



# Disability Retirement Benefits Application Form

Use this form to apply for a Public Service Pension Plan (PSPP) disability pension. Two types of disability pensions are available. A partial disability pension may be granted when medical evidence indicates that a member suffers from a physical or mental impairment that prevents them from performing the regular duties of their employment. A total disability pension may be granted when medical evidence indicates a member suffers from a physical or mental impairment that can be reasonably expected to last for the rest of their lifetime and prevents them from engaging in any gainful employment. The disability assessment will be based on a combination of medical evidence and rules applicable to the Plan.

If you have combined pensionable service (CPS), you will also need to complete an application for the related plan in order to start that disability pension. To avoid delays, submit this completed form before you would like your disability pension to commence.

Please send this completed form and the *Confidential Medical Statement* (after completion by your physician(s)) to:  
PSPP, 5103 Windermere Blvd. SW, Edmonton, AB T6W 0S9 Fax: 780-421-1652

## 1. Member Information

\_\_\_\_\_ member's first name      \_\_\_\_\_ member's middle name      \_\_\_\_\_ member's last name

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member social insurance number

\_\_\_\_\_ member's address      \_\_\_\_\_ member's address effective date (YYYY/MM/DD)

\_\_\_\_\_ city, town, village, etc.      \_\_\_\_\_ province      \_\_\_\_\_ postal code      \_\_\_\_\_ country (if outside of Canada)

\_\_\_\_\_ primary phone number      \_\_\_\_\_ ext.      \_\_\_\_\_ country code  
Work      Home      Cell      (if outside Canada/USA)

### To be eligible for a disability pension, you must:

- have commenced contributions to PSPP, or
  - have CPS and have commenced contributions to the Management Employees Pension Plan (MEPP)
- on or before June 30, 2007.

## 2. Pension Commencement Date

I want my pension to start on:

\_\_\_\_\_ date (YYYY/MM/DD)

If the date you give is before you stop participating in the Plan, or before PSPP receives your application, your pension commencement date will be adjusted to the closest possible date allowed under the rules of the Plan. We will send you a *Retirement Benefit Statement* with your pension options. This statement will show the pension commencement date used to calculate those options.



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### 3. Definition of Pension Partner

Persons are pension partners on any date on which one of the following applies:

- (a) they
  - (i) are married to each other, and
  - (ii) have not been living separate and apart from each other for a continuous period longer than three years;
- (b) if clause (a) does not apply, they have been living with each other in a marriage-like relationship
  - (i) for a continuous period of at least three years preceding the date, or
  - (ii) of some permanence, if there is a child of the relationship by birth or adoption.

If you are not certain how the definition of pension partner applies to you, please contact the Member Services Centre at 1-877-453-1PSP (1777).

**According to the definition above, I have a pension partner on the date that I am completing this form (please check one):**

**YES** If YES, please complete section 4. Pension Partner Information

**NO** If NO, please skip to section 5. Service Eligible for Purchase

### 4. Pension Partner Information

_____	_____	_____
pension partner's first name	pension partner's middle name	pension partner's last name
_____	_____	Please check one:
pension partner's date of birth (YYYY/MM/DD)	marital status (married/common law)	female      male

### 5. Service Eligible for Purchase

If you are currently paying for prior service, do you plan to complete your buyback payments?

- Yes, I will complete my payments.
- No, I will not complete my payments. Please prorate my service.
- N/A

Please refer to [www.pspp.ca](http://www.pspp.ca) for specific guidelines and payment deadlines.

If you were away from work for a period of time, please contact the Member Services Centre about your options for purchasing this service.



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## 6. Member Authorization

The information on this form is, to the best of my knowledge and belief, complete and accurate. I authorize my physician(s) to release to PSPP, its representative(s) and/or consulting physician(s), any information relating to the medical condition(s) which is the cause of my disability. This information is to be used to evaluate my application for a disability pension only and permission is NOT granted for any other use or disclosure. I acknowledge that I am aware that any other disability-related benefits that I receive might be reduced as a result of my receiving a PSPP disability pension.

\_\_\_\_\_ member's signature

\_\_\_\_\_ member's name (please print)

\_\_\_\_\_ date signed (YYYY/MM/DD)

### Please note:

- You are responsible for the cost of obtaining any information relating to your medical condition.
- **This is an official record that must be signed to be valid.** Mailing and fax information is at the top of page 1. Keep a copy of the completed form for your records.
- If you have questions, please contact the Member Services Centre, toll free, at 1-877-889-1PSP (1777).

**If you are participating in PSPP, your employer must complete the following section. If you are no longer participating in PSPP, completion of this section by your former employer is not required.**

## 7. Employer Use Only

a) Please explain whether the member is incapable of performing the duties of his or her position.

\_\_\_\_\_  
\_\_\_\_\_

b) Is the member receiving Workers' Compensation Board benefits?      YES      NO

If yes, select one:

temporary total disability      temporary partial disability      other

c) Is the member receiving long-term disability benefits?

\_\_\_\_\_

d) If there was a leave of absence this year, record the *estimated* service and salary for the leave period.

Pensionable Service \_\_\_\_\_ Pensionable Salary \_\_\_\_\_

## 8. Employer Certification

I certify that the information on this form is, to the best of my knowledge and belief, complete and accurate.

\_\_\_\_\_ employer name

\_\_\_\_\_ employer number

\_\_\_\_\_ member's termination date (YYYY/MM/DD)

\_\_\_\_\_ name of authorized person (please print)

\_\_\_\_\_ phone number

\_\_\_\_\_ ext.

\_\_\_\_\_ signature of authorized person

\_\_\_\_\_ date signed (YYYY/MM/DD)

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The information on this form will assist PSPP in determining eligibility for disability pension benefits for the patient. No information, in whole or in part, will be released to any unauthorized person(s) without the patient's prior written consent. This statement will be held in strictest confidence and used solely to enable an assessment of the patient's disability by an independent medical consultant. The information on this form must be completed by a physician and returned to the patient. Charges for the completion of this report, if any, are the responsibility of the patient.

## 1. Patient Information

\_\_\_\_\_

patient's first name

\_\_\_\_\_

patient's last name

\_\_\_\_\_

pension plan identification number

\_\_\_\_\_

patient's address

\_\_\_\_\_

city, town, village, etc.

\_\_\_\_\_

province/territory

\_\_\_\_\_

postal code

## 2. Physician Information

\_\_\_\_\_

physician's full name

\_\_\_\_\_

area code

\_\_\_\_\_

phone number

\_\_\_\_\_

address

\_\_\_\_\_

city, town, village, etc.

\_\_\_\_\_

province/territory

\_\_\_\_\_

postal code

## 3. Medical Relationship

- a) How long have you been treating the patient? \_\_\_\_\_
- b) When did you start treating the patient for the medical condition(s)? \_\_\_\_\_
- c) When did you last examine the patient? \_\_\_\_\_

## 4. Medical Assessment

- 1. a) What medical condition(s) are preventing the patient from working?  
\_\_\_\_\_  
\_\_\_\_\_

b) What was the date of onset? \_\_\_\_\_

c) Please list all relevant symptoms  
\_\_\_\_\_  
\_\_\_\_\_

2. Detail your findings on examination. Please attach supporting documentation such as reports, X-rays, or other tests.

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3. Please list any medication prescribed as a result of the medical condition(s) described in 1(a).

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4. Please list any medical history relating to the medical condition(s) described in 1(a).

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5. Describe any relevant medical problems other than the medical condition(s) described in 1(a).

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6. Describe any activities that worsen the patient's medical condition(s) described in 1(a).

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7. a) Do you consider the patient to be incapable of effectively performing the regular duties of employment as a result of the physical or mental impairment?  yes  no

b) Do you consider the patient to be suffering from a physical or mental impairment that can reasonably be expected to last for the remainder of the patient's lifetime and prevents the patient from engaging in any gainful occupation?  yes  no

8. The duration of the disability is:

- Temporary (reasonable probability for recovery)
- Permanent (low probability for recovery)

9. Please provide any additional information.

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## 5. Physician Certification

I certify that the information on this form is, to the best of my knowledge and belief, complete and accurate.

\_\_\_\_\_  
physician's signature

\_\_\_\_\_  
date (YYYY/MM/DD)