Veterans Affairs Canada | Anciens Combattants Canada

Canada

APPLICATION FOR DISABILITY BENEFITS

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. ○ Mrs. ○ Ms. ○ Miss ○ Other ○ Specify: _____

Family name	Given name(s)
Are you an employee of Veterans Affairs? Yes ○ No ○	
Service number(s)	Date of Enlistment/Enrolment (Year / Month / Day)
Service types (e.g. WWII, SDA, Reg. Forces, RCMP)	
Date of discharge (Year / Month / Day)	Place of discharge
Residence address	Mailing address (if different)
Province/State	Province/State
Country / Postal/Zip Code	Country / Postal/Zip Code
Home telephone No. (Area code)	Business or alternate telephone No. (Area code / Extension)

Date of birth (Year / Month / Day)	Maiden name (if applicable)	Alias(es)

Information about applicant ...continued

Protected information when completed.

Family name	Given name(s)	File No.

Marital status

Married ○ Single ○ Common-law ○

Separated ○ Divorced ○ Widow(er) ○

If married, are you currently living with your spouse? Yes ○ No ○

If no, please provide reason _____

If in a common-law relationship, have you lived together continually for the past year? Yes ○ No ○

If no, please provide reason _____

Full name of spouse/common-law partner

Maiden name (if applicable) _____

Date of birth of spouse/ common-law partner (Year Month Day)	Date of marriage or date common-law relationship began (Year Month Day)

Has your spouse/common-law partner ever applied for a disability or survivor benefits from the Department of Veterans Affairs? Yes ○ No ○

If yes, provide: ▶ File No. _____ Service No. _____

Information about your dependent children

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

*** Please check if child is disabled.**

B- APPLICANT'S STATEMENT

Protected information when completed.

Family name	Given name(s)	File No.

Disability being claimed	Have you ever received, are you in receipt of and/or are you making application for other compensation (e.g. Worker's Compensation; Third Party Liability) in respect of the claimed disability? Please attach additional details if applicable.	Yes ○ No ○

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* or the *Canadian Forces Members and Veterans Re-establishment and Compensation Act.* which came into force April 1, 2006, for the purpose of administering disability benefits. The information provided is protected from unauthorized disclosure by the *Privacy Act.* You may request a copy of this completed form by writing to the Access to Information and Privacy Coordinator's Office, Veterans Affairs Canada, P.O. Box 7700, Charlottetown, PE, C1A 8M9.

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 benefit, certain limited 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 disability description, effective date, name, and service number.

Canadian Forces members, please pay particular attention to the "Canadian Forces - Important Notice" on the accompanying General Information insert.

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/SERVICE INFORMATION

HO File No.
Service No(s).

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

Address

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* or the *Canadian Forces Members and Veterans Re-establishment and Compensation Act,* which came into force April 1, 2006, for the purpose of administering disability benefits. It will be protected by Canada's *Privacy Act* from disclosure to unauthorized persons. You may request a copy of this completed form by writing to the Access to Information and Privacy Coordinator's Office, Veterans Affairs Canada, P.O. Box 7700, Charlottetown, PE, C1A 8M9.

Client/applicant's signature	Date	Home telephone No. (Area code)
		Business telephone No. (Area code) (Extension)