Personal Information
Bank HRDC PPU 175

Questionnaire
for Disability Benefits, Canada Pension Plan

Contributor's Canadian Social Insurance Number

Contributor's Family Name

Contributor's Given Name

Information about Your Education, Work History, Benefit History and Medical Condition

Education

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

2. Have you attended a college or university?
☐ Yes ☐ No

If "**Yes**", please give number of years or diploma/degree obtained.

3. Have you ever had any technical or trade training or apprenticeship?
☐ Yes ☐ No

If "**Yes**", please state type.

4. **In the last two years**, have you been involved in any technical or trade training, apprenticeship or educational upgrading?
If "**Yes**", please provide dates, name and address of school(s), type of program. ☐ Yes ☐ No

Name of School(s)	Address of School(s)	Type of Program	Date

5. Do you have plans for training or upgrading? ☐ Yes ☐ No ▶ If you said "**Yes**", please explain.

Work History

6. Working at Time of Application

Are you working at the present time? ▶ ☐ Yes ☐ No ▶ If you said "**No**", please go to question 7.

If you said "**Yes**", please give the following details. ▶ ☐ Employee ☐ Self-Employed ☐ Volunteer

Type of Work: _____ ☐ Full-Time ☐ Part-Time ☐ Seasonal

Number of hours per day:	Number of days per week:	Salary per hour:	or per day:

Work History (continued)

7. Not Working at Time of Application

a) State the name and address of your most recent employer.

Name

Address

b) Date work started (with your most recent employer): Year Month

Date work stopped (last day with your most recent employer): Year Month Day

c) What kind of work did you do?

d) Why did you stop working?

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

☐ Yes ☐ No If you said "**Yes**", list type of work and dates (include any work done outside of Canada).

		Year	Month		Year	Month
1.	from			to		
2.	from			to		
3.	from			to		
4.	from			to		
5.	from			to		

Self - Employed

Note: If you are not self-employed, please go to question 15.

9. Please describe your business, including number of employees.

10. When did you start the business? Year Month

11. What type of work did you do in the business?

12. Is the business operating at the present time?

☐ Yes ☐ No

If you said "**No**", what has happened to the business? ☐ Sold ☐ Rented ☐ Profit Sharing ☐ Transferred

If you said "**Yes**", are you working in the business?

☐ Yes ☐ No

What type of work are you doing?

If you are not working in the business, how does it operate?

13. What was the latest year that an income tax return on the operation of the business was filed in your name? Year

14. Will you declare yourself as self-employed for income tax purposes this year?

☐ Yes ☐ No

Other Work Activity

15. In the past two years, did you do any other work at the same time as your main job (such as part-time farming, night or other employment)?

☐ Yes ☐ No If you said "**No**", please go to question 16.

If you said "**Yes**", please give the following details. Type of Work: _____

Date Work Started: Year Month	Date Work Stopped: Year Month	Number of Hours Worked per Day:

Name of Employer (if applicable)

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

Postal Code | Province | Country

16. Before you stopped working, did you have to do lighter or a different type of job?

☐ Yes ☐ No If you said "**Yes**", please explain and give the date(s) if possible.

17. Has your doctor told you when you can return to work? Year Month Day

☐ Yes ☐ No If you said "**Yes**", please supply date.

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

☐ Yes ☐ No If you said "**Yes**", please explain, giving any known dates.

Benefit History

19. Is your present condition covered by either one of the following:

An employer's sick leave benefit? ☐ Yes ☐ No

Any form of disability insurance? ☐ Yes ☐ No

If you said "**Yes**" to either of the above, please state the name of the insurance company(ies).

Workers' Compensation

20. Are any of your health problems covered by Workers' Compensation?

☐ Yes ☐ No If you said "**Yes**", please provide details in each case.

Claim Number	Province	Year	Reason	Type of Benefit

Medical Condition

21. State your:

Height: | Weight:

22. What is/are your main disabling condition(s)?

Medical Condition (continued)

23. Do you have any other health-related conditions or impairments?

☐ Yes ☐ No If you said "**Yes**", please explain.

24. What is the approximate date that you felt you could no longer work because of your disabling medical condition?

Year Month

25. Did your main disability result from an injury caused by an accident?

☐ Yes ☐ No If you said "**Yes**", please supply date and describe how the accident happened and the resulting injuries.

Year Month Day

26. Have you had to stop doing some activities such as hobbies, sports or volunteer work?

☐ Yes ☐ No If you said "**Yes**", please explain and state any dates you can remember.

27. Please describe any problems and/or limitations you have with the following:

Sitting	Hearing
Standing	Speaking
Walking	Remembering
Lifting	Concentrating
Carrying	Sleeping
Bending	Breathing
Personal Needs (eating, washing hair, dressing, etc.)	Driving a Car
Seeing	Using Public Transportation

28. Please state the name, address and telephone number of the medical doctor who will be completing your medical report.

Doctor's Full Name

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

Postal Code | Province | Country | Telephone Number (including area, city or regional code)

[ ] -

When did you first see this doctor? Year Month

When was your last visit? Year Month Day

What were the reasons for your visits?

29. Please state the names, addresses and telephone numbers of any other medical doctors or medical specialists you have seen **in the past two years** (space for two doctors provided).

1. Doctor's Full Name

Address (No., St., Apt. No.) | City, Town or Village | Telephone Number (including area, city or regional code)

Postal Code | Province | Country | [ ] -

When did you first see this doctor? Year Month | When was your last visit? Year Month Day

What were the reasons for your visits?

2. Doctor's Full Name

Address (No., St., Apt. No.) | City, Town or Village | Telephone Number (including area, city or regional code)

Postal Code | Province | Country | [ ] -

When did you first see this doctor? Year Month | When was your last visit? Year Month Day

What were the reasons for your visits?

30. In the past two years, were you admitted to hospital? ☐ Yes ☐ No If "**Yes**", state name and address of hospital(s) (space for two hospitals provided).

1. Name of Hospital

Hospital Address

When were you admitted? Year Month Day | When were you discharged? Year Month Day

Please explain why you were admitted. | Who was the attending doctor?

2. Name of Hospital

Hospital Address

When were you admitted? Year Month Day | When were you discharged? Year Month Day

Please explain why you were admitted. | Who was the attending doctor?

If there is not sufficient space to list all hospitalizations, please use a separate sheet of paper.

31. Please list any medications you now take. How often? What is the dosage?

32. Please list any other present and/or future medical treatments, examinations or investigations.

33. Please list any medical appliances you use, such as: crutches, cane, limb supports, splints, braces, wheelchair, hearing aid, heart pacemaker, ostomy apparatus, prosthesis.

IMPORTANT

I agree to notify Human Resources Development Canada of any improvements in my medical condition and of any work I may undertake.

Signature of Contributor / Applicant ▶ _____ Year Month Day