



# Application for a Canada Pension Plan Disability Benefit

(Disability benefit refers to the disability pension)

## Section A - Information about you

|   |  |  |                            |                                   |
|---|--|--|----------------------------|-----------------------------------|
| <b>(A1)</b> Social Insurance Number   |  | Preferred language<br><input type="radio"/> English <input type="radio"/> French |                            | FOR OFFICE USE ONLY<br>Date Stamp |
| Optional: <input type="radio"/> Mr. <input type="radio"/> Mrs. <input type="radio"/> Miss <input type="radio"/> Ms.   |  |  |                            |                                   |
| First name  |  | Middle name  | Last name(s)               |                                   |
| Date of birth (YYYY-MM-DD)  |  | Last name at birth (if different from above)                                     |                            |                                   |
| Home address (no, street, apt, RR), City/Town, Province/Territory, Country (if not Canada), Postal code   |  |  |                            |                                   |
| Mailing address (if different from home address)<br>(no, street, apt., PO box, RR), City/Town, Province/Territory, Country (if not Canada), Postal code               |  |  |                            |                                   |
| If you now live outside of Canada, in which Canadian province/territory did you last live?  |  | Telephone number   | Alternate telephone number |                                   |
| The best time for Service Canada to call you <input type="radio"/> Morning <input type="radio"/> Afternoon <input type="radio"/> Please don't call, send letters only |  |  |                            |                                   |
| <b>(A2)</b> Have you or your children ever applied for or received benefits under the Quebec Pension Plan? <input type="radio"/> Yes <input type="radio"/> No         |  |  |                            |                                   |

## Section B - Contributions to the Canada Pension Plan (CPP)

To help you meet the minimum amount of valid CPP contributions, Service Canada may consider certain provisions and/or agreements.

The information you provide in B1 to B3 will help us determine if any of the provisions or agreements apply to you.

### **(B1)** Dividing CPP contributions - Credit split provision

If you have been separated, divorced or in a common-law relationship that ended, the CPP contributions you and your former spouse or common-law partner made to the CPP during the time you lived together could be combined and equally divided.

We will review the information you provide below and let you know if a credit split could help you qualify for the CPP disability benefit.

|                              |                               |                                  |  |
|------------------------------|-------------------------------|----------------------------------|--|
| What is your current status: | <input type="radio"/> Single  | <input type="radio"/> Common-law | <input type="radio"/> Divorced                               |
|                              | <input type="radio"/> Married | <input type="radio"/> Separated  | <input type="radio"/> Surviving spouse or common-law partner |

If you are currently, or have ever been separated, divorced or in a common-law relationship that ended, please provide us with the dates you started and stopped living with your former spouse or former common-law partner.

|  |           |  |           |
|--|-----------|--|-----------|
| Date you started to live with your former spouse or common-law partner | (YYYY-MM) | Date of separation or end of common-law relationship | (YYYY-MM) |
|--|-----------|--|-----------|

For additional periods, please attach an extra sheet.

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**B2) Living or working in another country - International social security agreements**

If you have **lived and/or worked** in a country other than Canada, the credits you have accumulated in that country may help you qualify for the CPP disability benefit.

If Canada has an international social security agreement with the country(ies) you have indicated below, we will verify if it will help you qualify for the CPP disability benefit.

Have you ever lived or worked in another country?  Yes  No

If **Yes**, please fill out this table to help us determine if an international social security agreement could help you qualify for the CPP disability benefit.

| Name of Country | Your social identification number in that country | Dates lived in that country |              | Dates worked in that country |              | Have you asked for or received benefits from that country? |
|-----------------|---|-----------------------------|--------------|------------------------------|--------------|--|
|                 |   | From (YYYY-MM)              | To (YYYY-MM) | From (YYYY-MM)               | To (YYYY-MM) |  |
| 1.              |   |                             |              |                              |              | <input type="radio"/> Yes <input type="radio"/> No         |
| 2.              |   |                             |              |                              |              | <input type="radio"/> Yes <input type="radio"/> No         |

 For additional countries, please attach an extra sheet.

**? Note:** Your CPP contributions may also help you qualify for a benefit or pension from that country. For more information on international benefits go to [www.canada.ca/pension-international](http://www.canada.ca/pension-international).

**B3) If you worked less to care for young children - Child rearing provision**

If you worked less or stopped working because you were the primary caregiver for one or more children under the age of 7, you may have contributed little or nothing to the CPP. For this reason, we may be able to apply the child rearing provision. This could help you meet the minimum amount of valid CPP contributions needed to qualify for a disability benefit, and/or could increase the benefit amount you receive.

For the CPP, the **primary caregiver** is the person who is/was most responsible for the daily needs of the child(ren) until the age of 7. Some things a primary caregiver does are: watch over the child(ren), prepare meals, go to school meetings and events, or take the child(ren) to doctors appointments.


To qualify for the child rearing provision, you must have been the primary caregiver and:

1. received the Family Allowance (available before 1993); and/or
2. been eligible for the Canada Child Benefit, even if you did not receive it (available since 1993).

**Note:** Only one person can be the primary caregiver at any time. Therefore, this provision can only be applied to one account for the same time period and child(ren).

Please provide your child(ren)'s information below, **regardless of their current age**.

| Child's full name | Social Insurance Number | Child's date of birth (YYYY-MM-DD) | If the child was born outside Canada, tell us the date the child entered Canada (YYYY-MM-DD) |
|-------------------|-------------------------|------------------------------------|--|
| 1.                |                         |                                    |  |
| 2.                |                         |                                    |  |
| 3.                |                         |                                    |  |
| 4.                |                         |                                    |  |

 For additional children, please attach an extra sheet.

**Note:** If you do not provide the Social Insurance Number of the child(ren) and/or if the child(ren) was born outside of Canada, Service Canada will require a certified photocopy of an acceptable document confirming the child(ren)'s date of birth (e.g. birth certificate) and/or proof of the child(ren)'s date of entry into Canada (e.g. IMM 1000 or passport).

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**A) Were you the primary caregiver for these children when they were under the age of 7?**  Yes  No

**B) If there were periods of time when you were not the primary caregiver for the child(ren) listed, please provide the dates and reasons:**

|                |              |         |
|----------------|--------------|---------|
| From (YYYY-MM) | To (YYYY-MM) | Reason: |
| From (YYYY-MM) | To (YYYY-MM) | Reason: |

**? To help you determine how to complete the following questions, please see Annex A at the end of the application.**

**C) Did you or your current/former spouse or common-law partner receive the Family Allowance?**  Yes  No

If Yes, please indicate who received the benefit:  You  Your current/former spouse or common-law partner

Did you or your current/former spouse or common-law partner receive, or were either of you eligible for the Canada Child Benefit?  Yes  No

If Yes, please indicate who received or was eligible for the benefit:  You  Your current/former spouse or common-law partner

**D) If there were periods when you did not receive the Family Allowance or the Canada Child Benefit for the child(ren) listed above, please provide the dates and reasons:**

|                |              |         |
|----------------|--------------|---------|
| From (YYYY-MM) | To (YYYY-MM) | Reason: |
| From (YYYY-MM) | To (YYYY-MM) | Reason: |

**E) Please read this section if you were the primary caregiver, but did not receive the Family Allowance (available before 1993).**

The child rearing provision cannot be applied to both you and your current/former spouse or common-law partner's CPP benefit(s) for a child for the same time period.

If you were the primary caregiver, but did not receive the Family Allowance, we would not be able to apply this provision to your CPP benefit(s). However, your current/former spouse or common-law partner can choose to transfer their rights to the provision to you. They can do this by signing the waiver of rights below.

**Waiver of rights to the child rearing provision**

I declare that, for the child(ren) listed for this question and on any additional sheets, I have not and will not make any claims for the child rearing provision for the period(s) accredited to my current/former spouse or common-law partner. Once I give up my rights to the child rearing provision, the action cannot be reversed.

|                       |                         |                                 |
|-----------------------|-------------------------|---------------------------------|
| Name                  | Social Insurance Number | Telephone number during the day |
| Signature<br><b>X</b> | Date (YYYY-MM-DD)       |                                 |

 This is the end of the section of the application we are using to assess your contributions to the CPP.

**Service Canada will review the information you provide in the next section along with the medical information provided by your doctor, nurse practitioner, insurance company or provincial/territorial agency. This will help us determine how your medical condition(s) impacts your capacity to perform work-related activities.**

**Section C - Information about your medical condition(s)**

The information you provide in this section will help Service Canada understand how your medical condition(s) impact(s) your ability to perform work-related activities.

|  |                |
|--|----------------|
| <b>C1</b> When did you feel you could no longer work because of your medical condition(s)?                                   | Date (YYYY-MM) |
| This date is not always the same as the last day you went to work. It could be before or after you actually stopped working. |                |

**C2** a) State your main medical condition(s) that prevents you from working. If you do not know the medical name(s), describe in your own words.

b) List any additional medical conditions that prevent you from working.

**C3** a) I am:     right-handed     left-handed

b) List any aids you use to assist with your medical condition(s) and how often you use them. Some examples of aids include: crutches, cane, artificial limb, splints, braces, wheelchair, hearing aid, heart pacemaker, ostomy apparatus, CPAP or service animal.

**C4** Provide the details of any hospitalizations you have had in the past related to your medical condition(s).

|                            |                              |                             |                         |
|----------------------------|------------------------------|-----------------------------|-------------------------|
| Name of hospital           | City/Town                    | Province/Territory          | Country (if not Canada) |
| Date admitted (YYYY-MM-DD) | Date discharged (YYYY-MM-DD) | Name of attending physician |                         |
| Reason for admission:      |                              |                             |                         |

For additional hospitalizations, please attach an extra sheet.

**C5** List any medication(s) you are taking now.

A printout of your medication from a pharmacy can be attached instead.

| Name of medication | Dosage | How often |
|--------------------|--------|-----------|
| 1.                 |        |           |
| 2.                 |        |           |
| 3.                 |        |           |

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**C6** List past, current and future treatments for your medical condition(s).

| Type of treatment | From (YYYY-MM) | To (YYYY-MM) | Where the treatment was/will be received |
|-------------------|----------------|--------------|--|
| 1.                |                |              |  |
| 2.                |                |              |  |
| 3.                |                |              |  |

List past, current and future tests for your medical condition(s).

| Type of test | Date (YYYY-MM) | Hospital/clinic and city where test was/will be done |
|--------------|----------------|--|
| 1.           |                |  |
| 2.           |                |  |
| 3.           |                |  |

 For additional treatments or tests, please attach an extra sheet.

**C7** If you are receiving any disability benefits from an insurance company or a provincial/territorial agency, including a workers' compensation program, please provide details in the table below.

| Name of insurance company, provincial/territorial agency | Claim number | Medical condition | Start of benefit (YYYY) |
|--|--------------|-------------------|-------------------------|
| 1.   |              |                   |                         |
| 2.   |              |                   |                         |

If you are receiving a disability benefit from an insurance company or a provincial/territorial agency, you can ask them to send us your medical information. If we receive this information, you do not need to submit the **Medical Report for a Canada Pension Plan Disability Benefit (ISP2519)**.

Have you authorized the insurance company or the provincial/territorial agency to send us your medical information?

Yes  No If yes, please provide the name of the company/agency:

\_\_\_\_\_

**Repayment of benefits to a private insurance company and/or a provincial or municipal agency**

Service Canada may find that you qualified for a CPP disability benefit when you were receiving benefit payments from a private insurance company and/or a provincial or municipal agency. If we owe you a retroactive payment (up to 11 months) you may have to pay back the benefits you received from those organizations during that time.

Service Canada can reimburse a private insurance company and/or a provincial or municipal agency on your behalf. In order to do this, we need your written consent. The insurance company and/or a provincial or municipal agency will ask you to sign a consent form to allow us to pay them directly. If you choose not to do this, it is your responsibility to inform them.

**C8 Functional assessment - assessing your abilities**

In question C2, we asked you to state the medical condition(s) that prevents you from working regularly. With these next questions, we would like you to tell us **how** the medical condition(s) affects your ability to work. The answers and additional information you provide will be considered along with the medical information provided by your doctor, nurse practitioner, insurance company or provincial/territorial agency.

As you are answering the questions, think about all of your physical and mental limitations, regardless of what medical problem is causing them. Focus on what you can do, not how you feel.

Next, think about what it means to be a worker. All jobs are different, but working means you must be able to:

- get hired or create your own job;
- get ready for work;
- travel to and from work;
- deal with co-workers and clients;
- deliver a quality product or service; and
- follow a work schedule set by your employer and/or clients.

Then, compare your limitations to the demands of work, and provide your ratings on the next few pages based on your ability level most days. Assume you are using your aids such as crutches, cane, artificial limb, splints, braces, wheelchair, hearing aid, service animal or adaptive computer equipment.

If you do not have any limitations with the abilities being assessed, you can check the box at the top of each question block.

If you have any additional information about your abilities, you can provide the details in the area following each question block. The following examples could help you with the explanation/information you may want to provide in these areas.

**Examples****Physical abilities**

It is very difficult for me to remain standing for more than 10 minutes at any given time because of my back pain, even on my good days (one or two days a week). Up until a year ago, I was able to do this without a problem. I am most comfortable lying down. Hot baths help, but only briefly.

**Behaviours and emotional abilities**

In the last few months, my depression has gotten worse. I have a hard time getting myself out of bed most mornings (four to six days a week) because I feel so down. I find myself crying for no reason and I am often irritable with others. On my good days, I can spend some time with other people, but on my bad days, I cannot get myself to leave my home. I stopped volunteering for my son's hockey league because it's too hard being around others.

**Communication and thinking abilities**

In the last year, my fibromyalgia has made it very hard to sleep at night. On my good days (one or two days a week), I am able to sleep up to four hours, but on my bad days, I cannot sleep at all. Medications for pain and sleep leave me drowsy and "spacey" the next day. Because of this, I have a lot of difficulty organizing my thoughts and finding my words when I talk to others. I cannot concentrate on what I am supposed to do most of the time. I used to read novels for pleasure, but now I can't focus my attention for more than a couple of pages.

**Other daily abilities**

Starting last year, my fatigue has been overwhelming. I used to constantly be "on the go" running my home-based bookkeeping business, seeing new clients and driving my kids to sports and other activities. That ended when my condition flared and I had to let go of all my clients because I couldn't keep up. Now, I am unable to finish doing household chores without having to sit or lie down every half hour. Even washing myself has become too hard. I cannot hold my arms up long enough to finish washing my hair because I get so tired.

Social Insurance Number:

PROTECTED B (when completed)

**A) Physical abilities**

Check this box if you **do not** have **physical problems** that limit your ability to work. Otherwise, please answer the questions below by filling in the circles.

| How would you rate your ability to do the following?                  | Ability level most days |                       |                       |                       |                       |
|---|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
|   | Excellent               | Very good             | Good                  | Fair                  | Poor                  |
| 1. Remain on your feet for at least 20 minutes                        | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Walk a block (about 100 metres) on flat ground                     | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Go up and down 12-15 steps   | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. Get down into a kneeling or squatting position and back up again   | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. Bend down to pick up coins from the floor                          | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. Remove an item from your back pocket                               | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. Change a light bulb in the ceiling above your head                 | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. Sit for at least 20 minutes in a straight back chair               | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9. Transfer to and from a bed, chair, toilet, or car                  | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10. Drive a car   | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 11. Pull or push a heavy door to open it                              | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 12. Pick up two bags of groceries and walk a block (about 100 metres) | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 13. Open a can with a manual can opener                               | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 14. Pound a nail with a hammer  | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 15. Use your index finger to press the keys on a computer keyboard    | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 16. Stare at a computer screen for at least 20 minutes                | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

If you have any additional information about your **physical abilities**, please provide details below.

**Consider:**

(1) whether your abilities vary between **good days and bad days**; and,  
(2) whether your abilities have **improved or worsened over time**.

See page 6 of this application for an example of how to respond.

 If additional space is needed, please attach an extra sheet.

Social Insurance Number:

PROTECTED B (when completed)

**B) Behaviours and emotional abilities**

Check this box if you **do not** have **behavioural and emotional problems** that limit your ability to work. Otherwise, please answer the questions below by filling in the circles.

| How would you rate your ability to do the following?                                | Ability level most days |                       |                       |                       |                       |
|---|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
|   | Excellent               | Very good             | Good                  | Fair                  | Poor                  |
| 1. Work in a team   | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Change your usual work approach when asked to do so                              | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Keep at difficult tasks until you get them done                                  | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. Adjust easily to unexpected changes  | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. Figure out what to do when you are stressed                                      | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. Ask for help from co-workers when needed   | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. Deal with people you do not know   | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. Control your temper when dealing with others                                     | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9. Do what people in authority ask you to do  | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10. Control emotions and impulses that others would probably consider inappropriate | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 11. Manage your anxiety   | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 12. Handle being in public places or situations                                     | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |


If you have any additional information about your **behaviours and emotional abilities**, please provide details below.

**Consider:**

(1) whether your abilities vary between **good days and bad days**; and,

(2) whether your abilities have **improved or worsened over time**.

See page 6 of this application for an example of how to respond.

 If additional space is needed, please attach an extra sheet.



Social Insurance Number:

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**C) Communication and thinking abilities**

Check this box if you **do not** have **communication and thinking problems** that limit your ability to work. Otherwise, please answer the questions below by filling in the circles.

| How would you rate your ability to do the following?                    | Ability level most days |                       |                       |                       |                       |
|---|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
|   | Excellent               | Very good             | Good                  | Fair                  | Poor                  |
| 1. Understand what people say in everyday conversations                 | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Call to mind words that you want to use while talking to someone     | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Remember to do important things, such as keeping appointments        | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. Find your way to a familiar place, such as the bank or grocery store | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. Concentrate and focus your attention for at least 30 minutes         | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. Keep track of what you are doing, even if you are interrupted        | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. Learn new things such as organizing files according to a system      | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. Prioritize and plan your day   | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9. Decide between two options   | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10. Put together a shopping list of 10 or more items                    | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 11. Add and subtract numbers  | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 12. Read a short message  | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 13. Write an e-mail   | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

If you have any additional information about your **communication and thinking abilities**, please provide details below.

**Consider:**

- (1) whether your abilities vary between **good days and bad days**; and,
- (2) whether your abilities have **improved or worsened over time**.

See page 6 of this application for an example of how to respond.

 If additional space is needed, please attach an extra sheet.

Social Insurance Number:

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**D) Other daily abilities**

Check this box if you **do not** have problems performing your other daily activities. Otherwise, please answer the questions below by filling in the circles.

| How would you rate your ability to do the following?   | Ability level most days |           |      |      |      |
|--|-------------------------|-----------|------|------|------|
|  | Excellent               | Very good | Good | Fair | Poor |
| 1. Take care of your personal hygiene, such as bathing, brushing your teeth, combing your hair, or shaving                           | ○                       | ○         | ○    | ○    | ○    |
| 2. Take medication(s) as directed and handle medication(s) safely  | ○                       | ○         | ○    | ○    | ○    |
| 3. Dress yourself (including buttoning clothes and putting on shoes)   | ○                       | ○         | ○    | ○    | ○    |
| 4. Feed yourself   | ○                       | ○         | ○    | ○    | ○    |
| 5. Get to the bathroom in time   | ○                       | ○         | ○    | ○    | ○    |
| 6. Do housekeeping and home maintenance without frequent breaks, such as cleaning, laundry, meal preparation, shopping, or yard work | ○                       | ○         | ○    | ○    | ○    |
| 7. Answer the telephone  | ○                       | ○         | ○    | ○    | ○    |
| 8. Open and sort mail arriving at your home  | ○                       | ○         | ○    | ○    | ○    |
| 9. Manage your budget and pay bills  | ○                       | ○         | ○    | ○    | ○    |
| 10. Use public transportation  | ○                       | ○         | ○    | ○    | ○    |

If you have any additional information about your other daily abilities, please provide details below.

**Consider:**

(1) whether your abilities vary between good days and bad days; and,  
(2) whether your abilities have improved or worsened over time.

See page 6 of this application for an example of how to respond.

 If additional space is needed, please attach an extra sheet.

Social Insurance Number:

PROTECTED B (when completed)

### Section D - Information about your doctor or nurse practitioner

Service Canada may need more information to better understand your medical condition(s). The information you provide in this section will identify the health care providers who will be reporting on your medical condition(s).

|   |                         |   |  |
|---|-------------------------|---|--|
| <b>(D1)</b> Provide the following information about the doctor or nurse practitioner who will be reporting on your medical condition(s).                                      |                         |   |  |
| Doctor's or nurse practitioner's full name  |                         | <input type="radio"/> Family doctor   | <input type="radio"/> Nurse practitioner |
|   |                         | <input type="radio"/> Specialist (please specify) _____                               |  |
| Mailing address (no, street, apt., PO box, RR)  |                         | City/Town   |  |
| Province/Territory  | Country (if not Canada) | Postal code   | Telephone number                         |
| When did you first see this doctor or nurse practitioner about your medical condition?  | (YYYY-MM)               | When did you last see this doctor or nurse practitioner about your medical condition? | (YYYY-MM)                                |
| <b>(D2)</b> List all other doctors, nurse practitioners, specialists or other health care providers you have seen in the last two years related to your medical condition(s). |                         |   |  |
| a) Health care provider's full name   |                         | Specialty   |  |
| Mailing address (no, street, apt., PO box, RR)  |                         | City/Town   |  |
| Province/Territory  | Country (if not Canada) | Postal code   | Telephone number                         |
| When did you first see this health care provider?   | (YYYY-MM)               | When did you last see this health care provider?                                      | (YYYY-MM)                                |
| What were the reasons for your visit(s)?  |                         |   |  |
| b) Health care provider's full name   |                         | Specialty   |  |
| Mailing address (no, street, apt., PO box, RR)  |                         | City/Town   |  |
| Province/Territory  | Country (if not Canada) | Postal code   | Telephone number                         |
| When did you first see this health care provider?   | (YYYY-MM)               | When did you last see this health care provider?                                      | (YYYY-MM)                                |
| What were the reasons for your visit(s)?  |                         |   |  |

 For additional health care providers, please attach an extra sheet.

Social Insurance Number: \_\_\_\_\_

PROTECTED B (when completed)

### Section E - Information about your work

The information you provide in this section will help Service Canada understand how your medical condition(s) and treatments affect your ability to work regularly at any job. Be sure to include work done in Canada and in other countries.

**(E1)** Have you stopped working completely?     Yes     No

If Yes, select the reason why you stopped working.

Shortage of work/contract ended     Maternity/paternity     Dismissed/quit     Medical condition(s)/illness(es)

Other (provide details): \_\_\_\_\_

When completing questions E2-E4, if you had/have two or more jobs, please include information about the main job where you spent/spend the most time.

|   |  |  |                         |
|---|--|--|-------------------------|
| <b>(E2)</b> Title or position of current or last job  | First day on the job<br>(YYYY-MM-DD)   | Last day you went to work<br>(YYYY-MM-DD)              |                         |
| Name of your current or last employer   | Mailing address of your current or last employer<br>(no, street, apt., PO box, RR)   |  |                         |
| City/Town   | Province/Territory   | Country (if not Canada)                                |                         |
| Postal code   | Telephone number   |  |                         |
| <b>(E3)</b> Type of work in current or last job:  | <input type="radio"/> Full-time <input type="radio"/> Seasonal<br><input type="radio"/> Part-time <input type="radio"/> Volunteer<br><input type="radio"/> Self-employed               | Number of hours per day<br><br>Number of days per week |                         |
| <b>(E4)</b> Describe your duties in your current or last job  |  |  |                         |
| <b>(E5)</b> In the past 6 years, have you had any jobs other than the one listed in question E2? <input type="radio"/> Yes <input type="radio"/> No |  |  |                         |
| If Yes, please provide the following information.   |  |  |                         |
| <b>1</b>  | Job title/position   | From (YYYY-MM-DD)                                      | To (YYYY-MM-DD)         |
|   | Type of work: <input type="radio"/> Full-time <input type="radio"/> Seasonal<br><input type="radio"/> Part-time <input type="radio"/> Volunteer<br><input type="radio"/> Self-employed | Number of hours per day                                | Number of days per week |
|   | Name and address of employer   |  |                         |
| <b>2</b>  | Job title/position   | From (YYYY-MM-DD)                                      | To (YYYY-MM-DD)         |
|   | Type of work: <input type="radio"/> Full-time <input type="radio"/> Seasonal<br><input type="radio"/> Part-time <input type="radio"/> Volunteer<br><input type="radio"/> Self-employed | Number of hours per day                                | Number of days per week |
|   | Name and address of employer   |  |                         |

For additional work history, please attach an extra sheet.

Social Insurance Number:

PROTECTED B (when completed)

**E6** If you are or were self-employed, what is/was your involvement with the business?

Self-employment opportunities include: sole-proprietors, partnerships, and contractors. Self-employment activities could include: professional activities, fishing, farming, commission sales, managing, desk-work and/or supervising involved in operating a business (profession, trade or manufacture).

Will you declare yourself a self-employed person for income tax purposes this year?  Yes  No

Are you still working for your self-employed business?  Yes  No

**E7** Because of your medical condition(s), do/did you have to do a lighter job or different type of work?

Yes  No

If Yes, please describe.

**E8** Have you received regular Employment Insurance benefits in the last two years?

Yes  No If Yes, provide the periods.

From (YYYY-MM-DD)

To (YYYY-MM-DD)

From (YYYY-MM-DD)

To (YYYY-MM-DD)

*For additional times you received regular Employment Insurance, please attach an extra sheet.*

**E9** Education - Indicate highest level completed

**Primary school**

**Secondary school**

**College**

**University**

Complete

Less than 2 years

1 year

1 year

2 years or more

2 years

2 years

Diploma

Diploma

3 years

Degree

Post-graduate

If you are currently attending, have attended or completed college or university, answer the following:

Field of study

Date last attended/completed (YYYY-MM)

**E10** Have you had any technical, trade, or on the job training?  Yes  No

If Yes, provide the following details:

Title of training or program

Date completed (YYYY-MM)

Certificate received

\_\_\_\_\_

\_\_\_\_\_

Yes  No

\_\_\_\_\_

\_\_\_\_\_

Yes  No

Social Insurance Number:

PROTECTED B (when completed)

### Section F - Benefits for children

If you qualify for a CPP disability benefit, the information you provide in this section will help us determine if any child(ren) may qualify for the disabled contributor's child's benefit. To qualify, the child(ren) must be under the age of 18, or 18 to 25 years old and attending school full-time.

**F1** Do you have children?  Yes  No If No, please skip to **Section G**.

#### Who receives the payment?

- If you have custody and control of a child under the age of 18, we will send you the monthly payment.
- If you do not have custody and control of a child under the age of 18, we will send the monthly payment to the person or agency (custodian) that has custody and control of the child (consent to contact the person or agency is required - see question F3).
- If the child is 18 to 25 years old and attending school full-time, we will send the monthly payment to the child directly (consent to contact the child is required - see question F3).

For the purposes of the CPP, custody and control includes sole, shared, joint, etc., and formal and informal custody and control arrangements. More specifically, if you are sharing custody of a child, no matter how minimal, you are considered to have custody and control.

**Note:** If you do not provide the Social Insurance Number of the child(ren), Service Canada will require a certified photocopy of an acceptable document confirming the child(ren)'s date of birth (e.g. birth certificate).

**F2** Please include information about your child(ren) in the space below.

|  |   |   |
|--|---|---|
| <b>a) First child's full name</b>  | Date of birth (YYYY-MM-DD)                            | Social Insurance Number                                     |
| <input type="radio"/> Biological child <input type="radio"/> Legally adopted <input type="radio"/> Other (please specify): _____   |   |   |
| <b>Is this child 18 to 25 years old and attending full-time school, college or university now or within the past 11 months?</b><br><input type="radio"/> Yes <input type="radio"/> No    If Yes, please provide the child's address below. |   |   |
| If the child is under the age of 18, do you have custody and control?  | <input type="radio"/> Yes<br><input type="radio"/> No | If No, provide the custodian's full name and address below. |
| Custodian's full name  |   |   |
| Address (no, street, apt., RR), City/Town, Province/Territory, Country (if not Canada), Postal code  |   |   |
| <b>b) Second child's full name</b>   | Date of birth (YYYY-MM-DD)                            | Social Insurance Number                                     |
| <input type="radio"/> Biological child <input type="radio"/> Legally adopted <input type="radio"/> Other (please specify): _____   |   |   |
| <b>Is this child 18 to 25 years old and attending full-time school, college or university now or within the past 11 months?</b><br><input type="radio"/> Yes <input type="radio"/> No    If Yes, please provide the child's address below. |   |   |
| If the child is under the age of 18, do you have custody and control?  | <input type="radio"/> Yes<br><input type="radio"/> No | If No, provide the custodian's full name and address below. |
| Custodian's full name  |   |   |
| Address (no, street, apt., RR), City/Town, Province/Territory, Country (if not Canada), Postal code  |   |   |



Social Insurance Number: \_\_\_\_\_

PROTECTED B (when completed)

**Section G - Payment information**

**G1 Direct deposit**

If your application is approved, your monthly payments will be deposited into your account at your financial institution. The account must be in your name. A joint account is also acceptable.

To enroll for direct deposit banking, you must provide your banking information below.

Branch number (5 digits)

\_\_\_\_\_

Institution number (3 digits)

\_\_\_\_\_

Account number (maximum of 12 digits)

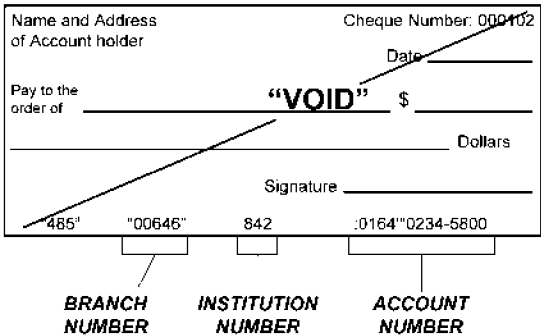
\_\_\_\_\_

Name(s) on the account

\_\_\_\_\_

Telephone number of your financial institution

\_\_\_\_\_



**Sharing your direct deposit information with the Canada Revenue Agency (CRA)**

Your direct deposit information can also be used by the CRA to deposit any income tax refunds, working income tax benefit advance payments, the Canada Child Benefit, the Universal Child Care Benefit, and GST/HST credit payments you may receive. If you agree, Employment and Social Development Canada (ESDC) can share your direct deposit information with the CRA.

For ESDC and the CRA to share your personal and direct deposit information, your permission (consent) is required.

By filling in the circle for "I agree", you agree with these two statements:

- I consent to ESDC sharing with the CRA my direct deposit information entered on this form for any payments I may receive from the CRA.
- I consent to ESDC sharing with the CRA my Social Insurance Number, last name, and date of birth so that the CRA can identify me correctly.

If you fill in the circle for "I do not agree", your information will not be shared. You may still update your banking information with the CRA by contacting them directly.

I agree     I do not agree

**Direct deposit outside Canada**

For direct deposit outside Canada, please contact us at 1-800-277-9914 from the United States, and at 613-957-1954 from all other countries (collect calls are accepted). The form and a list of countries where direct deposit service is available can be found at [www.directdeposit.gc.ca](http://www.directdeposit.gc.ca).



Social Insurance Number:

PROTECTED B (when completed)

### Section H - Consent for Service Canada to obtain personal information

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

**I give Service Canada my consent to obtain personal information about me that would help determine if I qualify or continue to qualify for CPP 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 other health care professionals
- educational institutions or other vocational agencies
- my accountant or bookkeeper for information on self-employment
- federal, provincial, territorial, or municipal government departments and agencies
- provincial or territorial workers' compensation boards
- financial institutions (for address updates only)
- medical facilities or hospitals
- administrators of insurance plans
- employers, former employers
- voluntary organizations
- employees (for the cases of self-employed persons)

**Note: Failure to check an option below could result in a delay in processing your application.**

**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 determine if I qualify or continue to qualify for CPP 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 if I do not give my consent, Service Canada:

- will make a decision based on the available information on my file;
- may stop paying me the benefits if I am already receiving them; and
- can require that I provide the necessary information.

|   |  |                   |
|---|--|-------------------|
| Applicant's address (no, street, apt., RR), City/Town, Province/Territory, Country (if not Canada), Postal code |  |                   |
| Applicant's name (print)  | Signature of applicant/authorized representative<br><b>X</b> | Date (YYYY-MM-DD) |

An **authorized representative** can act on your behalf. See information on **authorized representative** on page 19 of this application.

#### To be completed by a witness only if signed with a mark (e.g. X).

I have read the contents of this section to the applicant, who appeared to fully understand them and who made their mark in my presence.

|                                  |             |              |                   |
|----------------------------------|-------------|--------------|-------------------|
| First name of witness (print)    | Middle name | Last name(s) | Telephone number  |
| Signature of witness<br><b>X</b> |             |              | Date (YYYY-MM-DD) |

This signed consent is valid for up to 3 years unless you cancel it in writing. Service Canada requires your original signature, but we will use a photocopy and consider it as valid as the original when requesting personal information from the persons and organizations listed above.

Social Insurance Number:

PROTECTED B (when completed)

## Section I – Declaration and signature

### Privacy Notice Statement

Read the following information before you sign your application:

Your personal information is collected under the authority of the *Canada Pension Plan (CPP)* and will be used to determine your, and if applicable, your child(ren)'s benefit eligibility and entitlement. The Social Insurance Number (SIN) is collected under the authority of section 52 of the *CPP Regulations*, and in accordance with the Treasury Board Secretariat Directive on the SIN, which lists the CPP as an authorized user of the SIN. The SIN will be used as a file identifier and to ensure your exact identification so that contributory earnings can be correctly applied to your record to allow 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. Your personal information 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 CPP, other acts of Parliament and federal or provincial law. The information may be shared with the government of other countries in accordance with agreements for the reciprocal administration or operation of the foreign pension program and of the *CPP* and *Old Age Security Act*. The information you provide may also be used/disclosed for policy analysis, research and/or evaluation purposes but will not result in an administrative decision being made about you (such as a decision on your entitlement to a benefit).

Your personal information is administered in accordance with the *CPP*, the *Privacy Act*, the *Department of Employment Social Development Act* and other applicable laws. You have the right to the protection of, access to, and correction of your personal information, which is described in Personal Information Bank Canada Pension Plan Program (ESDC PPU 140 and 146). You can ask to see your file by contacting a Service Canada office. Instructions for requesting personal information are provided in the government publication entitled *Info Source*, which is available at the following web site address: [www.canada.ca/infosource-ESDC](http://www.canada.ca/infosource-ESDC). *Info Source* may also be accessed online at any Service Canada Centre.

You have the right to file a complaint with the Privacy Commissioner of Canada regarding the institution's handling of your personal information at: [www.priv.gc.ca/en/report-a-concern](http://www.priv.gc.ca/en/report-a-concern).

### Signature of applicant

I hereby apply for a disability benefit and, if applicable, a child's benefit under the Canada Pension Plan and declare that to the best of my knowledge and belief, all of the information herein is true and complete.

I agree to notify Service Canada of any changes that may affect my eligibility for benefits. These include: an improvement in my medical condition(s); a return to work (full-time, part-time, trial period or volunteer work); attendance at school or university; trade or technical training; any rehabilitation, or a change in custody of any child under the age of 18.

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.

|                                    |                          |
|------------------------------------|--------------------------|
| <b>Signature of applicant</b><br>X | <b>Date (YYYY-MM-DD)</b> |
|------------------------------------|--------------------------|

To be completed by a witness if the applicant signs with a mark (e.g. X).

I have read the contents of this application to the applicant, who appeared to fully understand them and who made their mark in my presence.

|   |             |              |                          |
|---|-------------|--------------|--------------------------|
| First name of witness (print)   | Middle name | Last name(s) | Telephone number         |
| Address (no, street, apt., RR), City/Town, Province/Territory, Country (if not Canada), Postal code |             |              |                          |
| <b>Signature of witness</b><br>X  |             |              | <b>Date (YYYY-MM-DD)</b> |

Social Insurance Number:

PROTECTED B (when completed)

To be completed ONLY by an authorized representative of the applicant

See information on authorized representative below.

I hereby apply for a disability benefit and, if applicable, a child's benefit under the Canada Pension Plan on behalf of the applicant and I declare that to the best of my knowledge and belief, all of the information herein is true and complete.

I agree to notify Service Canada of any changes that may affect the applicant's eligibility for benefits. These include: an improvement in the medical condition(s); a return to work (full-time, part-time, trial period or volunteer work); attendance at school or university; trade or technical training; any rehabilitation, or a change in custody of any child under the age of 18.

I also agree to notify Service Canada if and when I cease acting as the representative of the applicant and/or of any changes in the applicant's condition whereby the applicant is able to act on their own behalf.

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.

|   |  |                   |                  |
|---|--|-------------------|------------------|
| First name of representative (print)  | Middle name                            | Last name(s)      | Telephone number |
| Address (no, street, apt., RR), City/Town, Province/Territory, Country (if not Canada), Postal code |  |                   |                  |
| Relationship to the applicant   | Signature of authorized representative | Date (YYYY-MM-DD) |                  |
|   | X                                      |                   |                  |

Authorized representative

An authorized representative can act on your behalf. This person will have all of the rights and responsibilities that you would have as an applicant/beneficiary, such as signing the application and keeping Service Canada informed of any changes to your account. These could include changes to your telephone number, your medical condition(s) or a return to work.

An authorized representative could be any of the following:

- guardian
- lawyer
- curator
- trustee
- committee
- Power of Attorney (for CPP purposes, only POA for property is accepted)
- executor
- any other legal representative of that person

The authorized representative must be appointed under a law of Canada, a province or territory, or by the Minister, to manage your affairs. Legal documents must be submitted to support an authorized representative and could include:

- mandate
- trusteeship
- Power of Attorney documents (for CPP purposes, only POA for property is accepted)
- letterhead from a lawyer clearly stating they represent you
- an official CPP/Old Age Security program form. Contact us for more information.

An authorized representative cannot receive the paid benefits on your behalf unless it has been proven that you are not capable of managing your affairs.

This application contains information about the Canada Pension Plan disability benefit which is based on the Canada Pension Plan legislation. If there are any differences between what is in this application and the Canada Pension Plan legislation, the legislation is always right.

## Annex A - Child rearing provision guide

For the Canada Pension Plan (CPP), the primary caregiver is the person who is/was most responsible for the daily needs of the child(ren) until the age of 7. Some things a primary caregiver does are: watch over the child(ren), prepare meals, go to school meetings and events, or take the child(ren) to doctors appointments.

### Family Allowance (FA) - available before 1993

The FA program (once known as the **baby bonus**) sent monthly payments to parents or guardians of dependent children under the age of 18. For most families, payments were issued to the mother. The Canada Child Benefit replaced the FA program in 1993.

### Canada Child Benefit (CCB) - available since 1993. Previously known as Child Tax Benefit and Canada Child Tax Benefit

The CCB is a monthly benefit based on your net family income level, the number of children you have, and the ages of your children. In most families, payments are/were issued to the mother.

If you were the primary caregiver of one or more children and did not receive the CCB only because your family income was too high, you are considered to have been eligible for the CCB.

| Were you the primary caregiver? | Did you receive the Family Allowance (before 1993)?     | Did you receive or were you eligible for the Canada Child Benefit (since 1993)? | What do I complete in question B3?   |
|---------------------------------|---|---|--|
| Yes                             | Yes   | Yes   | <ul style="list-style-type: none"> <li>- Answer questions A), B), C) and D).</li> <li>- Skip the waiver of rights (E).</li> </ul>  |
| Yes                             | Yes   | No  | <ul style="list-style-type: none"> <li>- Answer questions A), B), C) and D).</li> <li>- Skip the waiver of rights (E).</li> </ul>  |
| Yes                             | No  | Yes   | <ul style="list-style-type: none"> <li>- Answer questions A), B), C) and D).</li> <li>- Skip the waiver of rights (E).</li> </ul>  |
| Yes                             | No, my current/ former spouse or common-law partner did | No  | <ul style="list-style-type: none"> <li>- Answer questions A), B), C) and D).</li> <li>- Request that your current/former spouse or common-law partner complete the waiver of rights (E).</li> </ul>  |
| Yes                             | No  | No, my current/former spouse or common-law partner received the payments        | <ul style="list-style-type: none"> <li>- Answer questions A), B), C) and D).</li> <li>- Skip the waiver of rights (E).</li> <li>- Provide a letter from the Canada Revenue Agency (CRA) indicating you would have been eligible for the CCB had you applied when you were the primary caregiver. Please contact the CRA for more information about obtaining this letter.</li> </ul>   |
| Yes                             | No, my current/ former spouse or common-law partner did | No, my current/former spouse or common-law partner received the payments        | <ul style="list-style-type: none"> <li>- Answer questions A), B), C) and D).</li> <li>- Request that your current/former spouse or common-law partner complete the waiver of rights (E).</li> <li>- Provide a letter from the Canada Revenue Agency (CRA) indicating you would have been eligible for the CCB had you applied when you were the primary caregiver. Please contact the CRA for more information about obtaining this letter.</li> </ul> |

If you are not sure of which situation applies to you, complete all questions in **B3** and Service Canada will review.

## Annex B - Certified photocopies of original documents

Please send certified true photocopies rather than original documents whenever submitting documents to Service Canada. If you must send your original documents, we suggest you 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 readable and if you have someone certify that it is a true copy of the original.

### How to get a certified true photocopy of an original document

Documents can be certified by Service Canada staff free of charge at any Service Canada Centre. If you cannot visit a Service Canada Centre, you can ask a member of one of the following professions 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 a financial institution
- medical and health practitioner: chiropractor, dentist, doctor, naturopathic doctor, nurse practitioner, ophthalmologist, optometrist, pharmacist, psychologist, registered nurse
- member of parliament or their staff
- member of a provincial legislature or their staff
- minister of religion
- municipal clerk
- official of a federal or provincial government department, or one of its agencies
- official of an embassy, consulate or high commission
- official of a country with which Canada has a reciprocal social security agreement
- police officer
- professional engineer
- social worker
- teacher
- university professor

**Note:** You cannot certify photocopies of your own documents and you cannot ask a relative to do it for you.

The person certifying the document(s) must:

- compare the original document to the photocopy;
- state their official position or title and sign and print their name;
- provide their telephone number;
- write the date they certified the document; and
- 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.**

**Note:** If your photocopy is missing any of the above elements, it will not be accepted and you will have to submit a new, properly certified photocopy. This could result in delays in processing your application.

If the document has information on more than one page, photocopy all pages. The person you ask to certify your photocopies can either certify each page, or only the first page as long as they indicate and attest to the total number of pages in the document, including any pages that are blank.

Please write your Social Insurance Number on any document or photocopy that you send to Service Canada.