

Canada/Philippines Agreement

Applying for a Philippine retirement pension

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

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

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

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

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

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

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

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

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

Return your completed application, forms and supporting documents to:

International Operations
Service Canada
P.O. Box 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.

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 année		month mois		day 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 Célibataire		☐ Married Marié (e)		☐ Widowed Veuf (veuve)	
☐ Separated since Séparé (e) depuis		☐ Divorced since Divorcé (e) depuis			
year année		month mois		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 substitution. 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?
Si "non", travaillez-vous régulièrement?

☐ or occasionally?
ou occasionnellement?

☐

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?
Êtes-vous hospitalisé ou confiné en institution?

☐ yes
oui

☐ no
non

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

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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 <i>Nom du médecin</i>	Address <i>Adresse</i>	Telephone Number <i>Numéro de téléphone</i>	Approximate <i>Approximativement</i>	
			year <i>année</i>	month <i>mois</i>

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 <i>Nom de l'établissement</i>	Address <i>Adresse</i>	Telephone Number <i>Numéro de téléphone</i>	Approximate <i>Approximativement</i>	
			year <i>année</i>	month <i>mois</i>

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. _____ First Name _____ Last Name _____ Relationship to disabled person _____
Prénom Nom de famille Lien de parenté avec la personne invalide
☐ Miss/ Mlle. _____

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

Please enclose a medical report with the application for disability 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 _____ b) Place of death _____
Date de décès _____ Lieu du décès _____
year month day City or Town Province, State or Territory Country
année mois jour Ville ou Village Province, État ou territoire 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 _____ the same or _____
Prénom et nom de famille à la naissance 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 (6^e 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		

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PART E. DECLARATION OF THE APPLICANT PARTIE E. DÉCLARATION DE LA PERSONNE QUI FAIT LA DEMANDE	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 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 influencer sur le droit à ces prestations. Signature: Signature: _____ Date: Date : _____ yearmonthday annéemoisjour	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 comprendre 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:Date: Signature: _____Date: _____	

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

Date on which application was received <i>Date de réception de la demande</i>		<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td colspan="4">year</td><td colspan="2">month</td><td colspan="2">day</td><td colspan="2"></td></tr><tr><td colspan="4">année</td><td colspan="2">mois</td><td colspan="2">jour</td><td colspan="2"></td></tr></table>												year				month		day				année				mois		jour																																																																									
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Canada / Philippines Agreement

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

Complete the attached forms:

- ***Canadian Residence*** [ISP 5013]
- ***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) retirement pension)

Original or certified documents to be submitted:

- Birth certificate for you and any children under age 21 (if applicable)
- Marriage certificate (if applicable)
- Two valid identification documents, such as passport, driver's license, resident or senior card (only required for a claim from the SSS)
- Proof of the dates of your entry(ies) into Canada and departure(s) from Canada (such as: Immigration 1000, passport, visa, ship or airline tickets etc.)
- Termination notice from your last employer or a letter of resignation (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.



CANADIAN RESIDENCE

Canadian Social Insurance Number: _____

☐ Mr. ☐ Mrs.

☐ Ms. ☐ Miss

Given Name and Initial

Family 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 (YYYY-MM-DD): _____

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 (Permanent Resident card, Record of Landing (IMM 1000), complete passport, airline tickets, etc.):

From YYYY-MM-DD	To YYYY-MM-DD	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 YYYY-MM-DD	Return YYYY-MM-DD	Destination	Reason

Canadian Social Insurance Number: _____

PROTECTED B (when completed)

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.

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 the *Old Age Security Act*, 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

Date (YYYY-MM-DD)

X _____

Telephone number

**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 - <i>Previous Year</i>						Total Contributory Earnings \$ _____	Employee's Pension Contribution \$ _____
January \$ _____	February \$ _____	March \$ _____	April \$ _____	May \$ _____	June \$ _____		
July \$ _____	August \$ _____	September \$ _____	October \$ _____	November \$ _____	December \$ _____		
2. Contributory Earnings - <i>Current Year</i>						Total Contributory Earnings \$ _____	Employee's Pension Contribution \$ _____
January \$ _____	February \$ _____	March \$ _____	April \$ _____	May \$ _____	June \$ _____		
July \$ _____	August \$ _____	September \$ _____	October \$ _____	November \$ _____	December \$ _____		
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 <i>Canada Pension Plan</i> , 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 _____ X				Phone Number _____		Date _____	

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.

THIS SPACE RESERVED FOR CLIENT SERVICE ADDRESS STAMP

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:

- 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;
- remuneration paid to the employee while he was engaged in excepted employment;
- an amount relative to the residence of a member of the clergy.

C.P.P. NO. _____