



## QUESTIONNAIRE FOR DISABILITY BENEFITS CANADA PENSION PLAN

<b>1. FIRST NAME AND INITIAL</b>	<b>LAST NAME</b>	<b>SOCIAL INSURANCE NUMBER</b>	
<b>EDUCATION</b>			
<b>2. What was the highest grade you completed in school?</b>  _____	<b>Have you attended college or university?</b> <input type="radio"/> Yes <b>If yes</b> , indicate number of years and/or diploma/degree obtained. <input type="radio"/> No  _____		
<b>3. Have you ever been involved in any technical, trade, or on the job training?</b> <input type="radio"/> Yes <b>If yes</b> , provide the following details: <div style="display: flex; justify-content: space-between; margin-top: 10px;"><div style="width: 30%;">Dates  _____</div><div style="width: 35%;">Type of program  _____</div><div style="width: 35%;">Certificate obtained  _____</div></div> <input type="radio"/> No			
<b>WORK HISTORY (BE SURE TO INCLUDE WORK DONE IN CANADA AND/OR OTHER COUNTRIES)</b>			
<b>EMPLOYEE</b>			
<b>4. Have you stopped working completely?</b> <input type="radio"/> Yes, go to question 5. <input type="radio"/> No, provide the following information:		<b>Type of Work</b> <div style="display: flex; justify-content: space-around; margin-top: 5px;"><input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Volunteer <input type="checkbox"/> Seasonal</div>	
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
<b>5. If you have stopped working completely, provide the following information:</b>		<b>What kind of work did you do in your most recent job?</b>	
Why did you stop working?		Date employment started YYYY-MM-DD	<b>Last day on the job</b> YYYY-MM-DD
<b>6. Name and full address of your present or most recent employer.</b>   			
<b>SELF-EMPLOYED</b>			
<b>7. If you are or were self-employed, provide the following information:</b>			
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?  			

**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
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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

YYYY-MM-DD

To

YYYY-MM-DD

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:☐ Noa) 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

Social Insurance Number

PROTECTED B (when completed)

## OTHER BENEFITS

13. a) If you are receiving any benefit from an insurance company, state the name of the insurance company.

Have you authorized the insurer to send us your medical report?

☐ Yes ☐ No

b) If you are receiving any benefit from the province, have you authorized the province to send us information about your benefit?

☐ Yes ☐ No

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

Social Insurance Number

PROTECTED B (when completed)

## 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, Apt., 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, Apt., 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**

The information you provide is collected under the authority of the *Canada Pension Plan* to determine your eligibility for a Canada Pension Plan (CPP) Disability benefit.

The Social Insurance Number (SIN) is collected under the authority of the *Canada Pension Plan* and in accordance with the Treasury Board Secretariat *Directive on the Social Insurance Number* which lists the Canada Pension Plan Regulations 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.

While submitting this application is voluntary, all of the information requested is required in order to determine your eligibility for CPP Disability. If you do not provide your personal information, the Department of Employment and Social Development Canada (ESDC) may not be able to process your application or may make a decision based on the information available.

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

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

Your personal information is administered in accordance with the *Department of Employment and Social Development Act*, the *Canada Pension Plan* and the *Privacy Act*. You have the right to the protection of, and access to, your personal information. It will be retained in Personal Information Bank ESDC PPU 140, 146 and 380. Instructions for obtaining this information are outlined in the government publication entitled *Info Source*, which is available at the following web site address: **www.infosource.gc.ca**. *Info Source* may also be accessed online at any Service Canada Centre.

**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

Date (YYYY-MM-DD)

Telephone Number

Use this space if required. Identify the number of the question the information belongs to.



Service  
Canada

## Service Canada Offices Disability

### Mail your forms to:

The nearest Service Canada office listed below.

From outside of Canada: The Service Canada office in the **province where you last resided**.

### Need help completing the forms?

Canada or the United States: **1-800-277-9914**

All other countries: **613-990-2244** (we accept collect calls)

TTY: **1-800-255-4786**

**Important:** Please have your social insurance number ready when you call.

### NEWFOUNDLAND AND LABRADOR

Service Canada  
PO Box 9430 Station A  
St. John's NL A1A 2Y5  
CANADA

### NOVA SCOTIA AND PRINCE EDWARD ISLAND

Service Canada  
PO Box 1687 Station Central  
Halifax NS B3J 3J4  
CANADA

### NEW BRUNSWICK AND QUEBEC

Service Canada  
PO Box 250 Station A  
Fredericton NB E3B 4Z6  
CANADA

### ONTARIO

Service Canada  
PO Box 2020 Station Main  
Chatham ON N7M 6B2  
CANADA

### MANITOBA AND SASKATCHEWAN

Service Canada  
PO Box 818 Station Main  
Winnipeg MB R3C 2N4  
CANADA

### ALBERTA / NORTHWEST TERRITORIES AND NUNAVUT

Service Canada  
PO Box 2710 Station Main  
Edmonton AB T5J 2G4  
CANADA

### BRITISH COLUMBIA AND YUKON

Service Canada  
PO Box 1177 Station CSC  
Victoria BC V8W 2V2  
CANADA

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