QUESTIONNAIRE FOR DISABILITY BENEFITS CANADA PENSION PLAN

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

EDUCATION

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

Have you attended college or university?

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

◯ No

3. Have you ever been involved in any technical, trade, or on the job training?

◯ Yes **If yes**, provide the following details:

◯ No

Dates	Type of program	Certificate obtained

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

EMPLOYEE

4. Have you stopped working completely?

◯ Yes, go to question 5.

◯ No, provide the following information:

Type of Work

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

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

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

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

Why did you stop working?	Date employment started (YYYY-MM-DD)	**Last day on the job** (YYYY-MM-DD)

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

SELF - EMPLOYED

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

a) Date business started (YYYY-MM-DD)

b) When did you actually stop working in the business? (YYYY-MM-DD)

c) Why did you stop working in the business?

d) Describe the business operation

e) What was your involvement with the business?

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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:

◯ sold ◯ rented ◯ profit sharing Date of disposition (YYYY-MM-DD)

If **no disposition** has been made of the business, how does it operate now and what arrangements are you contemplating in the future?

g) What was the last year that an income tax return on the operation of the business was filed in your name?

h) Will you declare yourself a self-employed person for income tax purposes this year?

◯ Yes ◯ No

OTHER WORK HISTORY

IF THERE IS INSUFFICIENT SPACE TO LIST ALL YOUR OTHER TYPES OF WORK, USE THE SPACE AT THE END OF THIS QUESTIONNAIRE.

8. In the past two years, did you do **any other work** in addition to your main job (such as part-time farming, night or other employment)?

◯ Yes **If yes**, provide the following details:
◯ No

Type of work	Number of hours per day	Number of hours per week	Work started (YYYY-MM-DD)	**Last day on the job** (YYYY-MM-DD)

Name and full address of employer

9. Have you done **any other type of work** in the last five years?

◯ Yes **If yes**, list the type of work and the dates.
◯ No

	From			To		
	Year	Month	Day	Year	Month	Day

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

◯ Yes **If yes**, please describe.
◯ No

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

◯ Yes **If yes**, give the date: (YYYY-MM)
◯ No

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

◯ Yes **If yes**, answer **one** of the following questions:
◯ No

a) The date you plan to **return** to your former employer/employment (YYYY-MM)

b) The date you will **start** a new job. (YYYY-MM)

c) The date you plan to start looking for work. (YYYY-MM)

OTHER BENEFITS

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

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

Claim Number	Province or Territory	Year	Injury

State type of benefit you now receive.	Percentage of pension awarded

15. Have you received regular Employment Insurance benefits in the last two years?
◯ **Yes** **If yes**, give the dates:
◯ No

From (YYYY-MM-DD)	To (YYYY-MM-DD)
From (YYYY-MM-DD)	To (YYYY-MM-DD)

MEDICAL INFORMATION

16. **When could you no longer work because of your medical condition?**	(YYYY-MM-DD)

17. Height	Weight	◯ Right-handed ◯ Left-handed

18. State the illnesses or impairments that prevent you from working. If you do not know the medical names, describe in your own words.

19. Describe how these illnesses or impairments prevent you from working.

20. If you have other health-related conditions or impairments, please describe them.

21. If you had to stop other activities (such as hobbies, sports or volunteer work), please explain and give dates activities ceased.

22. Explain any difficulties/functional limitations you have with the following:	
Sitting/Standing (How long?)	Seeing/Hearing
Walking (How long and how far?)	Speaking
Lifting/Carrying (How much and how far?)	Remembering
Reaching	Concentrating
Bending (How much?)	Sleeping
Personal needs (Eating, washing hair, dressing, etc.)	Breathing
Bowel and bladder habits	Driving a car (How long?)
Household maintenance (Cooking, cleaning, shopping and similar activities)	Using public transportation

INFORMATION ABOUT YOUR PHYSICIANS

23. Provide the following information about the physician who will be completing your medical report.

Physician's Full Name ◯ Family Physician ◯ Specialist (Please specify)

Address	City

Province or Territory	Country (If other than Canada)	Postal Code	Telephone Number

When did you first see this physician? (YYYY-MM) | When was your last visit? (YYYY-MM)

What were the reasons for your visits?

24. List all other physicians you have seen in the last two years (space for two physicians is provided). If there is insufficient space to list all of your physicians, use the space at the end of this questionnaire.

a) Physician's Full Name Specialty

Address	City

Province or Territory	Country (If other than Canada)	Postal Code	Telephone Number

When did you first see this physician? (YYYY-MM) | When was your last visit? (YYYY-MM)

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

b) Physician's Full Name Specialty

Address	City

Province or Territory	Country (If other than Canada)	Postal Code	Telephone Number

When did you first see this physician? (YYYY-MM) | When was your last visit? (YYYY-MM)

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

HOSPITALIZATION

25. If you have been admitted to hospital in the last two years, please provide the following information. Space for two hospitals is provided. If there is insufficient space to list all of the hospitals, use the space at the end of this questionnaire.

a) Name of hospital	Mailing address (No., Street, P.O. Box, R.R.)		
City	Province or Territory	Country (If other than Canada)	Postal Code
Date admitted (YYYY-MM-DD)	Date discharged (YYYY-MM-DD)	Name of attending physician	
Reason for admission and type of treatment			

b) Name of hospital	Mailing address (No., Street, P.O. Box, R.R.)		
City	Province or Territory	Country (If other than Canada)	Postal Code
Date admitted (YYYY-MM-DD)	Date discharged (YYYY-MM-DD)	Name of attending physician	
Reason for admission and type of treatment			

MEDICATION AND TREATMENT

26. List any medication you now take.

Name of medication	Dosage	How often

27. Describe other treatment you receive (such as counselling, physiotherapy).

28. If future treatments or medical tests are planned, please explain, giving dates.

29. List any medical devices you use (such as crutches, cane, artificial limb, splints, braces, wheelchair, hearing aid, heart pacemaker, ostomy apparatus).

VOCATIONAL REHABILITATION

30. If considered suitable, would you consent to a vocational rehabilitation assessment?

◯ Yes
◯ No **If no**, please explain.

31. Are you presently or have you ever been involved in a rehabilitation program?

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

DECLARATION AND SIGNATURE

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

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

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

Signature of Applicant or Representative	Date (YYYY-MM-DD)	Telephone Number

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