Disability Retirement Benefits Application Form

Use this form to apply for a Public Service Management (Closed Membership) Pension Plan (PSM(CM)PP) 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 that 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 being employed. The disability assessment will be based on a combination of medical evidence and pension legislation.

Please send this completed form and the *Confidential Medical Statement* (after completion by your physician(s)) to:
PSM(CM)PP, c/o Alberta Pensions Services Corporation (APS),
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 _____

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 (if outside Canada/USA) _____

❑ Work ❑ Home ❑ Cell

2. Definition of Pension Partner

"Pension partner" means

(i) a person who, at the relevant time, was married to an officer or former officer, and

(A) was not judicially or otherwise separated from him or her, or

(B) if so separated, was wholly or substantially dependent on him or her,

(ii) if there is no person to whom subclause (i) applies, a person who

(A) lived with the participant or former participant

(I) for the 5-year period immediately preceding the relevant time, or

(II) for the 2-year period immediately preceding the relevant time if there is a child born to that person and the participant or former participant, and

(B) was, during that period held out by the participant or former participant in the community in which they lived as his consort, or

(iii) if there is no person to whom subclause (i) or (ii) applies, a person who was married to but separated from the participant or former participant and not dependent on him at the relevant time

If you are not certain how the definition of pension partner applies to you, please contact the Member Services Centre at 1-800-358-0840.

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 3. *Pension Partner Information*

❑ **NO** If NO, please skip to section 4. *Pension Commencement Date*

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3. Pension Partner Information

pension partner's first name

pension partner's middle name

pension partner's last name

pension partner's date of birth (YYYY/MM/DD)

marital status (married/common law)

Please check one:
❑ female ❑ male

4. Pension Commencement Date

I want my pension to start on:

date (YYYY/MM/DD)

If the date you select is before PSM(CM)PP 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.

5. 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 PSM(CM)PP, 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.

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 1-800-358-0840.

Confidential Medical Statement

The information on this form will assist PSM(CM)PP 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 _____

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

_____

_____

Personal information provided on this form is collected for pension administration purposes. It is collected under the authority of the Alberta *Freedom of Information and Protection of Privacy Act*, section 33 and the Alberta *Public Sector Pension Plans Act*, section 9.2. If you have any questions regarding the collection of this information, contact the Member Services Centre at 1-800-358-0840 or write to: 5103 Windermere Blvd. SW, Edmonton, AB T6W 0S9.

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

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

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

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

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

7. a) Do you consider the patient has become 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 is 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.

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)