Temeljni pogoj za pridobitev pravic iz slovenskega pokojninskega in invalidskega zavarovanja je dopolnjena določena pokojninska doba po slovenskih predpisih. Od obsega dopolnjene pokojninske dobe zavisi tudi višina pokojnine, zato je zelo pomembno, da na vprašanja pod točko **4.5** natančno odgovorite, saj bomo le tako lahko pravilno ugotovili slovensko pokojninsko dobo.

4.6 Pod to točko Vas prosimo, da navedete ter priložite vsa dokazila s katerimi razpolagate za slovenske zaposlitve, ki ste jih navedli pod točko **4.5**. Ta dokazila potrebujemo v postopku ugotavljanja slovenske pokojninske dobe.

4.7 Za podajo izvedenskega mnenja potrebuje invalidska komisija poleg medicinske dokumentacije tudi čimveč podatkov o delovnem mestu, oziroma delu, ki ga je oseba iz točke **1** opravljala pri zadnjem delodajalcu v Sloveniji. V ta namen Vas prosimo, da natančno opišete kakšna dela ste opravljali, kakšne delovne priprave in naprave ste pri tem uporabljali. Opišite v kakšnih delovnih pogojih ste to delo opravljali, kakšne psihofiziološke zahteve so bile potrebne za opravljanje dela in podobno.

4.8 Ta točka se izpolni le v tistih primerih, ko oseba, ki vlaga zahtevek za slovensko invalidsko pokojnino, torej oseba iz točke **1** po 1.1.1966 v Sloveniji ni dopolnila najmanj enega leta zavarovanja iz katerega se vzamejo plače za izračun pokojninske osnove (to je najmanj 6 mesecev zavarovanja v enem koledarskem letu).
V teh primerih se (za razliko od splošnega načela po katerem se odmeri pokojnina od pokojninske osnove, izračunane od najugodnejšega osemnajstletnega povprečja plač oziroma zavarovalnih osnov po 1.1.1970 oziroma v določenih primerih po 1.1.1966) pokojnina odmeri od pokojninske osnove v višini povprečne izhodiščne plače, ki bi bila osebi glede na stopnjo dejanske strokovne izobrazbe v zadnjem letu zavarovanja pri zavodu določena po kolektivni pogodbi dejavnosti ali po splošni kolektivni pogodbi za zadnje koledarsko leto pred letom v katerem uveljavi pravico do pokojnine. Potrebujemo torej podatke ter dokazilo - spričevalo o dejanski strokovni izobrazbi, ki jo je oseba imela v zadnjem letu zavarovanja pri slovenskem zavodu.

Točka 5

Vprašanja pod to točko se nanašajo na spremembe zdravstvenega stanja osebe iz točke **1**.

5.1 S križcem je potrebno označiti odgovarjajoč kvadratek za Vaš primer, ter navesti datum spremembe zdravstvenega stanja.

5.2 Če je poškodbo povzročila tretja oseba, navedite priimek in ime in naslov osebe, ki je poškodbo povzročila.

5.3 Pod to točko želimo le opozoriti, da je k zahtevku za slovensko invalidsko pokojnino potrebno priložiti medicinsko dokumentacijo. V primeru, da je oseba iz točke **1** predhodno že vložila tudi zahtevek za kanadsko invalidsko pokojnino bo kanadski organ za zvezo pridobil dokumentacijo o predlagateljevi invalidnosti in zdravstvenem stanju iz arhiva. V primeru, da oseba iz točke **1** predhodno ni vložila zahtevka za kanadsko invalidsko pokojnino, pa bo moral predlagatelj na zahtevo kanadskega organa za zvezo izpolniti ter priskrbeti obrazce: "Vprašalnik", "Pooblastilo za dajanje podatkov", "Pooblastilo za izdajanje zdravniškega mnenja" in "Zdravniško poročilo".

Točka 6

Pri tej točki prosimo za podatke o pokojninskih dajatvah, ki jih oseba navedena v točki **1** že prejema iz kanadskega ali drugega tujega pokojninskega zavarovanja. Ti podatki niso nujno potrebni za odločitev o zahtevku za invalidsko pokojnino, vendar pa so lahko v primerih, ko so ostali podatki nepopolni, nosilcu zavarovanja v pomoč pri kompletiranju dokumentacije.

Točka 7

Podatke za katere prosimo v tej točki potrebujemo v izogib dvojnikom pokojninskih spisov. V Sloveniji se vodijo vsi pokojninski postopki za eno osebo pod isto pokojninsko številko, ki je osebi-predlagatelju dodeljena, ko prvič vloži zahtevek za dajatev.

Točka 8

S svojim podpisom potrjujete pravilnost podatkov, ki ste jih navedli v zahtevku. S podpisom tudi pooblaščate Human Resources Development of Canada, da je posreduje Zavodu za pokojninsko in invalidsko zavarovanje Slovenije vse podatke in dokumentacijo, ki lahko vplivajo na pravico do slovenske dajatve, ki jo uveljavljate.

Točka 9

Izjava priče, se zahteva le, če se oseba navedena v točki **1**, ki vlaga zahtevek za invalidsko pokojnino podpiše s križcem, v točki **8**.

Točka 10

Pooblastilo je potrebno izpolniti le v primeru, če ima oseba navedena v točki **1**, ki vlaga zahtevek za invalidsko pokojnino pooblaščenca.

Točka 11

Izpolni in potrdi kanadski organ za zvezo

Canada / Slovenia Agreement

Documents and/or information required to support your application [CAN/SI 1.3] for a Slovenian disability pension

Complete the attached form(s):

- ***Statement of Contributory Salary and Wages – Canada Pension Plan*** **[ISP2011]** (or provide a statutory declaration confirming date of cessation of Canada Pension Plan/Quebec Pension Plan contributions)

- ***Medical Report*** **[ISP 5052]** and ***Questionnaire for Disability Benefits*** **[ISP 5050]** (only required if you have never applied for a Canada Pension Plan disability benefit)

Originals or certified copies to be submitted:

- Birth certificate

- Proof of nationality

- Slovenian workbooks

- Final school report from the last Slovenian educational institution (if you have less than 1 year of insurance periods in Slovenia after January 1, 1966)

- Proof of legal representation or guardianship (if you are represented by a legal representative or guardian)

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.

Service Canada

PROTECTED B (when completed)

STATEMENT OF CONTRIBUTORY SALARY AND WAGES – CANADA PENSION PLAN

INFORMATION FOR APPLICATION FOR CANADA PENSION PLAN BENEFITS

- For the current year and the previous year you are requested to provide information on the contributor's salary and wages and contributions by the use of this form.
- A separate Statement of Contributory Salary and Wages is required from each employer for whom the contributor worked during the year(s) concerned.
- If the contributor was self-employed and was required to make self-employed contributions you are required to provide information on the contributor's self-employed earnings and contributions. Contact Service Canada to determine the information required.
- File applications for benefits immediately. Submit this Statement of Contributory Salary and Wages when completed.

A - TO BE COMPLETED BY THE APPLICANT

Type of benefit applied for ◯ Retirement ◯ Disability ◯ Survivors

1. Name and address of contributor's employer	2. To assist me in applying for a Canada Pension Plan benefit please complete Section B below and return the completed form to me or to Service Canada mentioned below. Signature of applicant / Date Name and address of applicant
Employer's Phone Number	Applicant's Phone Number

3. Name of contributor (please print)

Social Insurance Number of Contributor	Payroll number (If known)	Indicate year(s) for which information required

B - TO BE COMPLETED BY EMPLOYER

1. Contributory Earnings - *Previous Year*

January $	February $	March $	April $	May $	June $
July $	**August $**	**September $**	**October $**	**November $**	**December $**

Total Contributory Earnings $ | Employee's Pension Contribution $

2. Contributory Earnings - *Current Year*

January $	February $	March $	April $	May $	June $
July $	**August $**	**September $**	**October $**	**November $**	**December $**

Total Contributory Earnings $ | Employee's Pension Contribution $

3. Please indicate to which Plan the above contributions were made. ☐ Canada Pension Plan ☐ Quebec Pension Plan

4. In what month and year did/will the contributor last work and receive salary and wages?	Month	Year	Employer Account Number*

5. Important: If your records indicate a Social Insurance Number which differs from that shown in Section A, please enter the number you are using.

NOTE : A false or misleading statement may result in an administrative monetary penalty and interest, if any, under the *Canada Pension Plan*, or in the prosecution of an offence. Any benefits received or obtained to which there was no entitlement would have to be repaid.

6. Signature of Employer or Authorized Official and Title	Phone Number	Date
X		

INSTRUCTIONS FOR EMPLOYER

* Employer Account Number should be shown. It is the number assigned by the Federal or the Province of Quebec Taxing Authorities for the purpose of remitting Pension Plan Contributions.

Employee's Pension Contribution - Enter, in the appropriate area, the amount deducted as the EMPLOYEE'S contribution to the Canada Pension Plan or the Quebec Pension Plan. Note that the employer's matching contribution is NOT to be reported on this form.

Contributory Earnings -Enter the total contributory salary and wages earned. Do not include any form of remuneration that is not considered as contributory earnings under the terms of the Canada and Quebec Pension Plans. For instance:

a) remuneration paid to the employee before and during the month in which he reached the age of 18, or after the month in which he reached the age of 70;

b) remuneration paid to the employee while he was engaged in excepted employment;

c) an amount relative to the residence of a member of the clergy.

THIS SPACE RESERVED FOR CLIENT SERVICE ADDRESS STAMP

C.P.P. NO.

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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 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

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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

Service Canada

PROTECTED B (when completed)

Personal Information Bank
ESDC PPU 146

QUESTIONNAIRE FOR DISABILITY BENEFITS CANADA PENSION PLAN

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

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?

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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:

◯ 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

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 **X**	Date (YYYY-MM-DD)	Telephone Number

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