Canada/Philippines Agreement

Applying for a Philippine disability 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 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.

CAN-PHI 1

APPLICATION FOR RP SOCIAL SECURITY BENEFITS UNDER THE PHILIPPINES-CANADA SOCIAL SECURITY AGREEMENT

DEMANDE DE PRESTATIONS DE SÉCURITÉ SOCIALE DES PHILIPPINES EN VERTU DE L'ACCORD PHILIPPINES-CANADA EN MATIÈRE DE SÉCURITÉ SOCIALE

NOTE: This application must be completed by the contributor or, in the case of an application for survivor's or death benefit, by the pai claiming entitlement to benefits. The term "contributor" means the person who has made contributions to the RP Social Security schemes
Cette demande doit être remplie par le cotisant ou dans le cas d'une demande de prestations de survivants ou de décès, par l'ayant droit qui réclame les prestations. Le terme "cotisant" désigne la personne qui a versé des cotisations aux régimes de sécurité sociale des Philippines.

PLEASE PRINT/ *VEUILLEZ ÉCRIRE EN MAJUSCULES*

PART A. GENERAL INFORMATION ABOUT THE CONTRIBUTOR
PARTIE A. RENSEIGNEMENTS GÉNÉRAUX SUR LE COTISANT

1. _____
First name, Middle Initial, and Last Name
Prénom, initiales et nom de famille

3. Date of birth
Date de naissance
year / month / day
année / mois / jour

4. Place of birth
Lieu de naissance
City or Town / *Ville ou Village* | Province, State or Territory / *Province, État ou Territoire* | Country / *Pays*

2. a) Social Insurance Number in Canada
Numéro d'assurance sociale au Canada

b) Social Security Number in the Philippines
Numéro de sécurité sociale aux Philippines

c) Government Service Insurance System Number in the Philippines/*Numéro du Système d'assurance du service du gouvernement*

5. Address / *Adresse* _____ POSTAL CODE / *CODE POSTAL*

6. Civil Status / *État civil*
☐ Single / *Célibitaire* ☐ Married / *Marié (e)* ☐ Widowed / *Veuf (veuve)* ☐ Seperated since / *Séparé (e) depuis* (year / *année*, month / *mois*) ☐ Divorced since / *Divorcé (e) depuis* (year / *année*, month / *mois*)

7. Is the contributor receiving or has he (she) ever received or applied for benefits under the RP SOCIAL SECURITY LAW and/or the Government Service Insurance System (GSIS)?*Le cotisant reçoit-il ou a-t-il reçu ou demandé des prestations en vertu de la LOI SUR LA SÉCURITÉ SOCIALE DES PHILIPPINES et/ou du Système d'assurance du service du gouvernement (SASG)?*

☐ yes/ *oui* ☐ SSS ☐ no/ *non*
☐ GSIS/ SASG

If "yes", what type of benefit? (retirement, total/partial disability?)
Si "oui", genre de prestation? (retraite, invalidité totale/partielle?) _____

8. Has the contributor ever paid contributions to a social security plan in a country other than the Philippines?/ *Le cotisant a-t-il participé à un régime de sécurité sociale dans un pays autre que les Philippines?* ☐ yes/ *oui* ☐ no/ *non*

If "yes", in what country or countries?/*Si "oui", dans quel(s) pays?* _____

9. Qualified dependent children/*Enfants à charge admissibles*

Indicate the first and last names, and date of birth of each legitimate, legitimated, or legally adopted child who is unmarried, not gainfully employed, and not over 21 years of age, or over 21 years of age, provided that he is congenitally incapacitated and incapable of self-support physically or mentally, but not exceeding five, beginning with the youngest and without substitutio/*Inscrivez le prénom, le nom de famille et la date de naissance de chaque enfant légitime, légitimé ou adopté légalement, célibataire, ne travaillant pas et de moins de 21 ans ou de 21 ans et plus, atteint d'une invalidité congénitale ou incapable physiquement ou mentalement de subvenir à ses besoins, sans dépasser cinq enfants, en commençant par le plus jeune et sans substitution.*

First Name / *Prénom*	Last Name / *Nom de famille*	Date of Birth / *Date de naissance*			Address / *Adresse*
		Year / *Année*	Month / *Mois*	Day / *Jour*	

10. Employment History/*Historique d'emploi*

Employer *Employeur*	Period of Employment *Période d'emploi*		Address *Adresse*
	From/ *Du*	To/ *Au*	

If there is not enough space, please add a separate sheet giving the required information.
Si l'espace est insuffisant, veuillez donner les renseignements demandés sur une autre feuille.

PART B. APPLICATION FOR A RETIREMENT PENSION (Be sure you have completed PART A). You must be at least 60 years old and separated from employment.
PARTIE B. DEMANDE DE RETRAITE (la PARTIE A doit avoir été remplie). Vous devez être âgé d'au moins 60 ans et avoir cessé de travailler.

If you are between 60 and 65 years of age, have you stopped working? *Si vous avez entre 60 et 65 ans, avez-vous cessé de travailler?*

☐ Yes, I have stopped working on/*Oui, j'ai cessé de travailler le:* year/*année* month/*mois*

☐ No, I am still working./*Non, je travaille encore*

☐ No, I will stop working on/*Non, je cesserai le:* year/*année* month/*mois*

PART C. APPLICATION FOR THE DISABILITY AND DEPENDENT'S PENSION (Be sure you have completed PART A)
PARTIE C. DEMANDE DE PENSIONS D'INVALIDITÉ ET D'ENFANT À CHARGE (la PARTIE A doit avoir été remplie)

1. Exact date on which your disability began:
Date exacte du début de l'invalidité? year/*année* month/*mois* day/*jour*

2. Have you been previously granted disability benefits?
Avez-vous déjà reçu une pension d'invalidité?
☐ yes/ *oui* Dates/ *Dates* : _____
☐ no/ *non*

3. Have you stopped working completely?*Avez-vous complètement cessé de travailler?*

☐ yes/ *oui* If "yes", when did you stop?/*Si "oui", quand avez-vous cessé?* year/*année* month/*mois* day/*jour*

For what reasons?/*Pour quels motifs?* _____

☐ no/ *non* If "no", are you working regularly? ☐ or occassionally? ☐
Si "non", travaillez-vous régulièrement? ☐ *ou occasionellement?* ☐

4. Information about your last job?/*Renseignements au sujet de votre dernier emploi*

Name of last employer/*Nom du dernier employeur* _____

Period of employment/*période d'emploi* from/*du* year/*année* month/*mois* day/*jour* to/*au* year/*année* month/*mois* day/*jour*

What position did you hold? *Quelle était votre occupation?*	Describe your job/*Décrivez votre emploi*
Did you have to work outdoors? *Deviez-vous travailler à l'extérieur?* ☐ yes/ *oui* ☐ no/ *non*	Why did you leave this job?/*Pourquoi avez-vous quitté cet emploi?*

5. Are you in a hospital or confined in an institution? ☐ yes/*oui* ☐ no/*non*
Êtes-vous hospitalisé ou confiné en institution?
If "yes", give details/*Si "oui", veuillez préciser.*

Name of Hospital or Institution/*Nom de l'hôpital ou de l'institution* _____
Address/*Adresse* _____
Telephone number/Numéro de téléphone _____

6. Who is the physician best able to provide the Social Security System and/or the Government Service Insurance System with information about your disability?
Indiquez le nom du médecin le plus apte à renseigner le Système de sécurité sociale et/ou le Système d'assurance du service du gouvernement sur votre invalidité.

Physician's Name:
Nom du médecin: _____

Physician's address: _____ Telephone number:
Adresse du médecin: _____ *Numéro de téléphone:* _____

7. Who are the other physician(s) you have consulted about your disability?
Indiquez le nom d'autre médecins que vous avez consultés au sujet de votre invalidité.

Physician's name *Nom du médecin*	Address *Adresse*	Telephone Number *Numéro de téléphone*	Approximate *Approximativement*	
			year *année*	month *mois*

8. In what medical establishments were you treated or examined? (out-patient)
Dans quels établissements avez-vous été traité ou examiné? (clinique externe)

Name of establishment *Nom de l'établissement*	Address *Adresse*	Telephone Number *Numéro de téléphone*	Approximate *Approximativement*	
			year *année*	month *mois*

Information about the person completing the application on behalf of the disabled person.
Renseignements concernant la personne ayant rempli le formulaire de demande pour la personne invalide.

☐ Mr./ *M.*
☐ Mrs./ *Mme.*
☐ Miss/ *Mlle.*

First Name *Prénom* _____ Last Name *Nom de famille* _____ Relationship to disabled person *Lien de parenté avec la personne invalide* _____

Address: _____ Postal Code: _____ Telephone Number:
Adresse: _____ *Code postal:* _____ *Numéro de téléphone:* _____

Please enclose a medical report with the application for disabilty pension.
Veuillez joindre un rapport médical à la demande de pension d'invalidité.

PART D. APPLICATION FOR THE SURVIVING SPOUSE'S AND DEPENDENT PENSION (Be sure you have completed PART A)
PARTIE D. DEMANDE DE PENSIONS DE CONJOINT SURVIVANT ET D'ENFANT À CHARGE (La PARTIE A doit avoir été remplie)

1. Information about the deceased
Renseignements sur la personne décédée

a) Date of death *Date de décès* ____ ____ ____ ____ ____ ____ ____ ____
year *année* month *mois* day *jour*

b) Place of death *Lieu du décès* _____
City or Town *Ville ou Village* Province, State or Territory *Province, État ou territoire* Country *Pays*

2. Information about the surviving spouse
Renseignements sur le conjoint survivant _____
First and last names you are now using
Prénom at nom de famille utilisés actuellement

3. Your first and last names at birth
Prénom et nom de famille à la naissance
☐ the same or
les mêmes ou _____

4. Address of your permanent residence at the time of the contributor's death
Adresse de votre domicile permanent à la date du décès du cotisant

_____ Postal Code
_____ *Code postal* _____

5. Your current address (if different from that shown in Section 4)
Adresse actuelle (si différente de celle au Point 4)

_____ Postal Code
_____ *Code postal* _____

6. Your date of birth
Votre date de naissance

year *année* | month *mois* | day *jour*

7. Your place of birth / *Votre lieu de naissance*

City or Town *Ville ou Village* | Province, State or Territory *Province, État ou territoire* | Country *Pays*

8. Were you married to the contributor at the time of his/her death?
Étiez-vous marié(e) au cotisant lors de son décès?

☐ yes *oui* If "yes", give date and place of marriage *Si "oui", date et lieu du mariage*

year *année* | month *mois* | day *jour*

Place of Marriage
Lieu du mariage

☐ no *non* If "no", since when had you been living with the contributor?
Si "non", depuis quand cohabitez-vous avec le cotisant?

year *année* | month *mois* | day *jour*

Did any children result from your union with the contributor?
Un enfant est-il né de votre union avec le cotisant?

☐ yes *oui* ☐ no *non*

9. Surviving descendants other than those enumerated under Question No. 9 of PART A.
Descendants survivants autres que ceux énumérés à la question 9 de la Partie A.

Illegitimate minor Children (acknowledged natural and other illegitimate children)
Enfants mineurs illégitimes (naturels reconnus ou autres enfants illégitimes)

First Name *Prénom*	Last Name *Nom de famille*	Date of birth *Date de naissance*			Address/ Adresse (If minor, give name, address, and relationship of guardian.) *(Si mineur, indiquez le nom, l'adresse et le lien avec le tuteur.)*
		Year *Année*	Month *Mois*	Day *Jour*	

10. Surviving Ascendants (Do not complete if deceased is survived by legitimate minor children.)
Ascendants survivants (Ne pas remplir si le défunt a des enfants mineurs légitimes.)

Parents of Deceased
Parents de la personne décédée

First Name / *Prénom*	Last Name / *Nom de famille*	Address / *Adresse*

11. Surviving Collateral Relatives of Decedent (Do not complete if deceased is survived by ascendants or descendants.)
Parents collatéraux de la personne décédée (Ne pas remplir si le défunt a des ascendants ou descendants survivants.)

Brothers and Sisters of Deceased
Frères et soeurs du défunt

Name *Nom*	Date of birth *Date de naissance*			Address/ Adresse (If minor, give name, address, and relationship of guardian.) *(Si mineur, indiquez le nom, l'adresse et le lien avec le tuteur.)*	Remarks (state whether full-blood or half-blood) *Remarques (indiquez frère, soeur ou demi-frère, demi-soeur)*
	Year *Année*	Month *Mois*	Day *Jour*		

12. Other relatives within the 6th civil degree (Do not complete if deceased has living relatives falling under numbers 9 to 11.)
Autres parents (6e degré au maximum) (Ne pas remplir si le défunt a des parents tel qu' indiqué aux points 9 à 11.)

Name *Nom*	Date of birth *Date de naissance*			Address/ Adresse (If minor, give name, address, and relationship of guardian.) *(Si mineur, indiquez le nom, l'adresse et le lien avec le tuteur.)*	Exact relationship/ Lien de parenté exact
	Year *Année*	Month *Mois*	Day *Jour*		

PART E. DECLARATION OF THE APPLICANT
PARTIE E. DÉCLARATION DE LA PERSONNE QUI FAIT LA DEMANDE

I hereby apply, under the RP Social Security Law and/or Government Service Insurance System, for the benefits indicated above. I declare that, to the best of my knowledge, the information provided in this application is true and complete and I undertake to notify the Social Security System (SSS) and/or Government Service Insurance System (GSIS) of any change that might affect my entitlement to these benefits.

Par la présente, je demande en vertu de la Loi sur la sécurité sociale des Philippines et/ou du Système d'assurance du service du gouvernement des Philippines, les prestations indiquées précédemment. Je déclare que, à ma connaissance, les renseignements fournis dans la présente demande sont véridiques et complets et je m'engage à aviser le Système de sécurité sociale (SSS) et/ou le Système d'assurance du service du gouvernement (SASG) de tout changement pouvant influer sur le droit à ces prestations.

Signature:
Signature: _____

Date:
Date: _____
year / *année* | month / *mois* | day / *jour*

Declaration of witness where the applicant has signed with a cross (X) / Déclaration du témoin lorsque la personne qui fait la demande signe d'une croix (X)

I have read this application to the applicant, who appears to understand the contents and has signed with a cross (X). */ J'ai lu cette demande à la personne qui la fait, et elle a semblé en comprende le contenu et a signé d'une croix (X).*

_____
First and Last Name of Witness
Prénom et nom de famille du témoin

_____
Signature of Witness
Signature du témoin

Address of Witness / *Adresse du témoin*

_____

_____

AUTHORIZATION TO TRANSMIT PERSONAL INFORMATION AND TO DIVULGE MEDICAL INFORMATION
AUTORISATION DE TRANSMETTRE DES RENSEIGNEMENTS PERSONNELS ET DES RENSEIGNEMENTS DE NATURE MÉDICALE

For the purpose of this application made under the legislation of the Philippines, I authorize the International Affairs and Branch Expansion Division (IABE) of the Social Security System (SSS) and the Social Insurance Group of the Government Service Insurance System (GSIS) to transmit to the liaison agency and to the competent institution of Canada, designated in the Administrative Arrangement for the Application of the Agreement on Social Security between the Government of the Philippines and the Government of Canada, any information concerning the SSS and/or GSIS decision, except for any information with respect to the amount of employment earnings or contributions made to the Social Security System and/or Government Service Insurance System.

For the period to process this application, I also authorize the Social Security System and/or Government Service Insurance System to transmit to the competent institution of Canada any information it may hold concerning my state of health.

Pour le traitement de la présente demande déposée en vertu de la législation des Philippines, j'autorise la Division des Affaires internationales et de l'expansion de la direction générale (AIED) du Système de sécurité sociale (SSS) et au Groupe d'assurance sociale du Système d'assurance du service du gouvernement (SASG) à transmettre à l'organisme de liaison et à l'institution compétente du Canada, désignés dans l'Arrangement administratif pour l'application de l'Accord de sécurité sociale entre le gouvernement des Philippines et le gouvernement du Canada tout renseignements concernant une décision prise par le SSS et/ou le SASG, à l'exception de renseignements relatifs aux montants des gains tirés d'emplois et aux cotisations versées au Système de sécurité sociale et/ou au Système d'assurance du service du gouvernement .

En outre, j'autorise le Système de sécurité sociale et/ou le Système d'assurance du service du gouvernement, pour la période requise pour traiter cette demande, à fournir à l'institution compétente du Canada tout renseignement qu'il détient concernant mon état de santé.

Signature:
Signature: _____

Date:
Date: _____

TO BE COMPLETED BY THE COMPETENT INSTITUTION OF CANADA
À REMPLIR PAR L'ORGANISME COMPÉTENT DU CANADA

Date on which application was received
Date de réception de la demande

year / *année* month / *mois* day / *jour*

Information about the contributor / *Reseignements sur le cotisant*

Date of birth Date de naissance	Date of death Date de décès	Date of marriage Date de mariage	Date of divorce Date de divorce
year / *année* month / *mois* day / *jour*	year / *année* month / *mois* day / *jour*	year / *année* month / *mois* day / *jour*	year / *année* month / *mois* day / *jour*
☐ verified / vérifiée	☐ verified / vérifiée	☐ verified / vérifiée	☐ verified / vérifiée

Information about the surviving spouse / *Renseignements sur le conjoint survivant*

Date of birth / Date de naissance

year / *année* month / *mois* day / *jour*

☐ verified / vérifiée

Information about the qualified dependent children /*Renseignements sur les enfants à charge admissibles*

NAME *NOM*	DATE OF BIRTH *DATE DE NAISSANCE*	
		☐ verified / vérifiée
		☐ verified / vérifiée
		☐ verified / vérifiée
		☐ verified / vérifiée
		☐ verified / vérifiée

I hereby declare that the information concerning civil status given in this form was taken from original documents provided by the applicant.

J'atteste que les données relatives à l'état civil inscrites sur la présente formule ont été tirées des documents originaux fournis par le requérant.

Full name of Department:
Dénomination du service: _____

Signature:
Signature: _____

Date:
Date: _____

_____

Last name, first name and title of authorized person
Nom de famille, prénom et titre de la personne autorisée

SEAL
SCEAU

Canada / Philippines Agreement

Documents and/or information required to support your application [CAN/PHI 1] for a Philippine disability benefit

Complete the attached forms:

- ***Statement of Contributory Salary and Wages - Canada Pension Plan*** **[ISP 2011]** (only required if you are still working or if you stopped working less than two years before applying for a Government Service Insurance System (GSIS) disability benefit)

- ***Medical Report*** **[ISP-5052],** ***Questionnaire for Disability Benefits*** **[ISP-5050]**, ***Authorization to Disclose Information/Consent for Medical Evaluation*** **[ISP-5051]** and ***Authorization to Disclose Information/Consent for Medical Evaluation*** **[ISP-5060]** (only required if you have never applied for a Canada Pension Plan Disability benefit)

Original or certified documents to be submitted:

- Birth certificate for you and any children under age 21 (if applicable)

- Two valid identification documents, such as passport, driver's license, resident or senior card (only required for a claim from the SSS)

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.

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

Disponible en Français

Canada

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

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

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?

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

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.

RETURN THIS FORM WITH YOUR APPLICATION AND QUESTIONNAIRE TO SERVICE CANADA

Consent for Service Canada to Obtain Personal Information

Service Canada is authorized under Section 68 and 69 of the *Canada Pension Plan (CPP) Regulations* to receive personal (medical and non-medical) information about you to decide if you qualify or continue to qualify for CPP disability benefits. Your consent to permit Service Canada to obtain this information is necessary, should Service Canada need this information from persons and organizations listed on the following page.

Protecting your privacy:

Service Canada cannot give your personal information to any person or organization without your written consent, except where authorized by *CPP legislation*. Under the *Privacy Act*, you (or your authorized representative) have the right to request a copy of the information in your file and to request correction(s) to that information. Your personal information is retained in Personal Information Bank (ESDC PPU 146). Instructions for accessing this information are provided in the Info Source, a copy of which is located in Service Canada offices or at: **infosource.gc.ca**

Instructions:

- Complete Sections 1 and 2 of this form; and
- return this form with your application and questionnaire to **Service Canada**.

Section 1 - Client Information		
◯ Mr. ◯ Mrs. ◯ Miss ◯ Ms.	Canadian Social Insurance Number	
First Name and Initial	Last Name	
Mailing address (No., Street, Apt. No., P.O. Box, R.R.)	City, Town or Village	
Province or Territory	Country	Postal Code
Telephone Number	Fax Number	

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, nurse practitioners, consultant specialists, or health-care professionals
- medical facilities or hospitals
- educational institutions or other vocational agencies
- my accountant or book-keeper for information on self-employment
- administrators of insurance plans
- 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 _____
Date (YYYY-MM-DD)

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 _____
Date (YYYY-MM-DD)

This signed consent is valid for up to **3 years** unless you cancel it in writing. A photocopy or fax of this completed form is as valid as the original.

GIVE THIS FORM TO YOUR PHYSICIAN OR NURSE PRACTITIONER WITH THE MEDICAL REPORT

Consent for Service Canada to Obtain Personal Information

Service Canada is authorized under Section 68 and 69 of the *Canada Pension Plan (CPP) Regulations* to receive personal (medical and non-medical) information about you to decide if you qualify or continue to qualify for CPP disability benefits. Your consent to permit Service Canada to obtain this information is necessary, should Service Canada need this information from persons and organizations listed on the following page.

Protecting your privacy:

Service Canada cannot give your personal information to any person or organization without your written consent, except where authorized by *CPP legislation*. Under the *Privacy Act*, you (or your authorized representative) have the right to request a copy of the information in your file and to request correction(s) to that information. Your personal information is retained in Personal Information Bank (ESDC 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
- Give this form to **your physician or nurse practitioner** with the medical report.

Section 1 - Client Information		
◯ Mr. ◯ Mrs. ◯ Miss ◯ Ms.		Canadian Social Insurance Number
First Name and Initial		Last Name
Mailing address (No., Street, Apt. No., P.O. Box, R.R.		City, Town or Village
Province or Territory	Country	Postal Code
Telephone Number		Fax Number

Service Canada delivers Employment and Social 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, nurse practitioners,consultant specialists, or health-care professionals
- medical facilities or hospitals
- educational institutions or other vocational agencies
- my accountant or book-keeper for information on self-employment
- administrators of insurance plans
- 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 _____ (YYYY-MM-DD)

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 _____ (YYYY-MM-DD)

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.