



APPLICATION FOR DISABILITY PENSION

Protected information when completed.

HO file No.			
Decision No.			
Date of application	Year	Month	Day

Which official language do you wish to use

in oral communications? English French

in correspondence? English French

Which official language does your spouse/common-law partner wish to use

in oral communications? English French

in correspondence? English French

Representative: _____

A - INFORMATION ABOUT APPLICANT

Mr. <input type="radio"/> Mrs. <input type="radio"/> Ms. <input type="radio"/> Miss <input type="radio"/> Other <input type="radio"/> Specify: _____			
Family name		Given name(s)	
Service number(s)		Date of Enlistment/Enrolment	
Service types (e.g. WWII, SDA, Reg. Forces, RCMP)		Year	Month Day
Date of Discharge	Year	Month	Day
Residence address		Place of Discharge	
Province/State		Mailing address (if different)	
Country		Province/State	
Postal/Zip Code		E-mail address	
Home telephone No.		Country	
Area code	Postal/Zip Code		Business or alternate telephone No.
Year	Month	Day	Area code
Date of birth		Extension	
Maiden name (if applicable)		Alias(es)	

Information about applicant ...continued

Protected information when completed.

Family Name	Given Name(s)	File No.
<p>Marital status</p> <p>Married <input type="radio"/> Single <input type="radio"/> Common-law <input type="radio"/></p> <p>Separated <input type="radio"/> Divorced <input type="radio"/> Widow(er) <input type="radio"/></p>		
<p>If married, are you currently living with your spouse? Yes <input type="radio"/> No <input type="radio"/></p> <p>If no, please provide reason _____</p>		
<p>If in a common-law relationship, have you lived together continually for the past year? Yes <input type="radio"/> No <input type="radio"/></p> <p>If no, please provide reason _____</p>		
<p>Full name of spouse/common-law partner</p> <p>Maiden name (if applicable) _____</p>		
<p>Date of birth of spouse/ common-law partner</p> <p style="text-align: right; margin-right: 20px;">Year Month Day</p>	<p>Date of marriage or date common-law relationship began</p> <p style="text-align: right; margin-right: 20px;">Year Month Day</p>	
<p>Has your spouse/common-law partner ever applied for a disability or survivor pension from the Department of Veterans Affairs? Yes <input type="radio"/> No <input type="radio"/></p> <p>If yes, provide: ^{Unak} File No. _____ Service No. _____</p>		

Information about your dependent children

Full name	Relationship	Date of birth			Attending school? Check one (✓)		*	Name and address of person with whom child lives if other than applicant
		Year	Month	Day	Yes	No		

* Please check if child is disabled.

B- APPLICANT'S STATEMENT**Protected information when completed.**

Family Name	Given Name(s)	File No.
-------------	---------------	----------

Disability being claimed	Are you in receipt of or have you ever received other compensation, (e.g. WCB or another Government) for the medical disability or a similar disability for which you are now applying?	Yes <input type="radio"/>	No <input type="radio"/>
--------------------------	---	---------------------------	--------------------------

How is the claimed condition related to service? (Give details of relevant illness/injuries during service, including dates and circumstances, as well as medical treatment received.) Please provide listing of military occupation codes (MOCs), duties and time spent in each occupation, if available.

Describe how you have coped with the claimed condition since your injury/illness. Have you had any medical attention for this condition? When and where was this medical attention received?

What effect has this claimed condition had on your everyday activities?

Name and address of physician(s)/consultant(s) seen for this condition from whom information can be obtained.

Family Name	Given Name(s)	File No.
-------------	---------------	----------

C - DECLARATION

The information you provide on this form is collected under the authority of the *Pension Act* for the purpose of administering pension benefits. It is protected by Canada's *Privacy Act* from disclosure to unauthorized persons. As per the *Privacy Act* you may request a copy of this form in writing by quoting Personal Information Bank No. VAC/P-PU-055. Address your request to the Access to Information and Privacy Directorate of Veterans Affairs Canada.

If you are a still-serving Canadian Forces member, all your health benefits must be obtained through the Canadian Forces. If you are awarded a disability pension, certain limited pension information will be shared with the medical authorities of the Canadian Forces to enable them to fully assess and respond to your health needs. The information that will be shared is limited to your medical pension code, medical pension description, effective date, name, and service number.

Anyone who knowingly makes a false or misleading statement in an application is guilty of an offense.

I declare that the information provided here is, to the best of my knowledge, true and complete and knowing that it is of the same force and effect as if made under oath.

X

_____ Applicant's signature

_____ Date

For Office Use Only

Pension Officer's name	District	Telephone No. - -
Signature		Date



Protected information when completed.

AUTHORITY TO RELEASE MEDICAL INFORMATION

HO File No.
Service No(s).

Family Name	Given Name(s)	Date of birth (y-m-d)
Address		

FOR OFFICE USE ONLY

Name of doctor, hospital and/or institution
Address

I hereby give permission for a representative of the Department of Veterans Affairs to have access to any records you may have on my file, as well as any special treatment record.

The information received will be collected under the authority of the *Pension Act* for the purpose of administering pension benefits. It will be protected by Canada's *Privacy Act* from disclosure to unauthorized persons and maintained in Personal Information Bank No. VAC/P-PU-055.

Client's signature	Date	Home telephone No.
		Business telephone No.

Area code

Area code Extension