Canada / Italy Agreement

Applying for an Italian Anti-Tuberculosis benefit

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

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

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

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

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

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

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

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

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

Return your completed application, forms and supporting documents to:

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

Disclaimer:

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

CAN - IT/TBC
COD. CI071

☐ **APPLICATION FOR ITALIAN ANTI – TUBERCULOSIS BENEFITS UNDER THE ITALY - CANADA INTERNATIONAL SOCIAL SECURITY AGREEMENT**

DOMANDA DI PRESTAZIONI ECONOMICHE ANTITUBERCOLARI ITALIANE IN VIRTÙ DELL'ACCORDO INTERNAZIONALE DI SICUREZZA SOCIALE ITALO-CANADESE

☐ **TOTALIZATION OF INSURANCE PERIODS**
TOTALIZZAZIONE DEI PERIODI CONTRIBUTIVI

☐ **SUBMISSION OF MEDICAL CERTIFICATES**
TRASMISSIONE CERTIFICAZIONI MEDICHE

FOR CANADA
PER IL CANADA

To be completed by service Canada only
Spazio riservato all'Ufficio competente canadese

Date of receipt
Data di ricezione _____

Stamp and date
Timbro e data _____

SECTION I - APPLICATION FOR ITALIAN ANTI-TUBERCULOSIS BENEFITS UNDER THE ITALY-CANADA INTERNATIONAL SOCIAL SECURITY AGREEMENT

(The insured person or his/her family member must fill in this application)

SEZIONE I - DOMANDA DI PRESTAZIONI ECONOMICHE ANTITUBERCOLARI ITALIANE IN VIRTÙ DELL'ACCORDO INTERNAZIONALE DI SICUREZZA SOCIALE ITALO-CANADESE

(Da compilarsi a cura del richiedente beneficiario assicurato o familiare dell'assicurato)

1. INFORMATION ABOUT THE INSURED PERSON - DATI ANAGRAFICI DELL'ASSICURATO

(If you're applying and you are a family member, please give the insured person's details) - (da compilare anche nel caso di domanda presentata dal familiare)

Family name
Cognome _____

Name
Nome _____

Maiden name
Cognome di nascita _____

☐ Male
Maschio

☐ Female
Femmina

Italian personal identification number *(fiscal code)*
Numero di identificazione personale italiano *(Codice Fiscale)* _____

Canadian social insurance number
Numero di assicurazione sociale canadese _____

Date of birth *(dd/mm/yyyy)*
Data di nascita *(gg/mm/aaaa)* _____

Place of birth *(Town, Village - Province or Territory - Country)*
Luogo di nascita *(Città o Paese - Provincia o Territorio - Stato)* _____

Place of residence *(Town, Village - Province or Territory - Country)*
Luogo di residenza *(Città o Paese - Provincia o Territorio - Stato)* _____

Address
Indirizzo _____ n. _____ Postal code
Codice postale _____

Marital status
Stato civile

☐ Single
Celibe/Nubile

☐ Married
Coniugato/a

☐ Partner in civil union
Unito civilmente

☐ Common-law partner
Convivente de facto

☐ Widow/er
Vedovo/a

☐ Surviving civil partner
Vedovo/a da unione civile

☐ Divorced
Divorziato/a

☐ Separated
Separato/a

☐ Separated from registered partnership
Separato/a civilmente

2. PERSONAL DATA OF THE FAMILY MEMBER WHO IS CLAIMING BENEFITS - DATI ANAGRAFICI DEL FAMILIARE RICHIEDENTE

NOTE - Eligible family members: spouse/partner in civil union (no age limit and regardless of whether they are cohabiting), children (up to the age of 21 and children under 26 if they stay in education) children who are unable to work because of disability (no age limit), dependent brothers and/or sisters (up to the age of 21 or under 26 if they stay in education), dependent brothers and sisters with permanent disabilities (no age limit), dependent parents aged more than 60 (father) or more than 55 (mother).

NOTA - I familiari aventi diritto alla tutela previdenziale sono: il coniuge/partner unito civilmente (art. 1, comma 20, della legge 20 maggio 2016, n. 76), senza alcuna limitazione di età e di convivenza; i figli, fino al 21° anno di età e comunque non oltre il 26° anno se studenti universitari e a carico dell'assicurato; i figli permanentemente inabili al lavoro senza limiti di età; i fratelli, le sorelle a carico fino al 21° anno di età e comunque non oltre il 26° anno se studenti universitari; i fratelli, le sorelle a carico a prescindere dall'età, se permanentemente inabili; i genitori viventi a carico, purché abbiano superato i 60 anni di età per l'uomo ed i 55 anni per la donna.

Family name
Cognome _____

Name
Nome _____

Birth surname
Cognome di nascita _____

☐ Male
Maschio

☐ Female
Femmina

Italian personal identification number *(fiscal code)*
Numero di identificazione personale italiano *(Codice Fiscale)* _____

Canadian social insurance number
Numero di assicurazione sociale canadese _____

Date of birth *(dd/mm/yyyy)*
Data di nascita *(gg/mm/aaaa)* _____

Place of birth *(Town, Village - Province or Territory - Country)*
Luogo di nascita *(Città o Paese - Provincia o Territorio - Stato)* _____

Place of residence *(Town, Village - Province or Territory - Country)*
Luogo di residenza *(Città o Paese - Provincia o Territorio - Stato)* _____

Address
Indirizzo _____ n. _____

Postal code
Codice postale _____

Marital status *(to be completed if the insured person's spouse/partner in civil union is claiming benefits)*
Stato civile *(da compilare solo in caso di prestazione richiesta dal coniuge/partner unito civilmente dell'assicurato)*

_____

☐ Married
Coniugato/a

☐ Partner in civil union
Partner unito civilmente

Date of marriage/registered partnership *(dd/mm/yyyy)*
Data del matrimonio/dell'unione civile *(gg/mm/aaaa)* _____

3. YOU ARE CLAIMING COMPENSATION FOR - TIPO DI INDENNITÀ RICHIESTA

(please tick the appropriate box) - (contrassegnare con x l'apposita casella)

☐ DAILY ALLOWANCE - INDENNITÀ GIORNALIERA(IG)

Please attach medical documentation or health record of TB disease

***NOTE** - Employees are not eligible if they are on paid leave. If you are eligible, you can claim TB benefits as soon as the illness occurs. You can apply for TB benefits from the first day of your illness within 5 years of becoming ill. You qualify for such benefit if you submit medical documentation about TB treatment on a monthly basis. Your benefit stops on the date of recovery/stabilization (provided that you were on unpaid leave and received adequate medical treatment in a hospital or clinic for at least 60 days) and you may qualify for "Post-sanatorium" compensation. This compensation is paid for 24 months. You have to submit your stabilization certificate and a written confirmation of unpaid leave from your employer.*

Allegare documentazione sanitaria comprovante l'insorgere della malattia del soggetto per il quale si richiede la prestazione

***NOTA** - L'indennità non spetta nel caso in cui il lavoratore beneficiario della prestazione percepisca la retribuzione per il periodo di assenza dal lavoro. Il diritto all'indennità decorre dal giorno dell'inizio della malattia tubercolare e si prescrive nel termine di cinque anni. Per continuare a godere dell'indennità è necessario presentare con cadenza mensile la relazione medica sull'andamento della malattia. Dalla data della guarigione/stabilizzazione, a condizione che risultino almeno 60 giorni di cura (ricovero o cura ambulatoriale) e che durante il periodo di cura l'assistito non abbia svolto attività lavorativa, si ha diritto alla Indennità post sanatoriale per i successivi 24 mesi. A tal fine devono essere prodotti: certificato di stabilizzazione e dichiarazione di astensione dal lavoro durante il periodo di cura.*

☐ TREATMENT AND RECOVERY ALLOWANCE - ASSEGNO DI CURA E SOSTENTAMENTO (ACS)

Please attach documentation of medical work capacity evaluation

***NOTE** - ACS Certificate Requirements: personal details (Name, Surname, Place and date of birth, Place of residence of the patient) - Date of discharge from hospital/clinic after recovery or stabilization - Employment status – Medical report (reduced work capacity due to TB disease). You are eligible if you are assessed as less than 50% level of work capacity. Benefits are paid up to 24 months but you could get an extension of benefits if you still meet the necessary requirements.*

Allegare certificazione relativa alla riduzione della capacità lavorativa

***NOTA** - I certificati per ACS devono contenere i seguenti elementi: nome, cognome, luogo e data di nascita, residenza, data di dimissione dal luogo di cura per guarigione o stabilizzazione; attività svolta nella vita lavorativa; giudizio medico legale in merito alla eventuale riduzione della capacità di guadagno in relazione alla malattia tubercolare. La prestazione è riconosciuta in caso di ridotta capacità lavorativa a meno del 50%. Dura fino a 24 mesi ma se permangono i requisiti è rinnovabile.*

4. BENEFICIARY - BENEFICIARI

☐ INSURED PERSON
ASSICURATO

☐ SPOUSE/PARTNER IN CIVIL UNION
CONIUGE/PARTNER UNITO CIVILMENTE

☐ FAMILY MEMBER
FAMILIARE

☐ THE BENEFICIARY IS AN ACTIVE PERSON ON UNPAID LEAVE *(please tick in case of entitlement to IG – Compensation on daily basis)*
IL BENEFICIARIO LAVORATORE DICHIARA DI NON PERCEPIRE RETRIBUZIONE *(contrassegnare in caso di IG)*

Complete this section if you're applying and you are a family member or spouse/partner in civil union.
Da compilare se le prestazioni sono richieste dal coniuge/partner unito civilmente o da altro familiare.

Surname and name Cognome e nome	Italian personal identification number (fiscal code) Numero di identificazione personale italiano (Codice Fiscale)	Relationship to the insured person Grado di parentela con l'assicurato	Date of birth dd/mm/yyyy Data di nascita gg/mm/aaaa	Indicate whether student or disabled(*) Indicare se studente o inabile(*)	Cohabiting Y/N Convivente S/N

** If disabled, submit medical certificate – if family members are students aged from 21 to 26 please submit certificate of school attendance (Please attach the Canadian form ISP 1401 "Declaration of attendance at school or university"). If attending a College or University, the certificate must show the date of enrollment at first year as well as the duration of the study course leading to a degree.*

** Per familiari inabili allegare documentazione medica – per i familiari studenti dai 21 ai 26 anni allegare certificato di frequenza scolastica (Allegare il modulo canadese ISP 1401 "Dichiarazione di frequenza scolastica o universitaria"). Se si tratta di frequenza ad un College o ad una Università il certificato deve indicare la data di iscrizione al primo anno nonché la durata del corso legale di laurea.*

4.1 - IF YOU ARE CLAIMING TB BENEFITS FOR A FAMILY MEMBER OTHER THAN:
IN CASO DI RICHIESTA DI PRESTAZIONI PER UN FAMILIARE DIVERSO DA:

- SPOUSE/PARTNER IN CIVIL UNION - CONIUGE/PARTNER UNITO CIVILMENTE
- CHILD UP TO THE AGE OF 21 - FIGLIO DI ETÀ INFERIORE A 21 ANNI
- DISABLED CHILD AGED MORE THAN 21 - FIGLIO DI ETÀ SUPERIORE AI 21 ANNI SE INABILE

PLEASE FILL IN THIS SECTION:
COMPILARE LA SEGUENTE SEZIONE:

DOES YOUR FAMILY MEMBER RECEIVE INCOME FROM EMPLOYMENT, SELF-EMPLOYMENT OR ANY OTHER SOURCES?
IL FAMILIARE PERCEPISCE REDDITI DERIVANTI DA LAVORO SUBORDINATO, DA LAVORO AUTONOMO O DA ALTRE FONTI?

☐ YES SI ☐ NO NO

IF YES, COMPLETE THE SECTION BELOW WITH THE INCOME AMOUNT IN THE CURRENCY OF THE COUNTRY WHERE IT WAS EARNED:
IN CASO AFFERMATIVO, INDICARE L'IMPORTO DEI REDDITI E LA VALUTA DEL PAESE NEL QUALE VENGONO PRODOTTI:

TYPE OF INCOME TIPO DI REDDITO	FAMILY MEMBER FAMILIARE	PAYMENT PERIOD ANNO DI RIFERIMENTO
INCOME FROM EMPLOYMENT REDDITI DA LAVORO DIPENDENTE		Current year / Anno corrente 20 _ _ _
		Previous year / Anno precedente 20 _ _ _
INCOME FROM SELF-EMPLOYMENT, PROFESSIONAL OR BUSINESS INCOME REDDITI DA LAVORO AUTONOMO, PROFESSIONALE E DI PARTECIPAZIONE		Current year / Anno corrente 20 _ _ _
		Previous year / Anno precedente 20 _ _ _
RENTAL INCOME FROM HOME REDDITI DELLA CASA DI ABITAZIONE		Current year / Anno corrente 20 _ _ _
		Previous year / Anno precedente 20 _ _ _
PROPERTY *(except for the person's home)* AND RENTAL INCOME REDDITI DA IMMOBILI *(escluso il reddito della casa di abitazione)*		Current year / Anno corrente 20 _ _ _
		Previous year / Anno precedente 20 _ _ _
INCOME FROM CAPITAL GAINS REDDITI DA CAPITALE		Current year / Anno corrente 20 _ _ _
		Previous year / Anno precedente 20 _ _ _
INCOME FROM ARREARS REFERRING TO PREVIOUS YEARS *(except for severance pay and the relevant pre-payments and arrears)* REDDITI DA ARRETRATI RIFERITI AD ANNI PRECEDENTENTI *(esclusi i trattamenti di fine rapporto e le relative anticipazioni e competenze arretrate)*		Current year / Anno corrente 20 _ _ _
		Previous year / Anno precedente 20 _ _ _
INCOME FROM ANNUITIES REDDITI DA VITALIZI		Current year / Anno corrente 20 _ _ _
		Previous year / Anno precedente 20 _ _ _
INCOME FROM WELFARE ALLOWANCES REDDITI ASSISTENZIALI		Current year / Anno corrente 20 _ _ _
		Previous year / Anno precedente 20 _ _ _

4.2 - DO FAMILY MEMBERS RECEIVE ANY OTHER SOCIAL SECURITY BENEFITS?
I FAMILIARI PERCEPISCONO ALTRE PRESTAZIONI?

☐ YES / SI ☐ NO / NO

IF YES, PLEASE INDICATE THE TYPE OF BENEFIT* AND THE RELEVANT AMOUNT IN THE CURRENCY** OF THE COUNTRY OF THE PAYING INSTITUTION:

NEL CASO DI RISPOSTA AFFERMATIVA INDICARE IL TIPO DI PRESTAZIONE* E IL RELATIVO IMPORTO NELLA VALUTA** DEL PAESE DELL'ISTITUZIONE DEBITRICE:

FAMILY MEMBER / FAMILIARE	BENEFITS PAID BY SERVICE CANADA*** PRESTAZIONI EROGATE DALL'ISTITUZIONE CANADESE***		BENEFITS PAID BY ITALIAN INSTITUTION*** PRESTAZIONI EROGATE DALL'ISTITUZIONE ITALIANA***		BENEFITS PAID BY OTHER COUNTRIES*** PRESTAZIONI EROGATE DA ALTRI PAESI (diversi da Canada e Italia) ***	
	*	**	*	**	*	**
	*	**	*	**	*	**
	*	**	*	**	*	**
	*	**	*	**	*	**
	*	**	*	**	*	**
	*	**	*	**	*	**
	*	**	*	**	*	**
	*	**	*	**	*	**
	*	**	*	**	*	**

Calendar year of reference:
Anno di riferimento: _ _ _ _ _ _ _

Effective date of payment:
Data di decorrenza: _ _ _ _ _ _ _

Frequency of payment:
Frequenza del pagamento:

☐ Weekly / Settimanale ☐ Monthly / Mensile ☐ Other / Altro

_ _ _ _ _ _ _ _ _ _ _ _

*** Type of benefit:**

(a) - Remuneration in the event of sickness
(b) - Sickness insurance benefits for incapacity for work
(c) - Disability pension
(d) - Old age pension
(e) - Survivor's pension
(f) - Pension for accident at work or occupational disease
(g) - Unemployment benefit
(h) - Other (specify)

*** Tipo di prestazione:**

(a) - Pagamento della retribuzione in caso di malattia
(b) - Indennità dell'assicurazione malattia
(c) - Pensione d'inabilità
(d) - Pensione di vecchiaia
(e) - Pensione ai superstiti
(f) - Rendita per infortunio sul lavoro o malattia professionale
(g) - Indennità di disoccupazione
(h) - Altro (specificare)

***NAME OF THE PAYING SOCIAL SECURITY INSTITUTION - NOME DELL'ISTITUZIONE DI SICUREZZA SOCIALE

_____ _____
_____ Address / Indirizzo _____
_____ _____

SECTION II - TOTALIZATION OF INSURANCE PERIODS (Including Canadian Old age coverage)
(For Service Canada use only)

SEZIONE II - TOTALIZZAZIONE DEI PERIODI CONTRIBUTIVI (compresi i periodi riferiti all'assicurazione Old Age)
(Riservato al Service Canada)

SECTION III - SUBMISSION OF MEDICAL CERTIFICATES
(Please provide information and attach medical certificates)

SEZIONE III - TRASMISSIONE CERTIFICAZIONI MEDICHE
(Si prega di fornire le informazioni e allegare i certificati)

Service Canada is submitting the relevant medical-legal certificate (according to Canadian legislation) in a sealed envelope, upon request of Italian institution:
Su richiesta dell'istituzione italiana si trasmette in busta chiusa la seguente documentazione avente valore medico legale ai fini della normativa canadese:

☐ MEDICAL CERTIFICATE CONFIRMING WHEN THE PERIOD OF ILLNESS OCCURED
CERTIFICAZIONE ATTESTANTE L'INIZIO DELLA MALATTIA

☐ MONTHLY REPORT
RELAZIONE MENSILE

☐ RECOVERY/STABILIZATION CERTIFICATE
CERTIFICATO DI GUARIGIONE/STABILIZZAZIONE

SECTION IV - MANDATE FOR ASSISTANCE
SEZIONE IV - MANDATO DI ASSISTENZA

If you wish assistance from a Patronato, please complete the following:
Se desiderate assistenza da un Patronato completare la presente sezione:

I hereby, for the legal representation of the present application,
Il sottoscritto, per il patrocinio della presente domanda,

☐ give
ha

☐ do not give
non ha

mandate to the Patronato,
conferito mandato al Patronato,

☐ I enclose a copy of the legal representation.
si allega una copia del mandato di patrocinio.

CANADIAN INSTITUTION DATA
DATI ISTITUZIONE CANADESE

Institution name
Denominazione _____

Address
Indirizzo _____

Postal code
Codice postale _____

Date *(dd/mm/yyyy)*
Data *(gg/mm/aaaa)* _____

Stamp
Timbro

Signature
Firma _____

Canada / Italy Agreement

Documents and/or information required to support your application [CAN-IT/TBC] for an Italian Anti-Tuberculosis Benefit

Complete the attached forms:

- ***Declaration in Lieu of Certification* (*Dichiarazione Sostitutiva di Certificazione*)** (only if you are an Italian or European Union citizen)

- ***Declaration of Attendance at School or University* [ISP-1401C]** (only if you are claiming family benefits for children over age 18)

Original or certified documents to be submitted:

- Birth certificate for you and your dependants (unless you are an Italian or European Union citizen, in which case a *Declaration in Lieu of Certification* **(*Dichiarazione Sostitutiva di Certificazione*)** must be completed and provided with a photocopy of your valid passport)

- Medical documentation or health record of Tuberculosis disease

- Medical certificate attesting work capacity evaluation

- Medical certificate confirming when the period of illness occurred

- Medical report attesting the ongoing disease and treatment

- Medical certificate attesting a full recovery or a stabilized condition (no evidence of progression of disease) of the patient

- Medical certificate for the beneficiary if he or she is disabled

Original documents to be submitted:

- *Mandato di Assistenza* (only if you are applying through the Patronato) (refer to Section IV of the Application for Italian Anti-Tuberculosis Benefit form [CAN-IT/TBC])

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)

DECLARATION OF ATTENDANCE AT SCHOOL OR UNIVERSITY

SECTION A - TO BE COMPLETED BY STUDENT AFTER THE START OF FIRST DAY OF CLASS

1. Contributor's Social Insurance Number | Contributor's Given Name and Initial | Family Name

2. Your Social Insurance Number | Preferred Language ◯ English ◯ French | Your Given Name and Initial | Family Name

3. Your Home Address | Home Address (No., Street, Apt. No.,R.R.) | City, Town or Village | Province or Territory | Country | Postal Code

4. Mailing Address (If different from home address) | Mailing Address (No., Street, Apt. No., P.O. Box, R.R.) | City, Town or Village | Province or Territory | Country | Postal Code

5A. Student ID Number

5B. Name of School, University, College, Training Centre, etc.

6A. Type of Enrollment (if "Evening" or "Other", please provide an explanation in Number 8)

◯ Full Time ◯ Evening ◯ Other

6B. Number of courses per Term

6C. Enrolled In (Specify Course, Grade or Program)

7A Number of hours you are required to attend for course, grade or program.

Hours per week

7B When did your current attendance begin?

YYYY MM DD

7C When will your current attendance end?

YYYY MM DD

8. Give duration and reasons for any absence(s) during your current and past academic year plus any additional explanation with reference to question 6A if "Evening" or "Other" was selected.

9. Have you applied for or are you receiving a Canada Pension Plan Benefit as a result of the disability or death of a contributor not identified in question 1?

◯ Yes ◯ No

Social Insurance Number of that Contributor

10. Direct deposit (for Canada only) *For direct deposit to a financial institution outside Canada, please contact us.*

If your application is approved, your monthly payments will be deposited into <u>your</u> account at your financial institution. Complete the boxes below (you may need to contact your financial institution to get this information).

Branch Number (5 digits) | Institution Number (3 digits) | Account Number (maximum of 12 digits)

Name(s) on the account | Telephone number of your financial institution

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

SECTION B - DECLARATION AND SIGNATURE

I hereby declare that, to the best of my knowledge and belief, the information given above is true and complete. I understand to notify Service Canada should I **interrupt** or **terminate** my attendance at school or university. I hereby authorize the above school or university to provide the Canada Pension Plan Administration with information regarding my enrollment and attendance.

The information you provide is collected under the authority of the *Canada Pension Plan* legislation to determine your eligibility for benefits. The Social Insurance Number (SIN) is collected under the authority of section 52 of the *Canada Pension Plan Regulations* and in accordance with Treasury Board Secretariat Directive on the SIN as an authorized user of the SIN. The SIN will be used to ensure an individual's exact identification so that contributory earnings can be correctly posted allowing for benefits and entitlements to be accurately calculated.

Submitting this application is voluntary. However, if you refuse to provide your personal information, the Department of Employment and Social Development Canada (ESDC) will be unable to process your application.

The information you provide may be used and/or disclosed for policy analysis, research, and/or evaluation purposes. In order to conduct these activities, various sources of information under the custody and control of ESDC may be linked. However, these additional uses and/or disclosures of your personal information will never result in an administrative decision being made about you (such as a decision on your entitlement to a benefit).

The information you provide may be shared within ESDC, with any federal institution, provincial authority or public body created under provincial law with which the Minister of ESDC may have entered into an agreement, and/or with non-governmental third parties for the purpose of administering the *Canada Pension Plan*, other acts of Parliament and federal or provincial law as well as for policy analysis, research and/or evaluation purposes. The information may be shared with the government of other countries in accordance with agreements for the reciprocal administration or operation of that law and of the *Canada Pension Plan*.

Your personal information is administered in accordance with the *Canada Pension Plan* and the *Privacy Act*. You have the right of access to, and to the protection of, your personal information. It will be kept in Personal Information Bank ESDC PPU 146. Instructions for obtaining this information are outlined in the government publication entitled Info Source, which is available at the following Web site address: www.infosource.gc.ca. Info Source may also be accessed online at any Service Canada Centre.

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 Student	Date of Application YYYY MM DD	Telephone Number (including area code)
X		

SECTION C - TO BE COMPLETED BY SCHOOL OR UNIVERSITY AFTER THE START OF FIRST DAY OF CLASS

To the best of our knowledge and belief, the answers to the questions in Section A above, are correct unless otherwise stated below:

Additional comments:

Does the above noted course load meet or exceed the minimum requirement to be considered a full-time student at your school or university? ◯ Yes ◯ No

Name and Address of School or University	Name of Authorized Person
	Signature
	Title
	Date Telephone Number

FOR OFFICE USE ONLY

Approved pursuant to Section 59 of the Canada Pension Plan for continuing payment until advised otherwise.

Authorized signature **Date**

DICHIARAZIONE SOSTITUTIVA DI CERTIFICAZIONE
DECLARATION IN LIEU OF CERTIFICATION

Il sottoscritto _____, cittadino _____
I the undersigned _____, *a(n)* _____ *citizen*

nato a _____ il _____
born in _____ *on* _____

residente in _____
residing at _____

consapevole delle sanzioni, anche penali, in cui può incorrere in caso di false dichiarazioni, cosi come stabilito dall'art. 26 della legge 15/1968 (delle Italia),

aware of the penalties, including criminal penalties, to be incurred in case of false statements, as established under Article 26 of Law 15/1968 (of Italy),

DICHIARA quanto segue:
make the following DECLARATION:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Luogo e data
Place and date

Firma il Dichiarante
Signature of Declarant

_____ _____

La presente dichiarazione sostitutiva di certificazione, resa ai sensi dell'art. 2 della legge 15/1968 e successive modifiche, non è soggetta ad autentica della firma.

The signature of this declaration in lieu of certification, made in accordance with Article 2 of Law 15/1968 and subsequent amendments, does not need to be authenticated.