Canada / New Zealand Agreement

Applying for New Zealand Benefits

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; 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, Pharmacist, Psychologist, Nurse Practitioner, 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; Postmaster; Professional Engineer; Social Worker; Teacher.

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 250
Fredericton, NB E3B 4Z6
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.

Application for New Zealand Benefit or Pension

Work and Income NZ
Te Hiranga Tangata

This application will be processed under the terms of the agreement between the New Zealand Government and the Government of the country where the applicant resides

Use this form when applying for:

- **National Superannuation** (retirement pension)
- **Veterans Pension**
- **Widows Benefit**
- **Domestic Purposes Benefit for Widowers**
- **Invalids Benefit**

Bring these in with your application

- **Two forms of identity - to be at least 2 years old**
  (birth certificate, passport, driver's licence, etc.)
- **Marriage Certificate if you are a woman who has been married**
- **Bank Account details into which the benefit or pension is to be paid**

Take your completed application to:

OFFICE USE ONLY

Application form presented on:

STAMP

Applicant's details confirmed:

Forward to:
International Affairs
Work and Income New Zealand
P O Box 27-178
Wellington
New Zealand

Application for New Zealand Benefit or Pension

Work and Income NZ
Te Hiranga Tangata

What type of benefit or pension are you applying for? Tick a box

- **National Superannuation (retirement pension)** ☐ ▶ Complete Section **A** only
- **Veterans Pension** ☐ ▶ Complete Sections **A** and **D**
- **Widows Benefit** ☐ ▶ Complete Sections **A, B** and **C**
- **Domestic Purposes Benefit for Widowers** ☐ ▶ Complete Sections **A, B** and **C**
- **Invalids Benefit** ☐ ▶ Complete Sections **A, B** and **E**

Section A ▸ All applicants

Your name? Tick a box

☐ Mr ☐ Mrs ☐ Ms ☐ Miss

First names

Surname or Family name

Have you ever had any other names?
Give any other names including maiden names

Where do you live?
Give house number, street, town or city and country

Where do you want your mail sent?
Please give your mailing address if different from above

Your date of birth? Day Month 19 Year

Where were you born?
Give name of town, village, city and country

Are you? Tick a box

☐ Male ☐ Female

Are you? Tick one box only

☐ Never married ☐ Living with a partner ☐ Widowed
☐ Married ☐ Living apart/ separated ☐ Divorced

Have you ever been on a Work and Income New Zealand benefit or pension?

No ☐
Yes ☐ ▸ Give name of pension or benefit

Do you have a partner?
A partner could be a wife, husband or someone with who you have entered into a relationship in the nature of marriage

No ☐
Yes ☐ ▸ Give details below

Full name of partner

Partner's date of birth Day Month 19 Year

Is partner getting any payments from Work and Income New Zealand or on a overseas pension?

No ☐
Yes ☐ ▸ Type of payment or pension

Are you married to your partner?

No ☐ ▸ How long have you lived with your partner?
Years Months

Yes ☐ ▸ Date of marriage?
Day Month Year

All applicants to go to next page . . .

Section A continued ▸ All applicants

How long have you resided in New Zealand since the age of 20?
Give details below of all your stays in New Zealand giving dates of arrivals and departures

Date you started or restarted residence in New Zealand	Date you stopped residing in New Zealand	Length of time spent residing in New Zealand	
		Months	Years
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		
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/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		

Bring in your passport(s)

What bank account do you want the payments paid into?

Name of your bank

Your branch of that bank

The address of that branch

The account is in the name of:

The account number is:

Verified by .....

Declaration

- The statements and answers I have given in this application are true and complete.
- I will ensure that International Affairs of Work and Income New Zealand will be advised of any change of circumstance that may affect my entitlement to my New Zealand benefit or pension.
- I promise to advise International Affairs of any of the following changes:
  - If I become entitled to a benefit or pension from some other country
  - My marital status changes
  - I change my address
  - There are changes to the details of the bank account to which payments are credited
- I promise to advise the person, who, in the event of my death, would take care of my affairs and having knowledge of my New Zealand benefit or pension, would advise International Affairs immediately.

Signature of applicant

Date / /

Section B ▸ Only for applicants applying for Widows Benefit, DPB for Widowers or Invalids Benefit

Are you working at the moment?

No ☐

Yes ☐ Give details below

Who do you work for?
Give name and address of company, firm or person

What job do you do?

Is the job? Tick a box

☐ **Full-time** ☐ **Part-time**

How long have you worked there? ☐ years ☐ months

What is your weekly wage?
Show the amount in the currency of the country you are residing in

Give gross amount (before tax taken out)

You may be asked to show your latest pay slips

Did you get money from any of the following over the last 12 months?

- **Wages and salary**
- **Maintenance**
- **Farm or business income**
- **Interest from savings or investments**
- **Dividends from shares**
- **Pension fund payments**
- **Income from rents**
- **Income earned overseas**
- **Any other income**

No ☐

Yes ☐ ▸ **Give details below**
Show any amounts in the currency of the country you are residing in

From	Give gross amount (before tax taken out)

You may be asked to show details of extra income

Do you (and your partner if you have one) have any of the following?
Show any amounts in the currency of the country you are residing in.
Give latest estimate of value.

			Yours	Jointly owned	Partner's
• *Money in bank and savings accounts*	☐ No	☐ Yes ▸			
• Money lent to other people or organisations	☐ No	☐ Yes ▸			
• Money in bonds, shares, debentures or government stock	☐ No	☐ Yes ▸			
• Land and buildings other than your *home (give value)*	☐ No	☐ Yes ▸			

You may be asked to show bank books, share certificates etc.

What are the details of all the children in your care?
Give details of all the children dependent on you and living with you including:

- **Stepchildren**
- **Adopted children**
- **Children over 15 years old who are still at school**
- **Children at boarding school**

Child's full name	Date of birth	Relationship to you	Where living
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		

Section C
► Only for applicants applying for Widows Benefit or DPB for Widowers

What was the name of your late partner?

Your late partner could either be a late husband or wife or someone, who has since died, with whom you had entered into a relationship in the nature of marriage

First names

Surname or Family name

Date of late partner's death? Day Month Year

Place of death?
Give name of town, city, country

Were you married to your late partner?

No ▸ **How long had you lived together?**
years months

Yes ▸ **Date of marriage?** Day Month Year

Were you living apart from your late partner at the time of death?

No

Yes ▸ ***If married*** **had moves been made to get a divorce?**

No

Yes ▸ **Date divorce made final** Day Month Year

What is the name and address of the administrator of your late partner's estate?

Was your late partner a member of any superannuation, pension or life insurance fund?

No

Yes ▸ **Give names of companies, schemes or funds**

Section D
► Only for applicants applying for Veterans Pension

If you are the spouse/partner of a person who is getting a NZ Veterans Pension, you only need to complete Section A

Have you served in the Armed Forces, Mercantile Marine or the Emergency Reserve Corps?

No

Yes ▸ **Give details of your service below**

What country's forces did you serve with?

Name of Unit

Service Number

Rank at time of discharge

Date service commenced Day Month Year

Date discharged Day Month Year

What was your residential address in New Zealand before you started your service?

How long had you lived in New Zealand before start of service?
Years Months

Did you serve outside of New Zealand?

Yes ▸ **Give length of service**
Years Months

▸ **Give Theatres of Operation and approximate dates**

No ▸ **Give details of service on which claim is based, including any Campaign Stars awarded**

Section E ▸ Only for applicants applying for Invalids Benefit

Why are you applying for Invalid's Benefit?
Please give details of your condition and the length of time you have been affected

Who are the doctors who have treated you over the last 5 years?
Give their names and addresses

What hospitals have you been in over the last 5 years?
Give names and addresses of hospitals and year of admittance

Are you getting New Zealand Accident Compensation?

No ☐

Yes ☐ ▸ Give your ACC Reference Number

▸ At what ACC office and on what date did you apply?

Are you applying or have you applied for New Zealand Accident Compensation?

Yes ☐ ▸ At what ACC office?

▸ On what date?

Day | Month | Year

No ☐ ▸ Give reasons why you are not applying

Is your partner (if you have one) working at the moment?

No ☐

Yes ☐ ▸ Give details below

Who does your partner work for?
Give name and address of company, firm or person

What job does your partner do?

Is the job? Tick a box

☐ Full-time ☐ Part-time

How long has your partner worked there? ☐ years ☐ months

What is your partner's weekly wage?
Show the amount in the currency of the country you are residing in

Give gross amount (before tax taken out)

Latest pay slips may be asked for

Did your partner (if you have one) get money from any of the following over the last 12 months?

- Wages and salary
- Maintenance
- Farm or business income
- Interest from savings or investments
- Dividends from shares
- Pension fund payments
- Income from rents
- Income earned overseas
- Any other income

No ☐

Yes ☐ ▸ Give details below
Show any amounts in the currency of the country you are residing in

From	Give gross amount (before tax taken out)

Details of extra income may be asked for

Canada / New Zealand Agreement

Documents and/or information required to support your application [CAN-NZ 1] for a New Zealand Superannuation, Veteran's Pension and Invalids Benefit

Information to be submitted:

- New Zealand social security number

Complete the attached forms:

- **Canadian Residence [SC ISP5013]** indicating your period(s) of residence in Canada **(only if you are applying for a New Zealand Superannuation and/or Veteran's pension)**

- **Medical Report [ISP 2519], Questionnaire for Disability Benefits [ISP 2507], and Consent for Service Canada to Obtain Personal Information [ISP-2502B]** if you have never applied for a Canada Pension Plan Disability benefit **(only if you are applying for a New Zealand Invalids benefit)**

Original or certified documents to be submitted:

- Birth certificate

- Personal details page of your most recent passport

- Driver's license or other form of identity

- Marriage certificate if you are a married female

Photocopied documents to be submitted:

- Bank account details such as voided cheque, bank statement, etc., containing the name of the account holder and the account number

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.

Canada / New Zealand Agreement

Documents and/or information required to support your application [CAN-NZ 1] for a New Zealand Widows Benefit and/or Domestic Purposes Benefit for Widowers

Information to be submitted:

- New Zealand social security number

Original or certified documents to be submitted:

- Birth certificate for you, the deceased and any dependent children
- Marriage certificate
- Death Certificate
- Personal details page of your most recent passport
- Driver's license or other form of identity

Photocopied documents to be submitted:

- Bank account details such as voided cheque, bank statement, etc., containing the name of the account holder and the account number

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 when completed - B
Personal Information Bank
HRSDC PPU 175

CANADIAN RESIDENCE

Canadian Social Insurance Number _____

☐ Mr. ☐ Mrs.
☐ Ms. ☐ Miss

_____ _____
First Name and Initial Last Name

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

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

   - Date of arrival in Canada: _____
   - Place of arrival in Canada: _____

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

From (Year/Month/Day)	**To** (Year/Month/Day)	**City**	**Province/Territory**

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

Departure (Year/Month/Day)	**Return** (Year/Month/Day)	**Destination**	**Reason**

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

Name	**Address**	**City**	**Telephone Number**
			( ) -
			( ) -

DECLARATION OF APPLICANT

I declare that this information is true and complete. (It is an offence to make a misleading statement)

Signature: **X** _____ Date: _____
Year Month Day

Telephone number: ( ) - _____

Service Canada delivers Human Resources and Social Development Canada (also known as Human Resources and Skills Development Canada) programs and services for the Government of Canada.

Canada

Service Canada

Personal Information Bank
HRSDC PPU 140
Fichier de renseignements personnels
RHDSC PPU 140

Protected When Completed - B
Protégé une fois rempli - B

MEDICAL REPORT - RAPPORT MÉDICAL

SECTION A To be completed by Applicant - Doit être remplie par le demandeur

First Name and Initial - Prénom et Initiale	Last Name - Nom de famille	
Home Address (No., Street, Apt., or R.R.) Adresse du domicile (numéro, rue, app., ou route rurale)	City - Ville	Province or Territory Province ou territoire

Postal Code Code postal	Telephone No. - N° de téléphone	Date of Birth Date de naissance Y/A M D/J	**Social Insurance Number** **Numéro d'assurance sociale**

SECTION B To be completed by Physician - Doit être remplie par le médecin

Please provide factual objective opinions - Veuillez donner une opinion factuelle objective

1 Height - Taille Weight - Poids	**2** a) How long have you known the patient? Depuis quand connaissez-vous le patient?	b) When did you start treating the patient for the main medical condition? Quand avez-vous commencé à traiter le patient pour son état pathologique principal? Y/A M	c) Date of last visit Date de la dernière visite Y/A M D/J

3 **Diagnosis (es) - Diagnostic(s) :**

4 **Relevant/significant medical history relating to the main medical condition:**
Antécédents médicaux pertinents/importants reliés à l'état pathologique principal :

Please write legibly - Veuillez écrire lisiblement

Service Canada delivers Human Resources and Social Development Canada (also known as Human Resources and Skills Development Canada) programs and services for the Government of Canada.

Service Canada assure la prestation des programmes et des services de Ressources humaines et Développement social Canada (aussi connu sous le nom de Ressources humaines et Développement des compétences Canada) pour le gouvernement du Canada.

Social Insurance Number
Numéro d'assurance sociale

5 **Over the past two years, has the patient been admitted to a hospital/institution?**
Au cours des deux dernières années, le patient a-t-il été admis à l'hôpital ou dans une institution?

☐ Yes / Oui — **If yes,** please list: / **Dans l'affirmative,** veuillez indiquer **:**

☐ No / Non

Name of the Hospital(s)/Institution(s) - Nom de(s) l'hôpital(aux) ou de(s) l'institution (institutions)

The date(s) of admission La (les) date(s) d'admission Y/A M D/J	The reason(s) for admission La (les) raison(s) de l'admission

6A **Is there supporting evidence for the main medical condition? Please attach supporting documentation.**
Y a-t-il des preuves à l'appui de l'état pathologique principal du patient? Veuillez joindre les documents à l'appui.

Laboratory Reports Rapports de laboratoire	☐ Yes / Oui	☐ No / Non
X-ray reports Radiographies	☐ Yes / Oui	☐ No / Non
Consultants' opinions Opinions de consultants	☐ Yes / Oui	☐ No / Non
Other Autre	☐ Yes / Oui	☐ No / Non
Documentation to be returned Documents devant être retournés	☐ Yes / Oui	☐ No / Non

6B **Please describe relevant physical findings and functional limitations.**
Veuillez décrire les observations physiques et les limitations fonctionnelles pertinentes.

Social Insurance Number
Numéro d'assurance sociale

7 **Are further consultations or medical investigations planned relating to the main medical condition?**
Prévoyez-vous effectuer d'autres consultations ou évaluations médicales en rapport avec son état pathologique principal?

☐ Yes / Oui — **If yes,** please specify: / **Dans l'affirmative,** veuillez préciser :

☐ No / Non

8 **Is the patient currently on medication(s) as a result of the main medical condition?**
Le patient prend-il présentement des médicaments en raison de son état pathologique principal?

☐ Yes / Oui — **If yes,** please indicate dosage and frequency. / **Dans l'affirmative,** veuillez indiquer la dose et la fréquence.

☐ No / Non

9 **Treatment:** List type and response.
Traitement : Indiquez le genre et la réaction.

Social Insurance Number Numéro d'assurance sociale	FOR OFFICE USE ONLY - À L'USAGE EXCLUSIF DU BUREAU		
	☐ A.C. - C.V.	Initials - Initiales	Y/A M D/J

10 **Prognosis of the main medical condition of this patient - Pronostic au sujet de l'état pathologique principal du patient :**

11 **Additional Information - Renseignements supplémentaires**

SIGNATURE (Please print or use a stamp - Veuillez écrire en lettres moulées ou estampiller)

Physician's Full Name - Nom du médecin au complet

Address - Adresse

Postal Code
Code postal

☐ Family Physician
Médecin de famille

☐ Specialty
Spécialité _____

Signature X	Y/A M D/J	Telephone No. - N° de téléphone ( ) -

Please write legibly - Veuillez écrire lisiblement

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 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?

Service Canada delivers Human Resources and Social Development Canada (also known as Human Resources and Skills Development Canada) programs and services for the Government of Canada.

Social Insurance Number

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 — Year Month Day

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 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?

☐ Yes **If yes**, list the type of work and the dates.

☐ No

From Year Month Day	To 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:

☐ No

a) 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

Social Insurance Number

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

	Year	Month	Day		Year	Month	Day
From				To			
From				To			

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.

Social Insurance Number

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

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

Social Insurance Number

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.

Social Insurance Number

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).

Social Insurance Number

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 understand that it is an offence to make a false or misleading statement in an application for benefits.

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.

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*. 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 accessible under the *Privacy Act*. It will be 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.		Social Insurance Number
First Name and Initial	Last Name	
Mailing address (No., Street, Apt., PO Box, or R.R.)	City	
Province or Territory	Country (If other than Canada)	Postal Code
Telephone Number	Fax Number	

Service Canada delivers Human Resources and Social Development Canada (also known as 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 disability 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: _____

You or your representative's 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: _____

Witness 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.