# **Application for Disability Benefits**

If you are under age 65, have sufficiently contributed to the Québec Pension Plan and are disabled, you could be entitled to disability benefits under the Plan. There are two pensions:

- the disability pension;
- the pension for a disabled person's child.

The Régie can consider you to be disabled if your disability is severe and is expected to last indefinitely. You must be unable to do substantially gainful work on a regular basis because of your state of health.

However, **if you are between ages 60 and 65**, and your state of health prevents you from doing the **usual work** you left when you became disabled, you could be entitled to a disability pension.

Please note that the Régie's criteria for determining if a person is disabled are not the same as those of the Commission de la santé et de la sécurité du travail (CSST) and the Société de l'assurance automobile du Québec (SAAQ). The criteria used by insurance companies may also differ from those of the Régie.

#### The disability pension

Payment of a disability pension begins in the fourth month following the one as of which the person is considered disabled by the Régie. For example, if a person is deemed to be disabled by the Régie as of January, payment will begin four months later (in May). The last payment is made in the month of the person's 65th birthday.

#### Pension for a disabled person's child

If you are entitled to a disability pension, your children and any children you support, **who are not already receiving a pension under the Québec Pension Plan or the Canada Pension Plan,** could be entitled to a pension for a disabled person's child until age 18. You can apply for the following children:

- your child, whether or not he or she lives with you;
- the child of your spouse (your stepchild), if the child lives with you;
- any other child who lives with you or that you support.

#### How to apply

Return the form to the Régie as soon as you have finished filling it out. Do not wait for the Medical Report. The date we receive the application is very important because it can affect the date on which the pension becomes payable. However, the maximum retroactivity possible is 12 months from the date we receive the application, even if you were disabled before that time.

You must have the Medical Report completed by your physician. Be sure to ask him or her to send it back to the Régie as soon as possible. Your physician may charge you a fee for filling out the Medical Report. You are responsible for paying that fee.

#### Work outside Canada

If you participated in a social security plan in another country, you could be entitled to a pension under that plan. Pensions paid under the Québec Pension Plan are not reduced if you are receiving a pension from another country.

#### HOW TO COMPLETE YOUR APPLICATION FOR DISABILITY BENEFITS

- 1- Answer all the questions on the Application for Disability Benefits, unless you are instructed to skip a question.
- 2- If there is not enough space, continue your answer in section 26, OTHER INFORMATION.
- 3- Sign section 25, DECLARATION AND SIGNATURE.
- 4- Fill out and sign the AUTHORIZATION TO RELEASE MEDICAL AND PSYCHOSOCIAL INFORMATION.
- 5- Include a copy of all medical reports and test results that you have in your possession that concern your disability. (DO NOT SEND X-ray films.)
- 6- Place the form and all other documents in the envelope provided and mail it to the following address as soon as possible:

Régie des rentes du Québec Case postale 5200 Québec (Québec) G1K 7S9

7- Be sure to use sufficient postage, especially if you have enclosed additional documents.

#### INSTRUCTIONS FOR THE ENCLOSED MEDICAL REPORT FORM

- 1- You (the applicant) must fill out section 1 of the Medical Report, APPLICANT'S IDENTITY.
- 2- Have the other sections completed by your physician. He or she will send the report directly to the Régie.

IMPORTANT: The Régie has the right to require proof of birth at any time.

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For	more	intorn	nation
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By Internet: www.rrq.gouv.qc.ca

By telephone: Québec region: (418) 643-5185 Montréal region: (514) 873-2433 Toll-free: 1 800 463-5185 Service for the hearing impaired: 1 800 603-3540

#### ACCESS TO DOCUMENTS HELD BY PUBLIC BODIES AND THE PROTECTION OF PERSONAL INFORMATION

The information requested on this form is needed in order for the Régie to study your file. The information will be held by the Régie in accordance with the *Act respecting Access to documents held by public bodies and the Protection of personal information*, and cannot be provided to other persons or agencies or verified with them except in those cases provided for by law. It could also be used for research, assessments, enquiries or surveys.

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## **Application for Disability Benefits**

#### Write your social insurance number in this space\*

#### Please print

			IDENTIFIC	ATION	
1	Sex*	Family name*		Given name*	
	Μ	Family name at birth (if di	fferent)	Given name at birth (if different)	
•					
2		Date of birth*	Place of birth		
		year month day			
	Lang	Lage of correspondence	French English	province	country
3	Your	mother's family name at bi	rth*	Your mother's given name*	
-					
	Your f	ather's family name at birt	h*	Your father's given name*	
		·			
4	Your a	address (number, street, apartn	nent)*		
	City		Province	Country	Postal code
_					
5	Teleph	none area code	area	code	
	home	*	other I	e	extension
6	16	live enteide Oereede whe	GENERAL INF		
Ŭ	ii you	live outside Canada, wha	t was your last province of resid	ience in Canada?	
7	Наур	you ever participated in th	ne social security plan of anothe	ar country?	
•	_				
		-	-		
	Pleas	e indicate your social secur	ity numbers for those countries:		
	3/11				
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		GENE		RMATION	(cont.)			
Α.	Do you have children born af	ter 31 Decemb	er 1958 or did	you become	e responsible for children after that date?			
В.	Certain situations could help y	ou become eli	gible for a pen	sion or increa	ase the amount:			
	<ul> <li>if you received family benefits for a child (Québec family allowance or Canada Child Tax benefit);</li> </ul>							
	<ul> <li>if you did not receive such benefits because your family income was too high.</li> </ul>							
	because your family income wa	as too high? (Be	<b>ame</b> for a chilc enefits are usual	l born after 3 ly paid to the i	1 December 1958? If you did not, was it mother.)			
	Yes. Complete the table be	elow.						
	No. Go to section 9.							
	In	formation abo	out children b	orn after 31	December 1958			
	1st child Family name at birth			Given name				
	Date of birth year month day	Date of adoption of (if applicable)			t Date of death (if child died before age 7)			
		(	year	month				
	Place of birth (province, country)	Child born	Date of arrival in	Canada	Province of residence at time of arrival in Canada			
		outside Canada	year	month	•			
		I						
	2nd child Family name at birth			Given name				
	Date of birth	Date of adoption of	date child became	e your dependen	t Date of death (if child died before age 7)			
	year month day	(if applicable)	year	month	year month			
	Place of birth (province, country)	Child born	Date of arrival in	month	Province of residence at time of arrival in Canada			
		outside Canada						
	3rd child Family name at birth			Given name				
	Date of birth	Date of adoption of (if applicable)	date child became	e your dependen	t Date of death (if child died before age 7)			
	year month day	(il applicable)	year	month	year month			
	Place of birth (province, country)		Date of arrival in	Canada	Province of residence at time of arrival in Canada			
		Child born outside	year	month				
		Canada						
	lf	there are mo	ore than 3 ch	ildren, con	tinue in section 26.			
C.	Between the birth and the 7th benefits were not <b>paid in you</b>		ach of these ch	nildren, were	e there any periods during which the family			
	Yes							
	No							

8

### Write your social insurance number in this space

9       Have you ever applied for benefits from the Commission de la santé et de la sécurité du traveil (CSST) following a work-related accident or an occupational disease (whether or not it was related to your current incapacity)?         No       Yes. In what year?       For what reason?         Give your CSST file number.		BENEFITS FROM OTHER AGENCIES								
Give your CSST file number.         What is the current status of your file at the CSST?         I have not yet received an answer from the CSST.         I am currently receving an indemnity from the CSST.         I was receiving an indemnity from the CSST but have stopped receiving it.         The CSST rejected my application.         Did you undergo a medical examination for the CSST?         I have you ever applied for benefits from the Société de l'assurance automobile du Québec (SAAQ) (whether or not it was related to your current incapacity)?         No         I have you ever applied for benefits from an insurance company because of your disability?         No         I have you ever applied for benefits from an insurance company because of your disability?         No       Yes. In what year did the accident occur?         Give you completely stopped working?       Yes         Work HISTORY         I have you completely stopped working?       Yes         No. How many hours a week do you work?       What is your gross weekly salary?         B. Why did you totally or partially stop working?       Yes         No.       Sive the title of your job.         Briefly describe the work you did.       Yes         C. Name of your last employer       Telephone         L. Do you have another job?       Yes         No       Yes </th <th>9</th> <th></th>	9									
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11       Have you ever applied for benefits from an insurance company because of your disability?         No       Yes. Give the name of the company       Your file number         Did the insurance company ask for a medical opinion?       Yes       No         WORK HISTORY         12       A. Have you completely stopped working?       year       month       day		No Yes. In what year did the accident occur? Give your SAAQ file number								
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13       A. Date you started your current job or your last job		No. How many hours a week do you work? What is your gross weekly salary?								
<ul> <li>A. Date you started your current job or your last job</li> <li>B. Give the title of your job.</li> <li>Briefly describe the work you did.</li> <li>C. Name of your last employer</li> <li>D. Do you have another job?</li> <li>Yes</li> <li>No</li> </ul> 14 A. List the other jobs you held before the job described in section 13. Employer Type of work Duration Reason for leaving B. Are you currently self-employed or do you own a business? No Yes No. Go to section 15. C. Have you ever been self-employed or owned a business? Yes No. Go to section 15.		B. Why did you totally or partially stop working?								
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C. Name of your last employer       Telephone       area code         D. Do you have another job?       Yes       No         14       A. List the other jobs you held before the job described in section 13.       Reason for leaving         Employer       Type of work       Duration       Reason for leaving         B. Are you currently self-employed or do you own a business?       No       Yes. Go to section 15.         C. Have you ever been self-employed or owned a business?       Yes       No.       Go to section 15.										
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C. Have you ever been self-employed or owned a business? Yes No. Go to section 15.										
C. Have you ever been self-employed or owned a business? Yes No. Go to section 15.										
year month day										
D. If the business has been sold, dissolved or closed, give the date concerned.		year month day								
		D. If the business has been sold, dissolved or closed, give the date concerned.								

#### Write your social insurance number in this space

	INFORMATION ON YOUR STATE OF HEALTH								
15	Since when have you been unable to work on a regular basis because of your state of health?								
16	List the illnesses or impairments that prevent you from working or limit you in your work. If you do not know the exact medical terms, describe the problem in your own words.								
17	List all the medicines that you are currently taking.								
	Name of the medicine	The dose you take	How often you take it						
18									
10	Indicate any other treatment (physical therapy, psych you are treated.	notherapy, etc.) that you are							
	Treatment		Place						
19	Indicate, if possible, any special tests you have had causing your disability (x-rays, treadmill exercise, m								
	Type of test	Hospital or	clinic where the test was done						
20	Can you get around without aid?								
	Yes No. I must use: a cane crutches	s 🗌 a wheel chair							
	4/9								

INFORMATION ABO	OUT YOUR PHYSICIANS		
Name the physicians currently caring for you and any physicia	ans you have seen because of your disability.		
• Dr	Name the hospital, clinic or CLSC where you see this physician.		
Family doctor			
Specialist. What field?	– Hospital CLSC Clinic		
area code	Date you last saw j year month day		
	that physician		
Dr	_ Name the hospital, clinic or CLSC where you see this physician.		
Family doctor			
Specialist. What field?	– Hospital CLSC Clinic		
area code	Date you last saw year month day		
	that physician		
► Dr.	Name the hospital, clinic or CLSC where you see this physician.		
Family doctor			
Specialist. What field?			
area code			
	Date you last saw year month day that physician		
Dr	_ Name the hospital, clinic or CLSC where you see this physician.		
Family doctor			
Specialist. What field?	– Hospital CLSC Clinic		
area code	Date vou last saw year month day		
	that physician		
If there is not enough sp	ace, continue in section 26.		
2			
Have you been hospitalized in the last five years?	Yes. Give the following information.		
Approximate date Reason			
Name of the hospital	Location		
Approximate date Reason			
year month			
Name of the hospital	Location		
Approximate date Reason	1		
year month			
Name of the hospital	Location		
7/11			

#### Write your social insurance number in this space

	PENSION FOR A DISABLED PERSON'S CHILD							
3		Do you wish to apply for a pension for a disabled person's child for one or more dependent children? See " <b>Pension for a disabled person's child"</b> on the cover page for eligiblity requirements.)						
	No. Go to section 24. Yes. Give the names in the following sections.							
ſ	Sex Famil							
F	Date of birth year month day Place of birth (if the child was born outside Québec, provide proof of birth issued by an officer of civil status.)							
-	I  I  City  Country							
			hild, since when has he or	she been livir	ng with you?	year month day		
	Child's addr	ress						
	His or her n	nother's family na	ime at birth	His or her	mother's given name	at birth		
	His or her fa	ather's family nan	ne	His or her f	father's given name a	at birth		
ľ		ly name at birth		Given name		Social insurance number		
	⊢ F ⊡ M							
	Date	e of birth <sub>month</sub> day	Place of birth (if the child was	s born outside Qu	lébec, provide proof of bir	th issued by an officer of civil status.)		
			city		province	country		
	If the child i	s not your own cl	hild, since when has he or	she been livir	ng with you?	year month day		
	Please	Child's address						
	provide the following	His or her mothe	r's family name at birth		His or her mother's	given name at birth		
	information if it is not					given name at entit		
	the same as – that for the first child.	His or her father'	s family name		His or her father's g	given name at birth		
ł	-	v name at birth		Given name		Social insurance number		
ŀ	Date	e of birth	Place of birth (if the child was	s born outside Qu	lébec, provide proof of bir	th issued by an officer of civil status.)		
	year	month day	city		province	country		
	If the child i	s not your own c	hild, since when has he or	she been livir		year month day		
	Please provide the Child's address							
	following information if it is notHis or her mother's family name at birthHis or her mother's given name at birth							
	the same as that for the first child.       His or her father's family name       His or her father's given name at birth				iven name at birth			
ŀ	If there is not enough space, continue in section 26.							
	<b>B.</b> Do any o Pension		ose names appear above r	eceive a pens	sion under the Québe	ec Pension Plan or the Canada		
	No.       Yes. Indicate under what social insurance number.							

	APPLICATION	FOR DIRECT	DEPOSIT						
24	Do you wish to receive your pension by direct deposit in the financial institution of your choice? Yes. Give the following information. No. <b>Go to section 25.</b>								
	Name of the financial institution		r folio number						
	Address of the bank or caisse								
		If you do no	ot have a cheque, you						
	DECLARATIO	with equiva	· · · · · · · · · · · · · · · · · · ·						
25	I declare that all information given on this application is tr								
	I agree to inform the Régie des rentes du Québec if the between now and the time a decision is rendered.		je in my work situa	ation or my	state of hea	alth			
	Sign here	Date	year	month	day				
	If this application is not signed by the person who is information. Why was the person unable to sign the ap		a disability pensi	on, please	e give the fo	llowing			
	Are you related to the applicant?		In what capacity d	id you sign?	word "VOID" written across it. enumber on the back of the check. ancial institution can provide you n or my state of health nth day please give the following pu sign? (lawyer, power of attorney, etc.) Social insurance number Postal code				
	□ No □ Yes. If yes, how?			, ,	word "VOID" written across it. e number on the back of the check. nancial institution can provide you on or my state of health onth day 				
	Sex Family name	Given name		Social	insurance r	number			
	Address (number, street, apartment)								
	City	Province	Postal code						
	Telephone area code	area code	I	L					
	home                     othe	R INFORMATIO	N	e	xtension				
26	Use this space if needed. Indicate the section number co			ere.					



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#### Authorization to release medical and psychosocial information

Write your social insurance number in this space

Write your health insurance number in this space

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#### **Please print**

Identification												
Sex	Family name	Given name			Date of bi							
	Eamily name at birth (if different)				ye 	ar		mor	าเท	da	ay 	
ПМ			Given name at birth (if different)									
Your mother's family name at birth		Her given name										
Your father's family name at birth		His given name										

#### Autorization and signature

I authorize any physician, health professional, health care facility or social services institution to release to the Régie des rentes du Québec any pertinent medical or psychosocial information concerning me so that the Régie will have all the information needed to process my application for disability benefits.

This authorization is also given for the Commission de la santé et de la sécurité du travail, the Société de l'assurance automobile du Québec, the Secrétariat du Conseil du trésor, the Secrétariat de la santé et des services sociaux, the Services-conseils aux gestionnaires des réseaux de l'éducation, the Commission administrative des régimes de retraite et d'assurances as well as any administrator of a private insurance plan to which I have applied for benefits related to my state of health.

Unless revoked by me in writing, this authorization shall be in effect until a final decision is rendered by the Régie. The authorization covers all the medical and psychosocial information held before the date of the authorization and any obtained between the date of the authorization and the date of the final decision.

Sign here	
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Date		1				

**Note:** The original authorization remains on file at the Régie. A certified true copy of the original is considered to be authentic, pursuant to section 25 of the *Act respecting the Québec Pension Plan.* 



Régie des rentes du Québec

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