Service Canada

PROTECTED B (when completed)

Application for Canada Pension Plan Disability benefits under the Agreement on Social Security between Canada and Finland

CAN-FIN 2 (DI)

Preferred language for correspondence
◯ English ◯ French

Please:
- Read the enclosed guide
- Complete the unshaded areas only

SECTION 1 - INFORMATION ABOUT THE CONTRIBUTOR

For use by the Social Security Institution of Finland only

Date of receipt:

Verified by:

1. Finnish Population Register Number | Canadian Social Insurance Number

2. ◯ Male ◯ Female

Given Name and Initial | Family Name | Family Name at Birth

3. Name on Canadian Social Insurance Card
☐ same as question 2 or

4. Date of Birth (YYYY-MM-DD)
(Please provide birth certificate)

5. Marital Status
◯ Single ◯ Married ◯ Common-Law ◯ Separated ◯ Divorced ◯ Surviving spouse or common-law partner

6. Home Address (No., St., Apt.,RR.) | City, Town or Village

Province or Territory | Country | Postal Code

7. Mailing Address (No., St., Apt.,RR.) if different from Home Address | City, Town or Village

Province or Territory | Country | Postal Code

8. In which Canadian province did you last reside?

9. Indicate periods of residence and/or periods of employment in a country other than Canada and Finland.

Name of Country	Social Security Number in that Country	Residence From		Residence To		Employment From		Employment To		Has a benefit been requested?	
		Year	Month	Year	Month	Year	Month	Year	Month	Yes	No
										☐	☐
										☐	☐
										☐	☐

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10. Since January 1, 1966, have you or your spouse or common-law partner been eligible for Canadian Family Allowances or the Child Tax Benefit for a child born after December 31, 1958?

Contributor ☐ Yes ☐ No Spouse or Common-law partner ☐ Yes ☐ No

SECTION 2 - INFORMATION ABOUT THE CONTRIBUTOR'S CHILDREN

11. Do you have children under the age of 18 in your custody and control?

☐ Yes ☐ No If "**Yes**", please complete question 11 and attach a birth certificate for each child.

Do you have children between the ages of 18 and 25 in full time attendance at school or university?

☐ Yes ☐ No If "**Yes**", each child should complete a separate application.

11A. Child's Given Name _____ Family Name _____

Date of Birth (YYYY-MM-DD) _____

◯ Male ◯ Female

☐ Natural child ☐ Legally adopted child ☐ Other

If you answered "**Other**", please explain the circumstances.

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Verified by:

11B. Child's Given Name _____ Family Name _____

Date of Birth (YYYY-MM-DD) _____

◯ Male ◯ Female

☐ Natural child ☐ Legally adopted child ☐ Other

If you answered "**Other**", please explain the circumstances.

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Verified by:

If there is not sufficient space to list all your children in question(s) 11 and / or 12, please use a separate sheet of paper and attach it to this application.

12. If you have a natural or legally adopted child under the age of 18, in the custody and control of someone else, please provide the following information:

Child's Full Name	Custodian's Full Name	Custodian's Address
Child's Full Name	Custodian's Full Name	Custodian's Address

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13. On behalf of any of your children listed in question 11, has an application been made for, or have benefits been received from:

	Applied	Received
Canada Pension Plan	☐ Yes ☐ No	☐ Yes ☐ No
Quebec Pension Plan	☐ Yes ☐ No	☐ Yes ☐ No

If you answered "**Yes**" to either of the above, indicate under which Social Insurance Number.

Canadian Social Insurance Number _____

Canadian Social Insurance Number _____

SECTION 3 - TO BE SIGNED BY THE APPLICANT AND, IF APPLICANT SIGNS WITH MARK, BY A WITNESS.

Note: If you are applying on behalf of the applicant, indicate on a separate sheet of paper your full name and address, and the reason you are making this application.

14. Declaration and signature

I declare that, to the best of my knowledge, the information given in this application is true and complete. I authorize the social security institution of the country which is a Party to this Agreement to furnish to Service Canada all the information and evidence in its possession which relate or could relate to this application for benefits.

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

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

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

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

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

NOTE: If you make a false or misleading statement, you may be subject to an administrative monetary penalty and interest, if any, under the *Canada Pension Plan*, or may be charged with an offence. Any benefits you received or obtained to which there was no entitlement would have to be repaid.

Signature of Applicant _____

Date of Application (YYYY-MM-DD) _____

Telephone number (including area, city or regional code) _____

NOTE: Signature by mark is acceptable if witnessed by any responsible person who must complete the following declaration.

Canadian Social Insurance Number	**PROTECTED B** (when completed)

15. Declaration of witness

I read the contents of this application to the applicant who appeared to fully understand and who made his or her mark in my presence.

Signature of Witness

Name of Witness (Please print)

Address of Witness

TO BE COMPLETED BY THE LIAISON AGENCY IN CANADA

Date of Receipt Year Month Day	Eligibility Date Year Month Day	Date of Payment Year Month Day	Age A B T

Certified by:	Date	Verified by:	Date

Service Canada

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Personal Information Bank
HRSDC PPU 146

QUESTIONNAIRE FOR DISABILITY BENEFITS CANADA PENSION PLAN

1. FIRST NAME AND INITIAL	LAST NAME	CANADIAN SOCIAL INSURANCE NUMBER

EDUCATION

2. What was the highest grade you completed in school?

Have you attended college or university?

○ Yes **If yes**, indicate number of years and/or diploma/degree obtained.

○ No

3. Have you ever been involved in any technical, trade, or on the job training? ○ Yes ○ No **If yes**, provide the following details:

Dates	Type of program	Certificate obtained

WORK HISTORY (BE SURE TO INCLUDE WORK DONE IN CANADA AND/OR OTHER COUNTRIES)

EMPLOYEE

4. Have you stopped working completely?

○ Yes, go to question 5.

○ No, provide the following information:

Type of Work

☐ Full-time ☐ Part-time ☐ Volunteer ☐ Seasonal

Number of hours per day	Number of days per week	If seasonal, explain period(s) of work	Salary per hour	/or per day	/or per year

5. If you have stopped working completely, provide the following information:

What kind of work did you do in your most recent job?

Why did you stop working?	Date employment started Year Month Day	**Last day on the job** Year Month Day

6. Name and full address of your present or most recent employer.

SELF - EMPLOYED

7. If you are or were self-employed, provide the following information:

a) Date business started Year Month Day

b) When did you actually stop working in the business? Year Month Day

c) Why did you stop working in the business?

d) Describe the business operation

e) What was your involvement with the business?

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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: Date of disposition: Year Month Day

◯ sold ◯ rented ◯ profit sharing

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 Year Month Day	**Last day on the job** Year Month Day

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 Year Month Day	To Year Month Day

10. Because of your medical condition, did you have to do a lighter job or a different type of work?

◯ Yes If yes, please describe.

◯ No

11. Has your physician told you when you can return to work?

◯ Yes **If yes**, give the date: Year Month

◯ No

12. Do you plan to return to work or seek work in the near future?

◯ Yes **If yes**, answer **one** of the following questions:

◯ No

a) The date you plan to **return** to your former employer/employment Year Month	b) The date you **will start** a new job. Year Month	c) The date you plan to start looking for work. Year Month

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OTHER BENEFITS

13. If you are receiving any form of accident or illness/disability benefits, state the name of the insurance company

14. If any of your health problems are covered by Provincial workers' compensation benefits, provide details in each case.

Claim Number	Province or Territory	Year	Injury

State type of benefit you now receive.		Percentage of pension awarded
15. Have you received regular Employment Insurance benefits in the last two years?	From Year Month Day	To Year Month Day
◯ **If yes**, give the dates:	From Year Month Day	To Year Month Day
◯ No		

MEDICAL INFORMATION

16. **When could you no longer work because of your medical condition?**	Year Month Day

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

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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? Year Month

When was your last visit? Year Month

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? Year Month

When was your last visit? Year Month

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? Year Month

When was your last visit? Year Month

Were your visits related to your present medical condition? ◯ Yes **If yes**, explain the reasons for your visits. ◯ No

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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 (Year Month Day) | Date discharged (Year Month Day) | 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 (Year Month Day) | Date discharged (Year Month Day) | 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).

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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 ◯ No **If yes**, please provide details.

DECLARATION AND SIGNATURE

I realize that my personal information is governed by the *Privacy Act* and it can be disclosed where authorized under the Canada Pension Plan.

I agree to notify the Canada Pension Plan of any changes that may affect my eligibility for benefits. This includes: an improvement in my medical condition; a return to work (full, part-time, volunteer, or trial period); attendance at school or university; trade or technical training; or any rehabilitation.

NOTE: If you make a false or misleading statement, you may be subject to an administrative monetary penalty and interest, if any, under the *Canada Pension Plan,* or may be charged with an offence. Any benefits you received or obtained to which there was no entitlement would have to be repaid.

Signature of Applicant or Representative	Year Month Day	Telephone Number
X		

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

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GIVE THIS FORM TO YOUR PHYSICIAN WITH THE MEDICAL REPORT

Consent for Service Canada to Obtain Personal Information

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

Protecting your privacy:

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

Instructions:

- Complete Sections 1 and 2 of this form; and
- Give this form to **your physician** with the medical report.

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

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Consent to obtain personal information

I give Service Canada my consent to obtain personal information about me that would help decide if I qualify or continue to qualify for Canada Pension Plan disability benefits. For this reason, Service Canada may contact any of the following persons and organizations if necessary:

- medical doctors, consultant specialists, or health-care professionals
- medical facilities or hospitals
- educational institutions or other vocational agencies
- my accountant or book-keeper for information on self-employment
- administrators of insurance plans
- federal, provincial, territorial, or municipal government departments and agencies
- employers, former employers
- provincial or territorial workers' compensation boards
- financial institutions - for address updates only

Section 2 - I give my consent or I do not give my consent

○ I give my consent to Service Canada to obtain medical and other personal information about me from all persons and organizations listed above. I understand that this information may help in determining if I qualify or continue to qualify for Canada Pension Plan disability benefits.

○ I do not give my consent to Service Canada to obtain medical and other personal information about me from all persons and organizations listed above.

I understand that my refusal means:

- that Service Canada will make a decision based on the available information on my file;
- if I am already receiving disability benefits, Service Canada may stop paying me the benefits; and
- under certain circumstances, Service Canada can require that I provide the necessary information (*CPP Regulations* and Pension Appeals Board Rules of Procedures).

Signature _____ Date of signature _____
Year Month Day

To be completed by witness if signed with a mark "X" or by a representative of the applicant

First Name and Initial	Last Name
Telephone Number	

Signature _____ Date of signature _____
Year Month Day

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

Service Canada

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RETURN THIS FORM WITH YOUR APPLICATION AND QUESTIONNAIRE TO SERVICE CANADA

Consent for Service Canada to Obtain Personal Information

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

Protecting your privacy:

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

Instructions:

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

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

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Consent to obtain personal information

I give Service Canada my consent to obtain personal information about me that would help decide if I qualify or continue to qualify for Canada Pension Plan disability benefits. For this reason, Service Canada may contact any of the following persons and organizations if necessary:

- medical doctors, consultant specialists, or health-care professionals
- medical facilities or hospitals
- educational institutions or other vocational agencies
- my accountant or book-keeper for information on self-employment
- administrators of insurance plans
- federal, provincial, territorial, or municipal government departments and agencies
- employers, former employers
- provincial or territorial workers' compensation boards
- financial institutions - for address updates only

Section 2 - I give my consent or I do not give my consent

○ I give my consent to Service Canada to obtain medical and other personal information about me from all persons and organizations listed above. I understand that this information may help in determining if I qualify or continue to qualify for Canada Pension Plan disability benefits.

○ I do not give my consent to Service Canada to obtain medical and other personal information about me from all persons and organizations listed above.

I understand that my refusal means:

- that Service Canada will make a decision based on the available information on my file;
- if I am already receiving disability benefits, Service Canada may stop paying me the benefits; and
- under certain circumstances, Service Canada can require that I provide the necessary information (*CPP Regulations* and Pension Appeals Board Rules of Procedures).

Signature _____ Date of signature _____
Year Month Day

To be completed by witness if signed with a mark "X" or by a representative of the applicant

First Name and Initial	Last Name
Telephone Number	

Signature _____ Date of signature _____
Year Month Day

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

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MEDICAL REPORT

SECTION A To be completed by Applicant		
First Name and Initial	Last Name	
Home Address (No., Street, Apt. No., P.O. Box, R.R.)	City, Town or Village	
Province or Territory	Country	Postal Code
Telephone number	Date of Birth (Year Month Day)	Canadian Social Insurance Number

SECTION B To be completed by Physician			
Please provide factual objective opinions			
1. Height Weight	2 a) How long have you known the patient?	b) When did you start treating the patient for the main medical condition? Year Month	c) Date of last visit Year Month Day
3. Diagnosis(es)			
4. Relevant/significant medical history relating to the main medical condition:			

Please write legibly

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5. Over the past two years, has the patient been admitted to a hospital/institution?

☐ Yes **If yes,** please list:

☐ No

Name of the Hospital(s)/Institution(s)

The date(s) of admission Year Month Day	The reason(s) for admission
_____	_____
_____	_____
_____	_____

6A. Is there supporting evidence for the main medical condition? Please attach supporting documentation.

Laboratory Reports	☐ Yes	☐ No
X-ray reports	☐ Yes	☐ No
Consultants' opinions	☐ Yes	☐ No
Other	☐ Yes	☐ No
Documentation to be returned	☐ Yes	☐ No

6B. Please describe relevant physical findings and functional limitations.

Please write legibly

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7. Are further consultations or medical investigations planned relating to the main medical condition?

☐ Yes **If yes,** please specify:

☐ No

8. Is the patient currently on medication(s) as a result of the main medical condition?

☐ Yes **If yes,** please indicate dosage and frequency.

☐ No

9. Treatment: List type and response.

Please write legibly

Canadian Social Insurance Number

FOR OFFICE USE ONLY		
☐ A.C.	Initials	Year Month Day

10. Prognosis of the main medical condition of this patient:

11. Additional Information

SIGNATURE (Please print or use a stamp)

Physician's Full Name

Address

Postal Code

☐ Family Physician

☐ Specialty _____

Signature X	Year Month Day	Telephone No.

Please write legibly