Disability Insurance

Urban Operations Bargaining Unit

This plan is called the Disability Insurance Plan ("DI" for short). The DI Plan provides 70% of salary to employees who are injured or ill and can't do their regular job for a long time. It is a comprehensive plan that covers almost every type of disability.

Enrolment in the plan is mandatory and automatic. There are no forms to fill out to get on the plan.

The Disability Insurance Plan covers eligible employees only. Spouses and other family members are **not** covered.

Disability Insurance Premiums: Canada Post pays 50% of the monthly premium cost for DI and the employee pays the other 50%. The plan costs $2.09 per month for every $1,000 of salary.

When does coverage Start? All regular employees of Canada Post in the urban operations bargaining unit are covered from the date they were hired as regular employees. A regular employee is a permanent employee, full-time or part-time.

Part-time employees hired before March 10, 1985 who chose not to join and who are still part-time are not automatically covered. These employees have to pass a medical exam if they want to be covered by the plan.

Temporary employees working in Group 3 (maintenance) positions are covered, as are a small number of temporary employees who are entitled to the Disability Insurance benefit under clause 44.35 (Acquired Rights Regarding Entitlements) of the collective agreement.

Rural and Suburban Mail Carriers (RSMCs) are not eligible for coverage.

When does coverage end? Coverage ends on whichever one of these comes first:

- when your employment ends *(unless you are receiving DI at the time)*
- when you transfer into a position that does not qualify for DI, such as a temporary position
- when you retire *(unless you are receiving DI at the time)*
- when you reach age 64 and 9 months. *(Note, though, that you can receive DI benefits until you turn 65.)*

Can my coverage continue under special circumstances? You do not lose your Disability Insurance coverage if you are on benefits when your employment ends or when you take early medical retirement. In these circumstances, you will continue to receive disability payments for as long as you qualify medically.

For example, an employee receiving Disability Insurance benefits who is released by Canada Post for excessive absenteeism will continue to receive DI payments as long as he or she qualifies medically.

Does my coverage continue when I am off work (on leave)?

Maternity, Parental and Adoption Leave	DI coverage continues. CPC pays its share of the premiums and you pay your share of the premiums when you return to work
Any other leave of absence without pay of more than 30 calendar days (e.g. Education Leave, Care and Nurturing Leave, Sabbatical Leave, Personal Leave, Relocation Leave or leave for other reasons	Coverage continues. You must pay BOTH yours & employers share of the premiums when you return to work

Before going on any type of leave you should check to confirm your entitlements with a CUPW Shop Steward or a local Union officer. Also ensure that both the employer and CPC Human Resources / AccessHR are informed.

When you return to work, Canada Post will deduct the money owing from your pay, for a period twice as long as the period of your leave.

What do you get on DI? The Disability Insurance Plan pays you 70% of the salary you earned when you went on disability. This includes:

- Your hourly wage
- Rest Period Allowance (RPA)
- Isolated Post Allowance (IPA)

If you are a part-time employee, your DI benefit is based on your scheduled hours at the time of your disability.

If you are a part-time employee in an acting full-time position at the time of your disability, your DI benefit will be based on the full-time salary.

DI does **not** include:

- Boot allowance
- Shift premiums
- Householder payments
- Overtime

Wage increases that come into effect while you are on DI do not increase the amount of your DI benefit. However, your benefit does go up if there is a retroactive wage increase, provided the retroactive date is before you started getting benefits.

The DI benefit is adjusted every January by the cost of living. It can increase by up to 3% per year.

Your benefits are fully taxable as income. To reduce your tax payable when you are on DI, you can deduct the amount you paid in premiums since December 31, 1967 from your taxable income. You may also qualify for a Disability Tax Credit. You will need to apply for the credit and can obtain the form from the Canada Revenue Agency.

While on benefits, you can ask Sun Life to deduct income tax automatically from each cheque. This is known as "deduction at source". You will have to send a completed TD-1 form to Sun Life. This form is available from the Canada Revenue Agency. *If you live in Quebec, provincial income tax is automatically deducted at source.*

- Deduction at source is a good idea. It means you won't be hit with a big sum of money to pay back when tax time rolls around. If you choose not to have income tax automatically deducted from your benefit cheques, make sure to plan to save enough money to cover the taxes you will owe.
- Pension contributions are also tax deductible, regardless of whether you keep up your pension contributions while you are on DI, or pay them when you return to work. To continue paying into your pension while you are on DI, contact Pension Administration at CPC.

What happens to your other benefit plans when you are on DI:

- **Annual leave (paid or unpaid)** - No accumulation of annual leave credits while on disability.
- **Disability Insurance Plan** - You do not pay Disability Insurance premiums if you are receiving disability payments. Your premiums are waived.
- **Basic Life Insurance Plan** - Coverage continues. You must pay your share of the premiums when you return to work.
- **Dental Plan -** Coverage continues. You must pay your share of the premiums when you return to work.
- **Extended Health Care Plan -** Coverage continues. You must pay your share of the premiums when you return to work. *EHCP is an optional plan. You can also cancel your coverage at any time, including during a period of a leave of absence, but if you cancel your coverage during a leave of absence you cannot re-apply until you return to work.*

- **Vision/Hearing Plan -** Coverage continues. The employer pays the full share of the premiums.
- **Provincial and Territorial Health Care Plans (where premiums are payable) -** Coverage continues. The employer pays the premiums on your behalf, and you must re-pay your share when you return to work.
- **Canada Post Registered Pension Plan (CPRPP) -** The first three months on DI (sick leave without pay) will be counted as pensionable service. You may chose whether to have the remainder of your time on DI counted as pensionable service, but you must tell CPC Human Resources / AccessHR. You should also contact AccessHR about your options for payment of your contributions.

When you return from disability leave, how do you pay back the money you owe for other benefit plan premiums? When you return to work, Canada Post will deduct the money owing from your pay, but over a period twice as long as the period of your leave.

In cases of financial hardship, arrangements can be made for a longer pay-back period. *(See Clause 35.06 of the collective agreement — Recovery of Overpayment.)*

If you retire or stop working for Canada Post while on disability, Canada Post will bill you for the money you owe for other benefit premiums.

- **CUPW Life Insurance** - The union offers CUPW life insurance through Coughlin Insurance. This plan is different from the life insurance you have through the CUPW-Canada Post collective agreement. All CUPW members have basic life insurance coverage through the union plan at no cost.

  You can buy additional coverage. You pay premiums for this additional coverage. Basic life insurance coverage continues when you are off work as long you are a union member in good standing.

  You maintain your "good standing" by paying your union dues. If you are on DI, you can ask your union local to allow you to pay your dues at a later date. If you are facing serious financial hardship, you might be able to get your dues waived

  If you purchased extra insurance coverage from the union plan and are off work on disability for more than six months, you can apply to Coughlin Insurance to have your life insurance premiums waived. *Request the premium waiver promptly. The insurance company will not accept requests made more than 12 months after the date you became disabled.*

Qualifying for benefits:

Contact your union! You are urged to contact your Local Union Health & Safety Officer / First Vice-President before making a claim in order to insure that your rights are protected.

(The First Two Years): If you are ill or injured and want to make a disability claim, we strongly urge you to contact your shop Steward or the Local's Health and Safety officer / First Vice President right away for assistance with your claim.

When you apply for Disability Insurance, you will be dealing with the insurance company, Sun Life Financial. The insurance company may require you to undergo medical examinations and assessments to prove your claim.

In the CUPW-Canada Post collective agreement, Disability Insurance is in Clause 30.06.

Disability Insurance cases can be complex — every situation is different. **Make sure your rights are protected. Get your union involved right from the start.**

To qualify for Disability Insurance benefits, you must meet the insurance company's definition of being "totally disabled". This means that a doctor must say that you can't do your job.

Be sure to apply for benefits if you are ill or injured for a long time. **Do not assume that you will not qualify for benefits, or that the Short Term Disability (STD) plan will cover you for your entire illness — you have nothing to lose by applying.**

An example would be if you've had a heart attack and your doctor says you must be off work for nine months. If your disability claim is accepted, you can go on disability for up to two years.

During this two-year period, Sun Life will send letters to your doctor for updated medical information. Sun Life might ask you to undergo a medical exam by a doctor of their choice. The company might also ask you and your doctor to meet with a rehabilitation counsellor to assess whether you could participate in a gradual return-to-work program.

If you refuse Sun Life's requests, the insurance company could cut you off for non-compliance.

It is important to remember to always keep good records:

- Copies of any letters or forms you send to Sun Life or Canada Post.
- The names of Sun Life representatives and/or doctors with whom you have contact, as well as notes about these discussions, including dates.

Remember to contact your Local Union Health & Safety Officer / First Vice-President to help you make your claim and to make sure your rights are protected. **We know that we are repeating ourselves, but it is important!**

Note: Two other benefits are also related to disability, but are not part of the Disability Insurance Plan are:

- Short Term Disability (STD) Plan is in Article 20 of the collective agreement. You use your STDP before you can go on disability insurance.
- Injury-on-Duty Leave is in Article 24 of the collective agreement. Workplace injuries are covered by Injury-on-Duty Leave (IOD). This leave kicks in once your workplace injury is confirmed by the provincial or territorial workers' compensation board.

(When do I start receiving benefits?) If your claim is approved, benefits start on whichever one of these is the later date:

- If you were **not hospitalized** you must first use 5 personal days (or 5 days of leave without pay - *if you do not have any Personal Days*). You must then apply to Great West Life (GWL) for 30 weeks of Short Term Disability before applying for long term disability (DI). *GWL is suppose to inform you that you are getting close to the completion of your 30 weeks of STDP and mention that you should apply for long term disability (DI) if the condition is expected to continue.*
- **If hospitalized** you must inform your supervisor that you will be on Short Term Disability. Your Supervisor will contact GWL and inform them that you will be accessing up to 30 weeks of the STDP. You may be required to fill out STDP forms and you must also apply for long term disability (DI). *GWL is suppose to inform you that you are getting close to the completion of your 30 weeks of STDP and mention that you should apply for long term disability (DI) if the condition is expected to continue.*
- The day your Injury-on-Duty Leave ends. (This means your workers' compensation board will have disallowed your WCB claim). You will then receive DI benefits after you have accessed the following:
    - If you were **not hospitalized** you must first use 5 personal days (or 5 days of leave without pay - *if you do not have any Personal Days*). You must then apply to Great West Life (GWL) for 30 weeks of Short Term Disability before applying for long term disability (DI). *GWL is suppose to inform you that you are getting close to the completion of your 30 weeks of STDP and mention that you should apply for long term disability (DI) if the condition is expected to continue*
    - **If hospitalized** you must inform your supervisor that you will be on Short Term Disability. Your Supervisor will contact GWL and inform them that you will be accessing up to 30 weeks of the STDP. You may be required to fill out STDP forms and you must also apply for long term disability (DI). *GWL is suppose to inform you that you are getting close to the completion of your 30 weeks of STDP and mention that you should apply for long term disability (DI) if the condition is expected to continue.*

(After two years): After two years, it becomes more difficult and complex to continue to qualify for DI benefits because the definition of "total disability" changes. At this point, total disability means you can't do **any** job in the community that would pay you two-thirds of what your regular Canada Post job paid.

As your two-year cut-off date approaches, make sure to go to your doctor so that you can start preparing the information you need in order to qualify under the new definition of total disability. Whether or not you qualify will depend on your specific disability and the information you can provide.

As long as you are totally disabled, monthly DI benefits can continue until you turn 65. From time to time, Sun Life will want proof that you are still totally disabled.

If your claim to stay on disability benefits is turned down after two years, it will automatically go to appeal through the same process described in Appendix N of the collective agreement. If this doesn't happen you should contact the Union as soon as possible.

How to make a claim and get the forms:

To collect money from the Disability Insurance Plan, you need to make a claim. Sun Life must approve your claim.

Start right away. Starting early will help reduce delays and gaps in income. Start your claim as soon as you think you will be off work for a long time.

Great West Life is supposed to send you an information package near your completion of the 30 weeks STDP. The Disability Claim Kit should be included in GWL information package.

The Local Union Health & Safety Officer / First Vice President can also get a Disability Claim Kit for you.

The Disability Claim Kit contains 5 forms:

- Employee's Statement
- Employee's Medical Information and Attending Physician's Statement
- Voluntary Authorization
- Employer's Statement
- Rehabilitation Information

You fill out part or all of the *Employee's Statement*, *Employee's Medical Information and Attending Physician's Statement*, and the Voluntary Authorization for union representation.

On the Employee's Statement form: You need to provide specific information, such as facts about your illness, whether you have applied for a Disability Pension under the Canada/Quebec Pension Plan and your work history.

Do **NOT** fill out this form until your Physician / Doctor has completed his/her part of the Employee's Medical Information and Attending Physician's Statement form.

It is Important to remember:

- Read all the forms carefully before you fill them out. Fill them out properly and fully to avoid delays.
- Make sure you include your Canada Post employee number (HRID number) and Social Insurance Number where requested on the forms.
- Keep good records of all your medical information — make copies of doctors' notes and keep track of your medical appointments.
- Make copies of your completed Disability Insurance claim forms.

It takes time and effort to fill out this form. If you need to, get help from your friends and family to fill it out. If you are unsure about how to fill out any part of this form, please contact your Local Union Health & Safety Officer / First Vice President for assistance.

Signing The Form: The Employee's Statement contains two sections that ask for your signature:

- Section 12 (*Your declaration and authorization*). This section authorizes the employer and your doctor to provide information to Sun Life. **You should sign this section**.
- Section 13 (*Authorization to exchange medical information*). This section authorizes Sun Life to share your medical information with Canada Post. Signing this section is voluntary. However, if you do sign, you will be giving Sun Life and Canada Post the right to be in touch about your case without your knowledge. **It is neither necessary nor advisable for you to sign this section**.

    - Be sure to highlight how your illness or injury has affected your ability to work and carry on with your normal life (Section 3 — About your illness or injury). For example, your disability might have affected your ability to cook or garden, go on outings with your children, clean the house or use a computer. Before your disability, you might have gone to the movies a lot or coached sports.

Sun Life may send you other forms, such as a Lifestyle Questionnaire. You need to fill out this form and return it to Sun Life promptly. The questionnaire is lengthy. It includes questions about: your activities around the house; your education, skills and work experience; rehabilitation; doctors' visits; and how you feel about returning to work. If you need help filling out this form, please contact your local union office.

Return your completed Employee's Statement form to either CPC Human Resources/AccessHR or send it directly to Sun Life Assurance. **The Union recommends the completed forms be sent directly to Sun Life since they contain private and confidential medical information.**

On the Employee's Medical Information and Attending Physician's Statement form: You have to fill out Part 1 of this form with information about your illness or injury and your medical history. Your doctor will fill out the other parts of this form. Do not fill out your part of the form until your Physician / Doctor has completed his/her part of the form. You or your doctor can return the form directly to Sun Life.

You need to provide specifics about all the doctors you've seen for your injury or illness: their names and addresses, and the dates of your visits. You also need to include similar information about any doctors you visited and hospitals that treated you over the past five years for any other illness or injury.

Make sure your doctor:

- Makes a detailed report about why you can't do your job, filling in all the required parts of the form.
- Outlines your disability within the DI plan's definition of total disability. Total disability means you have an illness or injury that prevents you from doing your job.

Voluntary Authorization form: This form authorizes a union representative to act on your behalf in your claim and in case of an appeal. CUPW strongly urges you to fill in this form. Disability issues are complicated and time-consuming.

Canada Post completes the Employer's Statement form and forwards the Rehabilitation Information to the Occupational Health Services Representative. This representative completes the Rehabilitation Information form and returns it to Sun Life.

Rehabilitation programs: While you are on DI, Sun Life can make you undergo assessments for a rehab program or see a doctor of their choice.

The insurance policy states that failure to comply could result in suspension of DI benefits. Rehab can involve gradual return-to-work or modified duties. Any rehab program requires the agreement of Sun Life, Canada Post and your doctor.

Contact your local union any time you are approached by Sun Life or CPC about the possibility of a rehab program. Sun Life could try to pressure you into a program that may not be best for you. Use your right to have a union representative present when you are in discussions with the Sun Life rehab counsellor.

- If you are involved in a rehabilitation program, a rehabilitation counsellor might ask to visit you at home. You do not have to agree to a home visit. **The Union strongly recommends that you do not agree to a home visit.** If you do not want a home visit, suggest another location, e.g., a coffee shop, CUPW office, or Sun Life office, if there is one in your community.. Make sure to have a local union representative with you.
- Your DI benefit and any pay you get from a return-to-work program can't add up to more than what you were earning before you went on disability.
- You can get money back for certain costs related to rehab, such as training, visual aids or special equipment. The maximum you can get is three times your gross monthly benefit.

Members who submit a claim for DI are often in a sensitive state because of their illness. It helps to have someone in your corner during a vulnerable time. Contact your Local Union Health & Safety Officer / First Vice-President before making a claim in order to insure that your rights are protected.

Other disability benefits: If you are applying for Disability Insurance benefits, you will be expected to apply for a total disability pension from Canada/Quebec Pension Plan (C/QPP). Contact your nearest C/QPP office or visit www.sdc.gc.ca. Your claim for DI will not be jeopardized if you do not qualify for the C/QPP disability pension.

If you are totally disabled, you could qualify for benefits under the Canada Post Registered Pension Plan (CPRPP). This is called a medical retirement. There is no pension penalty if you are approved for a medical retirement. However, your pension will be calculated based on your current years of service. **You are strongly advised to contact the union and consider all the financial pros *and* cons before deciding to go down this road.**

If you decide to go this route, contact Canada Post Pension Plan at (877) 480-9220 and ask for a medical retirement package. You will need to take this package to your doctor to be filled out. This information will then be sent to Health Canada, which decides whether or not you qualify for a medical retirement.

It is important to remember that:

- The total benefits received from these pension plans cannot exceed the amount you are receiving from DI.
- Sun Life will top up your pension payments so that your total income adds up to the amount you were getting on DI.
- DI benefits continue as long as you qualify medically. You cannot receive DI benefits beyond age 65.

What if your DI claim is turned down: You will get a written decision from Sun Life. As soon as this happens, contact your Local Union Health & Safety Officer / First Vice President for assistance in making an appeal. You are unlikely to win your appeal without the union's help

You may have to supply additional medical information to make sure that your appeal is successful. Talk to your union representative about this. Sun Life will routinely start an appeal process for your claim. The appeal process is outlined in Appendix N of the collective agreement (Disability Insurance Plan Appeal Process):

- **Step 1** Your claim is sent to a Sun Life disability team leader within five working days. **(Note that normally none of the time limits outlined in the appeal process are met.)** The team leader reviews the claim with the occupational health nurse and the union representative. The union can only be involved if you signed the Voluntary Authorization form. The team leader is supposed to give a written decision of the appeal within 10 working days from the date your claim was denied.
- **Step 2** If the team leader denies your appeal, your claim goes up another level to a Sun Life senior disability analyst. You might have to submit more medical information. The senior disability analyst issues a final decision within 10 working days of getting the file and any new medical information.
- **Step 3** If your claim is denied at this stage, you can't file a grievance. The only other thing you can do is go to the courts. This option is almost never used because of the hassles, time and expense involved. Make sure you do everything you can to avoid ending up in this situation by getting the union involved in your claim right from the start. ***The union does not take Disability Insurance cases to court.***

What if Sun Life cuts off your DI benefits: Sun Life must inform you in writing before cutting you off benefits. If Sun Life cuts off your DI benefits but your doctor says you still can't go back to work, you should immediately contact the union. Your union will help you appeal this cut-off.

Option:

- You can stay on leave without pay for up to five years. However, the time you were on DI counts leave without pay so it must be subtracted from the five year limit.

If I go back to work and discover I can't handle the work, will I have to start a new claim? Yes. Even if you go back for 1 day you have to start again with the Short Tem Disability Plan. You must once again follow the process as outlined in the "When do I start receiving benefits?" portion of this information package.

If you have any questions regarding **Disability Insurance** you can contact CPC Human Resources / AccessHR at:

AccessHR
Canada Post Corporation
B125 2701 Riverside Drive
Ottawa, Ont
K1A 0B1
1-877-807-9090
www.accesshr@canadapost.ca

You can also contact Sun Life at:

Sun Life Assurance
Po Box 48810 Station Bentall
Vancouver, BC
V7X 1A6
(Vancouver) 1-800-663-5655 or (Toronto) 1-800361-9606

On the following pages you will find:

1) Employee's Statement form *(6 pages)*
2) Employee's Medical Information and Attending Physician's Statement form *(6 pages)*
3) Voluntary Authorization *(2 pages)*
4) Disability Tax Credit Certificate *(12 pages)*

CANADA POST / POSTES CANADA

From anywhere... to anyone

Employee's Statement

Claim for Disability Insurance Policy No. 50800

Sun Life Financial

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.

IMPORTANT:

- Please complete this form and return it to Sun Life Financial. The address is included at the end of this form.
- You must notify Sun Life Financial promptly if:
  - your medical condition improves so that you are able to work,
  - you begin working either as a full-time or part-time employee or as a self-employed person, or
  - you change your address.
- Fraudulent claims are very costly for all participants in benefit plans. It is Sun Life Financial's practice to prosecute fraudulent claims.

1 About you

Last Name	Given Name	Maiden Name (for Quebec residents)
Address (street number and name, apartment or suite)		
City	Province	Postal Code
Home Telephone No.	Date of Birth (d/m/y)	Employee Identification No.

How are you sending the Employee's medical Information and Attending Physician's Statement? (check one)

☐ I am sending the form to Sun Life Financial.

☐ My doctor is sending the form directly to Sun Life Financial.

2 About your employment

Team Leader	Telephone No.
Work Location Postal Code	Shiftt
Work Location (City, Plant or Post Office)	

3 About your illness or injury

1. From what date did your illness or injury prevent you from working? Date (d/m/y)

2. Are you confined to your house? No ☐ Yes ☐ Are you confined to your bed? No ☐ Yes ☐

   Are you confined to hospital? No ☐ Yes ☐

3. Describe your daily activities.

4. Have your normal daily activities been limited in any way since your illness or injury began?
   No ☐ Yes ☐▶ If yes, please give details.

4 Illness or injury as a result of an accident

1. Is your illness or injury the result of an accident?
   No ☐▶ Continue with the next section **"Canada/Quebec Pension Plan benefits."**
   Yes ☐▶ Answer the following questions.

2. Where did the accident happen?
   At home ☐
   At work ☐
   Other ☐

3. When did the accident happen? Date (d/m/y)

4. How did the accident happen?

5. If it was a motor vehicle accident, were you the driver? No ☐ Yes ☐

6. If your illness or injury is the result of an accident, are you taking legal action against any other person or organization?

Yes ☐▶

Name of Lawyer		
Address		Telephone
City	Province	Postal Code

No ☐▶ Please explain why you are not taking legal action.

5 Canada/Quebec Pension Plan benefits

1. Have you applied for a Disability Pension under the Canada/Quebec Pension Plan?

Yes ☐▶ When did you apply? Date (d/m/y)

No ☐▶ Give reasons why you have not applied.

2. If you have applied for a Disability Pension, has your application been approved?

Yes ☐▶ Please include a copy of the Notice of Entitlement with this form.

No ☐▶ If you have been denied or you are appealing a decision, please explain and give dates.

6 Your other income

Please list any amounts of money you are currently receiving or expect to receive each month from the following sources. We may take some of these amounts into consideration when we calculate your Long-Term Disability benefit.

Source	Name of source & Policy Number	Have you applied for this income? Yes	No	Are you receiving or do you expect to receive this income? Current	Expected	Amount per MONTH
Other Group/Association Plans		☐	☐	☐	☐	
Other Government Plans		☐	☐	☐	☐	
Auto insurance		☐	☐	☐	☐	
Canada Post Pension Plan		☐	☐	☐	☐	
Criminal Victims Benefit		☐	☐	☐	☐	
Other (please give details)		☐	☐	☐	☐	

7 Workers' Compensation benefits

1. Are you receiving, or do you expect to receive, Workers' Compensation benefits? No ☐ Yes ☐▶ Please continue.

   What is the claim number ☐ How much is the benefit per week? $ ☐

2. Have you attached a copy of a decision letter from Workers' Compensation Board (WCB) or CSST, if applicable?

   No ☐▶ If no, is WCB's or CSST's decision pending? No ☐ Yes ☐

   Yes ☐

3. Have you received a permanent disability award?

   No ☐▶

   Yes ☐▶ When was the permanent disability award approved? Date (d/m/y) ☐

   What was the effective date of the permanent disability award? Date (d/m/y) ☐

   Was (or is) it a monthly benefit? No ☐ Yes ☐▶ What was (or is) the amount? $ ☐

   Was it a lump sum settlement? No ☐ Yes ☐▶ What was the amount? $ ☐

4. If your claim has been denied or terminated, have you appealed the decision?

   Yes ☐▶ If yes, when did you appeal it? Date (d/m/y) ☐

   No ☐▶ If no, please explain why.

   ☐

   What level of appeal was it (if known)?

   Please describe.

8 Your education and acquired skills

1. What is the highest grade level you completed or the highest degree you obtained?

2. Please describe other educational training or skills upgrading (include on-the-job training, special interest courses, etc.). In addition, list any other skills you have acquired. These skills may include typing, computer skills, operation of equipment, supervisory skills, special licenses, etc. They may also include skills acquired through volunteer work, hobbies and interests. Please use extra sheets if necessary.

9 Your work history

Attach a resume if available.

From	To	Employer	Job Title and Duties

10 Returning to work

1. When do you expect to be able to return to your own job? Date (d/m/y)

2. When do you expect to be able to return to do any other job? Date (d/m/y)

3. Have you tried to return to work already?

   No ☐

   Yes ☐► Please answer the following questions

   What were the dates that you returned to work?

   From Date (d/m/y) to Date (d/m/y)

   If your return to work was not successful, please explain why.

11 Automatic deposit of your monthly benefit payments

For your convenience, your Disability Insurance payments will be deposited directly into your account at any bank, trust company, Caisse populaire or credit union in Canada. If you want payments deposited into a chequing account, please attach a voded cheque from that account. If you want payments deposited into a savings account, please provide details.

Bank Name		
Address		
Bank Number ☐☐☐	Branch/Transit Number ☐☐☐☐☐	Account Number ☐☐☐☐☐☐☐

12 Your declaration and authorization

Fraudulent claims are costly for all participants in benefit plans. As Administrator of this plan, we may verify the accuracy of the information given in support of your claim.

If you are age 60 or over, please attach a copy of your birth certificate, baptismal record, passport or drivers license as proof of age.

You must also sign and complete the Member's Authorization on the Attending Physician's Statement.

- I certify that the statements on this form are true and complete.
- I understand that Sun Life Assurance Company of Canada may investigate this claim. I authorize Sun Life Assurance Company of Canada, it's agents and service providers to use and exchange information needed for underwriting, administration and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. I agree that Sun Life Assurance Company of Canada and my Plan Sponsor may share financial information related to my claim for purposes relevant to the management of the Plan. I understand that the information about me pertaining to this claim may be reviewed in the event this Plan is audited.
- I agree that a photocopy of this authorization or electronic version is as valid as the original and shall continue to have effect throughout the duration of my claim.
- I authorize Sun Life Assurance Company of Canada and my Plan Sponsor and their medical consultants to exchange information about me, except for details relating to diagnosis, treatment or medication, that is relevant to this claim for the purpose of planning and managing my rehabilitation and return to work.
- I authorize Sun Life Assurance Company of Canada to provide to the Disability Management Provider for Canada Post copies of relevant correspondence relating to this claim for the purpose of monitoring the status and progress of this claim.
- I agree to notify Sun Life Assurance Company of Canada promptly if there is a change in my condition that affects my ability to return to work or a change in my monthly income.

Name (please print)	
Signature X	Date (d/m/y)

13 Authorization to exchange medical information

a) I hereby authorize the Disability Management ("DM") provider for Canada Post to provide to Sun Life Assurance Company of Canada a copy of all of my medical information including specific test results, diagnosis, treatment, narrative comments and independent medical examination report, which the DM provider for Canada Post has in its possession in connection with my claim under the short-term disability program for the purpose of assisting in the transition and subsequent adjudication of any claim I may make under the Long Term Disability Insurance Plan.

Name (please print)	
Signature X	Date (d/m/y)

To facilitate rehabilitation, the DM provider for Canada Post will request copies of relevant medical information related to my claim under the Long Term Disability Insurance Plan from SunLife Assurance Company of Canada. This information will be forwarded confidentially to the DM provider for Canada Post. It will be filed in my Employee Health Record and will only be available to the DM provider for Canada Post.

I understand that this is a voluntary authorization and that I do not have to sign it.

Name (please print)	
Signature X	Date (d/m/y)

To ensure prompt submission, please fax this form, along with any other information in support of your claim that you would like to submit, to the number that appears below for the Sun Life Assurance Company of Canada Group Disability Management Office that manages your claims. Please retain the original copy for your records. You do not need to mail information that you fax. If you are unable to fax this information, you can mail it to the appropriate address. If you are not sure which office to send your information to, please contact your Benefits Administrator.

Halifax:	Montreal:	Toronto:	Vancouver:
Fax: 1-866-639-7850	Fax: 1-866-639-7846	Fax: 1-866-639-7851	Fax: 1-866-639-7829
PO Box 11480 Stn CV	PO Box 11037 Stn CV	PO Box 950 Stn A	PO Box 48810 Stn Bentall
Montreal QC H3C 5P5	Montreal QC H3C 4W8	Toronto ON M5W 1G5	Vancouver BC V7X 1A6

CANADA POST / POSTES CANADA

From anywhere... to anyone

Employee's medical information and attending physician's statement

Claim for disability insurance policy no. 50800

Sun Life Financial

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.

To the attending physician: Please fill out this form completely and as soon as possible to ensure that there is no delay of any payments to the employee. Sun Life Assurance Company of Canada will use the information on this form to determine the employee's eligibility for disability benefits. Your accurate and detailed completion of this form will help us to arrive at a just decision. **The employee must complete and sign Part 1 of the form before you complete Part 2.** The employee is responsible for the cost of completing this form. If the employee's claim is approved, Sun Life Financial and Canada Post Corporation will jointly review the employee's progress and potential to return to work. From time to time, Sun Life Financial may request up-to-date medical or fitness information from you to support these reviews.

Part 1: Employee information (The employee must complete Part 1 of the form before the physician completes Part 2)

1 Employee information

Last name (Quebec residents – maiden name)	First name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
Address (street number and name)			Apartment or suite
City	Province		Postal code
Home telephone number	Employee identification number	Social insurance number (for tax purposes)	

2 About your illness or injury

Attach extra sheets, if necessary.

1. Please describe your present illness or injury and how it prevents you from working. Include a description of which duties of your job you are *unable* to perform because of your illness or injury. As well, list the duties of your job you are *able* to perform.

2. When did your symptoms first appear? Date (dd-mm-yyyy)

3. Have you ever had the same or similar illness or injury? ☐ No ☐ Yes If yes, please explain and give dates.

4. On what date did you first see a doctor for this illness or injury? Date (dd-mm-yyyy)

5. Is your illness or injury work related? ☐ No ☐ Yes If yes, please explain.

6. Did the doctor recommend a change in your daily habits or restrictions on the type of work you could do? ☐ No ☐ Yes If yes, please describe the change and the date the recommendation was made.

2 About your illness or injury (continued)

7. What treatment are you presently receiving (medicine, diets, advice from a doctor, physiotherapy, etc.)?

8. Do you have an active, valid driver's licence? ☐ No ☐ Yes If yes, please specify class
If your driving has been restricted as a result of your illness or injury, please give details.

9. List all the doctors you have seen for *this* illness or injury and any doctors you plan to see in the near future about *this* illness or injury.

Doctor	Address	Date of visit (dd-mm-yyyy)

3 Your general medical history

Attach extra sheets, if necessary.

1. List all of the doctors you have seen during the past five years for any other illness or injury.

Doctor	Address
Nature of illness	Date of visit (dd-mm-yyyy)

Doctor	Address
Nature of illness	Date of visit (dd-mm-yyyy)

2. Please list names and addresses of all hospitals where you have been treated during the past five years, including any type of surgery.

Hospital	Address
Nature of illness/surgery	Date of stay (dd-mm-yyyy)

Hospital	Address
Nature of illness/surgery	Date of stay (dd-mm-yyyy)

4 Employee's authorization and signature

I authorize my doctor to collect, use and disclose information with Sun Life Assurance Company of Canada, its agents, and service providers, for the purposes of Underwriting, administration and adjudicating claims under this plan. I agree that a photocopy or electronic version of this authorization is as valid as the original.

Signature	Date (dd-mm-yyyy)
X	

Part 2: Attending Physician's Statement

1 History

1. What was the date of the patient's first appointment for this illness or injury? Date (dd-mm-yyyy)

2. What was the date of the patient's latest appointment? Date (dd-mm-yyyy)

3. Did you recommend that the patient stop work? ☐ No ☐ Yes

   If yes, as of what date Date (dd-mm-yyyy)

4. How often are the patient's appointments?
   ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other Please specify:

5. Was the patient's illness or injury caused by an accident? ☐ No ☐ Yes
   If yes, give details and the date of the accident.

6. Describe the pertinent symptoms, their severity, their duration and their impact on the illness or injury (including the patient's ability to work).

7. When did the symptoms first appear? Date (dd-mm-yyyy)

8. Has the patient ever had a similar or related condition? ☐ No ☐ Yes
   If yes, state when and describe the condition.

9. Is the condition due to injury or illness caused by employment? ☐ Unknown ☐ No ☐ Yes
   If yes, give details.

10. Is the condition due to or related to pregnancy? ☐ No ☐ Yes If yes, give date of confinement.

    From Date (dd-mm-yyyy) to Date (dd-mm-yyyy)

11. How is the patient restricted or limited by the condition?

12. What is the patient's current status?
    ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

2 Clinical findings

Please describe the physical findings in relation to the illness or injury.

3 Diagnoses

What are the diagnoses that have led to the illness or injury? Please list in order of their importance to the patient's illness or injury and their impact on the claimant. If the condition is psychiatric, use DSM IV terminolgy.

4 Investigations

What procedures and examinations were done? Please include copies of the reports of X-rays, ECGs, laboratory data and all other investigations related to the illness or injury.

5 Treatment

1. Was the patient hospitalized? ☐ No ☐ Yes If yes, give dates.

   From Date (dd-mm-yyyy) to Date (dd-mm-yyyy)

2. Was surgery performed? ☐ No ☐ Yes If yes, give details.

Date (dd-mm-yyyy)	Type of surgery
Date (dd-mm-yyyy)	Type of surgery

3. What medications were given to the patient? Please include name, dosage and the dates of any medication changes.

4. Was surgery performed? ☐ No ☐ Yes If yes, give frequency and duration.

5. Was physiotherapy/chiropractic treatment given? ☐ No ☐ Yes If yes, give frequency and duration.

6. What other treatments were given?

5 Treatment (continued)

7. Please describe the results of the treatment plan.

8. How well has the patient been able to comply with the treatment plan?

9. Please give the names, specialties and appointment dates of any consulting physicians.

Name	
Speciality	Appointment date (dd-mm-yyyy)

Name	
Speciality	Appointment date (dd-mm-yyyy)

Name	
Speciality	Appointment date (dd-mm-yyyy)

Name	
Speciality	Appointment date (dd-mm-yyyy)

6 Cardiac

Complete if applicable.

1. What is the functional capacity (American Heart Association)? If class 3 or 4, please include a copy of stress test or cardiac echograms.

☐ Class 1 (no limitation) ☐ Class 2 (slight limitation)
☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

2. What is the latest blood pressure reading for the patient?

7 Return to work plan

1. Which of the following best describes the progress of the patient's condition since the patient stopped working? ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed

2. Please describe any functional (physical or psychological) restrictions of the patient.

3. In what period can recovery of usual functional abilities be anticipated?
☐ 1-3 months ☐ 4-6 months ☐ 7-9 months ☐ over 9 months

7 Return to work plan (continued)

4. Have you scheduled a reassessment for this patient? ☐ No ☐ Yes

   If yes, give date. Date (dd-mm-yyyy)

5. Please describe any other factors that may affect this patient's ability to return to work.

6. In your opinion, how motivated is the patient to return to work?
   ☐ Highly motivated ☐ Motivated ☐ Slightly motivated ☐ Not motivated

8 Additional information

1. In your opinion, does the patient have any physical or mental limitations that would prevent the patient from handling his/her own financial affairs? ☐ No ☐ Yes
   If yes, give details of any physical or mental limitations.

2. Would it be of assistance to speak to a Sun Life Assurance Company of Canada Medical Director?
   ☐ No ☐ Yes

9 Physician information

Any information provided by you to Sun Life Assurance Company of Canada regarding this claim may be disclosed to your patient and/or those authorized by him/her to receive such disclosure unless you notify us in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of your patient or in harm to a third party.

Last name	First name	
Address (street number and name)		Apartment or suite
City	Province	Postal code
Specialty	Telephone number	Fax number
Signature X		Date (dd-mm-yyyy)

To keep this document confidential, please send this form to the nearest Sun Life claims office listed below:

Halifax:	Montreal:	Toronto:	Vancouver:
Fax: 1-866-639-7850	Fax: 1-866-639-7846	Fax: 1-866-639-7851	Fax: 1-866-639-7829
PO Box 11480 Stn CV	PO Box 11037 Stn CV	PO Box 950 Stn A	PO Box 48810 Stn Bentall
Montreal QC H3C 5P5	Montreal QC H3C 4W8	Toronto ON M5W 1G5	Vancouver BC V7X 1A6

Voluntary Authorization for Union Representation and Release of Medical Information for Disability Insurance Claims Only - CUPW

Step 1. – To be completed by employee and sent Sun Life Financial with completed Disability Insurance application

I acknowledge that, under Appendix "N" of the CPC/CUPW collective agreement, I may authorize a Union Representative to represent me.

Therefore, I authorize a Union Representative to represent me in the process outlined in Appendix "N" of the collective agreement. I hereby authorize Sun Life Assurance Company of Canada ("Sun Life" or the Insurance Carrier) to release to my Union Representative all information, including medical information, contained in my file with Sun Life Assurance Company of Canada.

I agree that a photocopy of this authorization or electronic version is as valid as the original and shall continue to have effect throughout the duration of my claim.

Name of Employee	Signature of Employee
Employee Identification Number	Date
Work Location	City

Step 2: To be completed by Access HR and forwarded to CUPW Regional Office

_____

Name of Access HR representative, address and telephone number

Step 3: To be sent to CUPW Regional office by Access HR

Upon receipt of this form via facsimile, the Regional CUPW office will fill in the name of the Union Representative, as follows:

_____

Name, address and telephone number

The form will then be returned by the Regional CUPW office to Access HR indicated above who will distribute it to the following parties:

- Sun Life Regional Office
- Disability Management Provider
- Employee
- Employee's Benefits File

Employee Name: _____

NOTE: This second page of the authorization may be sent without the 1st page and will be considered as part of the original form. This situation may apply when a new union representative is assigned to this claim.

DISABILITY TAX CREDIT CERTIFICATE

This form is separated into two sections: the introduction and the form itself. The introduction includes the following:

- general information about the disability amount;
- definitions;
- how to change your return for previous years;
- what to do if you disagree with our decision about your eligibility;
- a questionnaire to help you determine if you may be eligible for the disability tax credit; and
- where you send this form.

The form itself includes an **application** (**Part A**), and a **certification** (**Part B**). Both parts of the form must be completed.

Who uses this form – and why?

Individuals who have a severe and prolonged (defined on the next page) impairment in physical or mental functions, or their legal representative, use this form **to apply** for the disability tax credit (DTC) by completing Part A of the form.

Qualified practitioners use this form **to certify** the effects of the impairment by completing Part B of the form.

Note

For information to help qualified practitioners complete this form, go to **www.cra.gc.ca/qualifiedpractitioners**.

What is the disability amount?

The disability amount is a non-refundable tax credit used to reduce income tax payable on your income tax and benefit return. This amount includes a supplement for persons under 18 years of age at the end of the year. All or part of this amount may be transferred to your spouse or common-law partner, or another supporting person. For more information, go to **www.cra.gc.ca/disability** or see Guide RC4064, *Medical and Disability-Related Information.*

The disability amount is entered on **line 316** (self), **line 318** (transferred from a dependant), or **line 326** (transferred from your spouse or common-law partner) of your income tax and benefit return when you are eligible for the DTC.

Are you eligible?

You are eligible for the DTC only if we approve this form. A qualified practitioner has to complete and certify that you have a severe and prolonged impairment and its effects. To find out if you **may** be eligible for the DTC, use the self-assessment questionnaire in this introduction.

If you receive Canada Pension Plan or Quebec Pension Plan disability benefits, workers' compensation benefits, or other types of disability or insurance benefits, **it does not necessarily mean you are eligible for the DTC**. These programs have other purposes and different criteria, such as an individual's inability to work.

The Canada Revenue Agency must validate this certificate for you to be eligible for the DTC. If we have already told you that you are eligible, do not send another form unless the previous period of approval has ended or if we tell you that we need one. **You must tell us immediately if your condition improves.**

You can send the form to us at any time during the year. By sending us your form before you file your income tax and benefit return, you may prevent a delay in your assessment. We will review your application before we assess your return. Keep a copy of the completed form for your records. **We do not accept photocopies or facsimile copies of this form when completed and signed.**

Fees – You are responsible for any fees that the qualified practitioner charges to complete this form or to give us more information. However, you may be able to claim these fees as medical expenses on line 330 or line 331 of your income tax and benefit return.

Related programs

If a child under 18 years of age is eligible for the DTC, that child is also eligible for the **child disability benefit**, an amount available under the Canada child tax benefit. For more information, go to **www.cra.gc.ca/benefits** or see Booklet T4114, *Canada Child Benefits.*

If you are eligible for the DTC and you have working income, you may be eligible for the **working income tax benefit disability supplement**. For more information, go to **www.cra.gc.ca/witb** or see line 453 in the *General Income Tax and Benefits Guide.*

If you are eligible for the DTC, you may be eligible to open a **registered disability savings plan**. For more information, go to **www.cra.gc.ca/rdsp** or see Guide RC4460, *Registered Disability Savings Plan.*

Do you use a teletypewriter (TTY)?

TTY users can call **1-800-665-0354** for bilingual assistance during regular business hours.

If you use an operator-assisted relay service, call **1-800-959-8281** during regular business hours. We need your written permission to discuss your information with the relay operator. Send a letter (we will keep it on file until you ask us to change it) to your tax centre giving us your name, address and social insurance number, the name of the telephone company that you are authorizing to discuss your information during relay calls, your signature, and the date you signed the letter.

Agents are available Monday to Friday (except holidays) from 8:15 a.m. to 5:00 p.m. From February 18 to April 30, these hours are extended to 9:00 p.m. on weekdays, and from 9:00 a.m. to 5:00 p.m. on Saturdays (except Easter weekend).

If you have a visual impairment, you can get our publications in braille, large print, etext, or MP3 by going to **www.cra.gc.ca/alternate** or by calling **1-800-959-2221**. You can also get your personalized correspondence in these formats by calling **1-800-959-8281**.

(Vous pouvez obtenir ce formulaire en français à **www.arc.gc.ca** ou en composant le **1-800-959-3376**.)

Canada

Definitions

Inordinate amount of time – is a clinical judgement made by a qualified practitioner who observes a recognizable difference in the time required for an activity to be performed by a patient. Usually, this equals three times the normal time required to complete the activity.

Life-sustaining therapy – You must meet **both** the following conditions:

- the therapy is required to support a vital function, even if it alleviates the symptoms; and
- the therapy is needed at least **3 times per week**, for an average of at least **14 hours per week**.

You must dedicate the time for the therapy – that is, you have to take time away from normal, everyday activities to receive it. If you receive therapy by a portable device (such as an insulin pump) or an implanted device (such as a pacemaker) the time the device takes to deliver the therapy does **not** count towards the 14-hour per week requirement. However, the time you spend setting up a portable device does count.

Do **not** include activities such as following a dietary restriction or regime, exercising, travelling to receive the therapy, attending medical appointments (other than appointments where the therapy is received), shopping for medication, or recuperating after therapy.

For 2005 and later years, life-sustaining therapy includes a regular dosage of medication that needs to be adjusted on a daily basis. The activities directly related to determining dosage are considered part of the therapy, except activities related to exercise, or following a dietary regime such as carbohydrate calculation.

The time spent by a primary caregiver performing and supervising activities related to the therapy of a child because of his or her age can be counted toward the 14-hour per week requirement.

Examples of life-sustaining therapy:

- Chest physiotherapy to facilitate breathing
- Kidney dialysis to filter blood

Markedly restricted – You are markedly restricted if, **all or substantially all of the time** (at least 90% of the time), you are unable or it takes you an inordinate amount of time (defined above) to perform one or more of the basic activities of daily living (see Question 4 on the next page), even with therapy (other than therapy to support a vital function) and the use of appropriate devices and medication.

Prolonged – An impairment is prolonged if it has lasted, or is expected to last, for a continuous period of at least 12 months.

Qualified practitioner – Qualified practitioners are medical doctors, optometrists, audiologists, occupational therapists, physiotherapists, psychologists, and speech-language pathologists. The table on page 2 of the form lists which sections of the form each can certify.

Significantly restricted – means that although you do not **quite** meet the criteria for markedly restricted, your vision or ability to perform a basic activity of daily living (see Question 4 on next page) is still substantially restricted all or substantially all of the time (at least 90% of the time).

How to change your return

If you need us to adjust a tax year to allow a claim for the disability amount, include Form T1-ADJ, *T1 Adjustment Request*, or a letter containing the details of your request, with your completed Form T2201.

If a representative is acting on your behalf you must provide us with Form T1013, *Authorizing or Cancelling a Representative*, or a signed letter authorizing the representative to make this request.

What if you disagree with our decision?

If we do not approve your form, we will send you a notice of determination to explain why your application was denied. Check your copy of the form against the reason given, since we base our decision on the information provided by the qualified practitioner.

If you have additional information from a qualified practitioner that we did not have in our first review of the form, send that information to the Disability Tax Credit Unit of your tax centre (see the next page) and we will review your file again.

You also have the right to file a formal objection to appeal the decision. The time limit for filing an objection is 90 days after we mail the notice of determination.

Note
Asking us to review your file again does not extend the time limit for filing an objection.

If you choose to file a formal objection, your file will be reviewed by the Appeals Branch. You should send either a completed Form T400A, *Objection – Income Tax Act*, or a signed letter to:

Chief of Appeals
Sudbury Tax Services Office
1050 Notre Dame Avenue
Sudbury ON P3A 5C1

You may also file an objection electronically through our secure Web page at **www.cra.gc.ca/myaccount**.

For more information, visit **www.cra.gc.ca** or see Pamphlet P148, *Resolving Your Dispute: Objection and Appeal Rights Under the Income Tax Act.*

What if you need help?

If you need more information after reading this form, go to **www.cra.gc.ca/disability** or call **1-800-959-8281**.

Forms and publications

To get our forms and publications, go to **www.cra.gc.ca/forms** or call **1-800-959-2221**.

Self-assessment questionnaire

Answer these questions to determine if you **may** be eligible for the disability tax credit (DTC). **This questionnaire does not replace the form itself.**

Note

If your answers indicate you **are not eligible** for the DTC, and you still feel that you should be able to claim it, see page 1 of the form for instructions on how to apply.

1. Has your impairment in physical or mental functions lasted, or is it expected to last, for a continuous period of at least 12 months?

Yes ☐ No ☐

If you answered **yes**, answer Questions 2 to 5 below.

If you answered **no**, you **are not eligible** for the DTC. To claim the disability amount, the impairment has to be **prolonged** (defined on the previous page).

2. Are you blind?

Yes ☐ No ☐

3. Do you receive **life-sustaining therapy** (defined on the previous page)?

Yes ☐ No ☐

4. Do the effects of your impairment cause you to be **markedly restricted** (defined on the previous page) all or substantially all of the time (at least 90% of the time) in one or more of the following basic activities of daily living, even with the appropriate therapy, medication, and devices?

- speaking
- hearing
- walking
- elimination (bowel or bladder functions)
- feeding
- dressing
- mental functions necessary for everyday life

Yes ☐ No ☐

5. Do you meet **all** the following conditions?

- Because of the impairment, you are **significantly restricted** (defined on the previous page) in two or more of the basic activities of daily living listed in Question 4, or you are **significantly restricted** in vision and one or more of the basic activities of daily living listed in Question 4, even with appropriate therapy, medication, and devices.
- These significant restrictions exist together, all or substantially all of the time (at least 90% of the time).
- The cumulative effect of these significant restrictions is equivalent to being **markedly restricted** (defined on the previous page) in a **single** basic activity of daily living.

Yes ☐ No ☐

If you answered **yes** to Question 1 and to any one of Questions 2 to 5, you **may be eligible** for the DTC. To apply for the DTC, complete Part A of the form. Then, take the form to a qualified practitioner who can certify the effects of the impairment for you by completing Part B of the form. If the qualified practitioner certifies the form, send it to us for approval. We will review the form and advise you in writing if you are eligible for the DTC.

If you answered **no** to all of Questions 2 to 5, you **are not eligible** for the DTC. For you to be eligible for the DTC, you have to answer **yes** to at least one of these questions. Even if you cannot claim the disability amount, you may have expenses you can claim on your income tax and benefit return. For more information, see Guide RC4064, *Medical and Disability-Related Information.*

Where do you send this form?

Complete and send the **original** certified form to the Disability Tax Credit Unit of your tax centre. Use the chart below to get the address.

If you are normally served by the tax services office in:	Send your form to the following address:
British Columbia, Regina, or Yukon	Surrey Tax Centre 9755 King George Boulevard Surrey BC V3T 5E6
Alberta, London, Manitoba, Northwest Territories, Saskatoon, Thunder Bay, or Windsor	Winnipeg Tax Centre PO Box 14006, Station Main Winnipeg MB R3C 0E5
Barrie, Sudbury (the area of Sudbury/Nickel Belt only), Toronto Centre, Toronto East, Toronto North, or Toronto West	Sudbury Tax Centre 1050 Notre Dame Avenue Sudbury ON P3A 5C1
Laval, Montréal, Nunavut, Ottawa, Rouyn-Noranda, Sherbrooke, or Sudbury (other than the Sudbury/Nickel Belt area)	Shawinigan-Sud Tax Centre PO Box 4000, Station Main Shawinigan QC G9N 7V9
Chicoutimi, Montérégie-Rive-Sud, Outaouais, Québec, Rimouski, or Trois-Rivières	Jonquière Tax Centre 2251 René-Lévesque Blvd Jonquière QC G7S 5J2
Kingston, New Brunswick, Newfoundland and Labrador, Nova Scotia, Peterborough, or St. Catharines	St. John's Tax Centre PO Box 12071, Station A St. John's NL A1B 3Z1
Belleville, Hamilton, Kitchener/Waterloo, or Prince Edward Island	Summerside Tax Centre 275 Pope Road Summerside PE C1N 6A2
International Tax Services Office (deemed residents, non-residents, and new or returning residents of Canada)	International Tax Services Office PO Box 9769, Station T Ottawa ON K1G 3Y4

DISABILITY TAX CREDIT CERTIFICATE

6729

Protected B when completed

Part A – To be completed by the person with the disability (or a legal representative)

Step 1: Complete Part A (**please print**). Remember to sign, where applicable, at the bottom of this page.

Step 2: Take this form to a qualified practitioner (use the table on the next page to find out who can certify the sections that apply). The qualified practitioner completes Part B.

Step 3: Complete and send the **original** certified form (Part A and Part B) to your tax centre (see the chart on the previous page). **This form must be submitted in its entirety** (pages 1 to 9).

When reviewing your application, if we need more information, we may contact you or a qualified practitioner (named on this certificate or any attached document) who knows about your impairment.

Information about the person with the disability

First name and initial	Last name	☐ Female ☐ Male
Mailing address (Apt No – Street No Street name, PO Box, RR)		Social insurance number
City	Province or territory / Postal code	Date of birth (Year Month Day)

Information about the person claiming the disability amount (if different from above)

First name and initial	Last name	Social insurance number

The person with the disability is: ☐ my spouse or common-law partner ☐ other (specify) _____

Answer the following questions for **all** of the years that you are claiming the disability amount for the person with the disability.

1. Does the person with the disability live with you? ☐ Yes ☐ No
   If **yes**, for which year(s)? _____
2. If you answered **no** to Question 1, does the person with the disability depend on you for regular and consistent support for one or more of the basic necessities of life such as food, shelter, or clothing? ☐ Yes ☐ No
   If **yes**, for which year(s)? _____

Give details about the regular and consistent support you provide for food, shelter or clothing to the person with the disability (if you need more space, attach a separate sheet of paper). We may ask you to provide receipts or other documents to support your request for the transfer of the disability amount.

_____

_____

_____

As the person claiming the disability amount, I certify that the information given on this form is, to the best of my knowledge, correct and complete.

Signature	Telephone number	Date (Year Month Day)
It is a serious offence to make a false statement.		

Authorization

As the person with the disability or their legal representative, I authorize the qualified practitioner(s) having relevant clinical records to provide or discuss the information contained in those records on or with this certificate to the Canada Revenue Agency for the purpose of determining eligibility for the disability tax credit or other related programs.

Signature	Telephone number	Date (Year Month Day)

Privacy Act, Personal Information Bank number CRA PPU 218

Part B – Must be completed by the qualified practitioner

Protected B
when completed

Before completing this form, read the instructions below.
For more information, go to **www.cra.gc.ca/qualifiedpractitioners**.

Your patient must have an impairment in physical or mental functions which is both severe and prolonged. You must assess the following two criteria of your patient's impairment **separately**:

- **Duration** of the impairment – The impairment must be prolonged (it must have lasted, or be expected to last, for a continuous period of at least 12 months).
- **Effects** of the impairment – The effects of your patient's impairment must be such that, even with therapy and the use of appropriate devices and medication, your patient is restricted all or substantially all of the time (at least 90% of the time).

  The effects of your patient's impairment must fall into one of the following categories:
  - Vision
  - Markedly restricted in a basic activity of daily living
  - Life-sustaining therapy
  - The cumulative effect of **significant restrictions** (for patients who are significantly restricted in two or more of the basic activities of daily living, including vision, but do not quite meet the criteria for **markedly restricted**)

Step 1: Complete **only** the section(s) on pages 3 to 8 that apply to your patient. See the table below to find out which page(s) to complete and to determine which sections you can certify.

Note
Whether completing this form for a child or an adult, assess your patient relative to someone of a similar chronological age who does not have the marked or significant restriction.

	Section:	Go to:	To certify the applicable section, you have to be a:
	Vision	Page 3	Medical doctor or optometrist
Markedly restricted in a basic activity of daily living	• Speaking	Page 3	Medical doctor or speech-language pathologist
	• Hearing	Page 3	Medical doctor or audiologist
	• Walking	Page 4	Medical doctor, occupational therapist, or physiotherapist (physiotherapist can certify only for 2005 and later years)
	• Elimination (bowel or bladder functions)	Page 4	Medical doctor
	• Feeding	Page 5	Medical doctor or occupational therapist
	• Dressing	Page 5	Medical doctor or occupational therapist
	• Performing the mental functions necessary for everyday life	Page 6	Medical doctor or psychologist
	Life-sustaining therapy	Page 7	Medical doctor
	Cumulative effects of significant restrictions in two or more basic activities of daily living, including vision (applies to 2005 and later years)	Page 8	Medical doctor or occupational therapist (occupational therapist can only certify for walking, feeding and dressing)

Step 2: Complete the "**Effects of impairment**," "**Duration**," and "**Certification**" sections on page 9.

Definition

Markedly restricted – means that **all or substantially all of the time** (at least 90% of the time), and even with therapy (other than therapy to support a vital function) and the use of appropriate devices and medication, either:

- your patient is unable to perform one or more of the basic activities of daily living (see above); or
- it takes your patient an **inordinate amount of time** (defined in the introduction of this form) to perform one or more of the basic activities of daily living.

Vision (Complete this section if applicable, and **all sections on page 9.**)

Not applicable ☐

Your patient is considered **blind** if, even with the use of corrective lenses or medication:

- visual acuity in **both** eyes is 20/200 (6/60) or less with the Snellen Chart (or an equivalent); or
- the greatest diameter of the field of vision in **both** eyes is 20 degrees or less.

Is your patient **blind**, as described above? Yes ☐ No ☐

If **yes**, in what year did your patient's blindness begin (this is not necessarily the same as the year in which the diagnosis was made, as with progressive diseases)? Year ☐☐☐☐

What is your patient's visual acuity **after correction**? Right eye _____ Left eye _____

What is your patient's visual field **after correction** (in degrees if possible)? Right eye _____ Left eye _____

Speaking (Complete this section if applicable, and **all sections on page 9.**)

Not applicable ☐

Your patient is considered **markedly restricted** in speaking if, all or substantially all of the time (at least 90% of the time), he or she is **unable** or takes an **inordinate amount of time** to speak so as to be understood by another person familiar with the patient, in a quiet setting, even with appropriate therapy, medication, and devices.

Notes

Devices for speaking include tracheoesophageal prostheses, vocal amplification devices, and other such devices.

An **inordinate amount of time** means that speaking so as to be understood takes **three times** the normal time required by an average person who does not have the impairment.

Examples of markedly restricted in speaking:

- Your patient must rely on other means of communication, such as sign language or a symbol board, all or substantially all of the time (at least 90% of the time).
- In your office, you must ask your patient to repeat words and sentences several times, and it takes an inordinate amount of time for your patient to make himself or herself understood.

Is your patient **markedly restricted** in speaking, as described above? Yes ☐ No ☐

Is the marked restriction in speaking present **all or substantially all of the time** (at least 90% of the time)? Yes ☐ No ☐

If **yes**, when did your patient's marked restriction in speaking begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)? Year ☐☐☐☐

Hearing (Complete this section if applicable, and **all sections on page 9.**)

Not applicable ☐

Your patient is considered **markedly restricted** in hearing if, all or substantially all of the time (at least 90% of the time), he or she is **unable** or takes an **inordinate amount of time** to hear so as to understand another person familiar with the patient, in a quiet setting, even with the use of appropriate devices.

Notes

Devices for hearing include hearing aids, cochlear implants, and other such devices.

An **inordinate amount of time** means that hearing so as to understand takes **three times** the normal time required by an average person who does not have the impairment.

Examples of markedly restricted in hearing:

- Your patient must rely completely on lip reading or sign language, despite using a hearing aid, to understand a spoken conversation, all or substantially all of the time (at least 90% of the time).
- In your office, you must raise your voice and repeat words and sentences several times, and it takes an inordinate amount of time for your patient to understand you, despite the use of a hearing aid.

Is your patient **markedly restricted** in hearing, as described above? Yes ☐ No ☐

Is the marked restriction in hearing present **all or substantially all of the time** (at least 90% of the time)? Yes ☐ No ☐

If **yes**, when did your patient's marked restriction in hearing begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)? Year ☐☐☐☐

Walking (Complete this section if applicable, and **all sections on page 9.**)

Not applicable ☐

Your patient is considered **markedly restricted** in walking if, all or substantially all of the time (at least 90% of the time), he or she is **unable** or requires an **inordinate amount of time** to walk even with appropriate therapy, medication, and devices.

Notes

Devices for walking include canes, walkers, and other such devices.

An **inordinate amount of time** means that walking takes **three times** the normal time required by an average person who does not have the impairment.

Examples of markedly restricted in walking:

- Your patient must always rely on a wheelchair outside of the home, even for short distances.
- Your patient can walk 100 metres (or approximately one city block), but only by taking an inordinate amount of time, stopping because of shortness of breath or because of pain, all or substantially all of the time (at least 90% of the time).
- Your patient experiences severe episodes of fatigue, ataxia, lack of coordination, and problems with balance. These episodes cause your patient to be incapacitated for several days at a time, in that he or she becomes unable to walk more than a few steps. Between episodes, your patient continues to experience the above symptoms, but to a lesser degree. However, these symptoms cause him or her to require an inordinate amount of time to walk, all or substantially all of the time (at least 90% of the time).

Is your patient **markedly restricted** in walking, as described above?	Yes ☐ No ☐
Is the marked restriction in walking present **all or substantially all of the time** (at least 90% of the time)?	Yes ☐ No ☐
If **yes**, when did your patient's marked restriction in walking begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)?	Year ☐☐☐☐

Elimination – bowel or bladder functions (Complete this section if applicable, and **all sections on page 9.**)

Not applicable ☐

Your patient is considered **markedly restricted** in elimination if, all or substantially all of the time (at least 90% of the time), he or she is **unable** or requires an **inordinate amount of time** to personally manage bowel or bladder functions, even with appropriate therapy, medication, and devices.

Notes

Devices for elimination include catheters, ostomy appliances, and other such devices.

An **inordinate amount of time** means that personally managing elimination takes **three times** the normal time required by an average person who does not have the impairment.

Examples of markedly restricted in elimination:

- Your patient needs the assistance of another person to empty and tend to his or her ostomy appliance on a daily basis.
- Your patient is incontinent of bladder functions, all or substantially all of the time (at least 90% of the time), and requires an inordinate amount of time to manage and tend to his or her incontinence pads on a daily basis.

Is your patient **markedly restricted** in elimination, as described above?	Yes ☐ No ☐
Is the marked restriction in elimination present **all or substantially all of the time** (at least 90% of the time)?	Yes ☐ No ☐
If **yes**, when did your patient's marked restriction in elimination begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)?	Year ☐☐☐☐

Feeding (Complete this section if applicable, and **all sections on page 9.**) Not applicable ☐

Your patient is considered **markedly restricted** in feeding if, all or substantially all of the time (at least 90% of the time), he or she is **unable** or requires an **inordinate amount of time** to feed himself or herself, even with appropriate therapy, medication, and devices.

Notes

Feeding oneself **does not** include identifying, finding, shopping for or otherwise procuring food.

Feeding oneself **does** include preparing food, **except** when the time associated is related to a dietary restriction or regime, even when the restriction or regime is required due to an illness or health condition.

Devices for feeding include modified utensils, and other such devices.

An **inordinate amount of time** means that feeding takes **three times** the normal time required by an average person who does not have the impairment.

Examples of markedly restricted in feeding:

- Your patient requires tube feedings, all or substantially all of the time (at least 90% of the time), for nutritional sustenance.
- Your patient requires an inordinate amount of time to prepare meals or to feed himself or herself, on a daily basis, due to significant pain and decreased strength and dexterity in the upper limbs.

Is your patient **markedly restricted** in feeding, as described above?	Yes ☐ No ☐
Is the marked restriction in feeding present **all or substantially all of the time** (at least 90% of the time)?	Yes ☐ No ☐
If **yes**, when did your patient's marked restriction in feeding begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)?	Year ☐☐☐☐

Dressing (Complete this section if applicable, and **all sections on page 9.**) Not applicable ☐

Your patient is considered **markedly restricted** in dressing if, all or substantially all of the time (at least 90% of the time), he or she is **unable** or requires an **inordinate amount of time** to dress himself or herself, even with appropriate therapy, medication, and devices.

Notes

Dressing oneself **does not** include identifying, finding, shopping for or otherwise procuring clothing.

Devices for dressing include specialized buttonhooks, long-handled shoehorns, grab rails, safety pulls, and other such devices.

An **inordinate amount of time** means that dressing takes **three times** the normal time required by an average person who does not have the impairment.

Examples of markedly restricted in dressing:

- Your patient cannot dress without daily assistance from another person.
- Due to pain, stiffness, and decreased dexterity, your patient requires an inordinate amount of time to dress on a daily basis.

Is your patient **markedly restricted** in dressing, as described above?	Yes ☐ No ☐
Is the marked restriction in dressing present **all or substantially all of the time** (at least 90% of the time)?	Yes ☐ No ☐
If **yes**, when did your patient's marked restriction in dressing begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)?	Year ☐☐☐☐

Mental functions necessary for everyday life

Not applicable ☐

(Complete this section if applicable, and **all sections on page 9.**)

Your patient is considered **markedly restricted** in performing the mental functions necessary for everyday life (described below) if, all or substantially all of the time (at least 90% of the time), he or she is **unable** or requires an **inordinate amount of time** to perform them by himself or herself, even with appropriate therapy, medication, and devices (for example, memory aids and adaptive aids).

Note
An **inordinate amount of time** means that your patient takes **three times** the normal time required by an average person who does not have the impairment.

Mental functions necessary for everyday life include:

- adaptive functioning (for example, abilities related to self-care, health and safety, abilities to initiate and respond to social interaction, and common, simple transactions);
- memory (for example, the ability to remember simple instructions, basic personal information such as name and address, or material of importance and interest); and
- problem-solving, goal-setting, and judgement, taken together (for example, the ability to solve problems, set and keep goals, **and** make appropriate decisions and judgements).

Note
A restriction in problem-solving, goal-setting, or judgement that markedly restricts adaptive functioning, all or substantially all of the time (at least 90% of the time), would qualify.

Examples of markedly restricted in the mental functions necessary for everyday life:

- Your patient is unable to leave the house, all or substantially all of the time (at least 90% of the time) due to anxiety, despite medication and therapy.
- Your patient is independent in some aspects of everyday living. However, despite medication and therapy, your patient needs daily support and supervision due to an inability to accurately interpret his or her environment.
- Your patient is incapable of making a common, simple transaction, such as a purchase at the grocery store, without assistance, all or substantially all of the time (at least 90% of the time).
- Your patient experiences psychotic episodes several times a year. Given the unpredictability of the psychotic episodes and the other defining symptoms of his or her impairment (for example, lack of initiative or motivation, disorganized behaviour and speech), your patient continues to require **daily** supervision.
- Your patient is unable to express needs or anticipate consequences of behaviour when interacting with others.

Is your patient **markedly restricted** in performing the mental functions necessary for everyday life, as described above?	Yes ☐ No ☐
Is the marked restriction in performing the mental functions necessary for everyday life present **all or substantially all of the time** (at least 90% of the time)?	Yes ☐ No ☐
If **yes**, when did your patient's marked restriction in the mental functions necessary for everyday life begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)?	Year ☐☐☐☐

Life-sustaining therapy

(Complete this section if applicable, and **all sections on page 9.**)

Not applicable ☐

Life-sustaining therapy for your patient must meet **both** of the following conditions:

- Your patient needs this therapy to support a vital function, even if this therapy has alleviated the symptoms.
- Your patient needs this therapy at least 3 times per week, for an average of at least 14 hours per week.

Your patient must dedicate the time for the therapy—that is, the patient has to take time away from normal, everyday activities to receive it. If your patient receives therapy by a portable device, such as an insulin pump, or an implanted device, such as a pacemaker, the time the device takes to deliver the therapy **does not** count towards the 14-hour per week requirement. However, the time your patient spends setting up a portable device **does** count.

Do not include activities such as following a dietary restriction or regime, exercising, travelling to receive the therapy, attending medical appointments (other than appointments where the therapy is received), shopping for medication, or recuperating after therapy.

For 2005 and later years

- If your patient's therapy requires a regular dosage of medication that needs to be adjusted daily, the activities directly related to determining and administering the dosage **are** considered part of the therapy (for example, monitoring blood glucose levels, preparing and administering the insulin, calibrating necessary equipment, or maintaining a log book of blood glucose levels).
- Activities that are considered to be part of following a dietary regime, such as carbohydrate calculation, as well as activities related to exercise, **do not count** toward the 14-hour requirement (even when these activities or regimes are a factor in determining the daily dosage of medication).
- If a child is unable to perform the activities related to the therapy because of his or her age, the time spent by the child's primary caregivers performing and supervising these activities **can** be counted toward the 14-hour per week requirement. For example, in the case of a child with Type 1 diabetes, supervision includes having to wake the child at night to test his or her blood glucose level, checking the child to determine the need for additional blood glucose testing (during or after physical activity), or other supervisory activities that can reasonably be considered necessary to adjust the dosage of insulin (excluding carbohydrate calculation).

Examples of life-sustaining therapy:

- Chest physiotherapy to facilitate breathing
- Kidney dialysis to filter blood
- Insulin therapy to treat Type 1 diabetes in a child who cannot independently adjust the insulin dosage (for 2005 and later years)

Does your patient need this therapy **to support a vital function**?	Yes ☐ No ☐
Does your patient need this therapy at least **3 times per week**?	Yes ☐ No ☐
Does this therapy take an average of at least **14 hours per week**?	Yes ☐ No ☐
If **yes**, when did your patient's therapy begin to meet the above conditions (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)?	Year ☐☐☐☐

Provide details of the therapy (for example dialysis, or for persons with diabetes, insulin pump or multiple daily injections):

Cumulative effect of significant restrictions – applies to 2005 and later years (Complete this section if applicable, and **all sections on page 9**.)

Not applicable ☐

Answer the following questions to determine if your patient may be eligible for the disability tax credit. Also answer the questions at the bottom of this page.

1. Does your patient have an impairment in physical or mental functions that has lasted, or is expected to last, for a continuous period of at least 12 months? Yes ☐ No ☐

2. Even with appropriate therapy, medication, and devices, has the impairment resulted in a **significant restriction**, that is not quite a **marked restriction** (defined below), in **two** or more basic activities of daily living or in **vision** and **one** or more of the basic activities of daily living? Yes ☐ No ☐

3. Do these significant restrictions exist together, **all or substantially all of the time** (at least 90% of the time)? Yes ☐ No ☐

4. Is the cumulative effect of these significant restrictions equivalent to being markedly restricted in a single basic activity of daily living (see examples below)? Yes ☐ No ☐

Note
You **cannot** include the time spent on life-sustaining therapy.

If you answered **yes** to all of the above questions, your patient may be eligible for the disability tax credit.

Definitions

Markedly restricted – means that **all or substantially all of the time** (at least 90% of the time), and even with therapy (other than therapy to support a vital function) and the use of appropriate devices and medication, either:

- your patient is unable to perform one or more of the basic activities of daily living; or
- it takes your patient an inordinate amount of time to perform one or more of the basic activities of daily living.

Significantly restricted – means that although your patient does not **quite** meet the criteria for markedly restricted, his or her vision or ability to perform a basic activity of daily living is still substantially restricted **all or substantially all of the time** (at least 90% of the time).

Examples

Examples of cumulative effects equivalent to being markedly restricted in a basic activity of daily living:

- Your patient can walk for 100 metres, but then must take time to recuperate. He or she can perform the mental functions necessary for everyday life, but can concentrate on any topic for only a short period of time. The cumulative effect of these two significant restrictions is equivalent to being markedly restricted, such as being unable to perform one of the basic activities of daily living.
- Your patient always takes a long time for walking, dressing and feeding. The extra time it takes to perform these activities, when added together, is equivalent to being markedly restricted, such as taking an inordinate amount of time in a single basic activity of daily living.

Answer the following question(s) to certify your patient's condition:

Does your patient meet the four conditions for the cumulative effect of significant restrictions described **above**? Yes ☐ No ☐

If **yes**, tick at least two of the following, as they apply to your patient.

☐ vision ☐ speaking ☐ hearing ☐ walking ☐ elimination (bowel or bladder functions)

☐ feeding ☐ dressing ☐ mental functions necessary for everyday life

If **yes**, when did the cumulative effect described above begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)? Year ____

Part B – (continued) **Patient's name:** _____ **Protected B** when completed

Complete **all** of the sections on this page.

Effects of impairment

The effects of your patient's impairment must be those which, even with therapy and the use of appropriate devices and medication, cause your patient to be restricted **all or substantially all of the time** (at least 90% of the time).

Note
Basic activities of daily living are limited to walking, speaking, hearing, dressing, feeding, elimination, and mental functions necessary for everyday life. Working, housekeeping, managing a bank account, and social or recreational activities are **not** considered basic activities of daily living.

Examples of effects of impairment:

- For a patient with a walking impairment, you might state the number of hours spent in bed or in a wheelchair each day.
- For a patient with an impairment in mental functions necessary for everyday life, you might describe the degree to which your patient needs support and supervision.

Describe the effects of your patient's impairment(s) on his or her ability to perform **each** of the basic activities of daily living that you indicated are or were markedly or significantly restricted (include the diagnosis, if available). If you need more space, attach a separate sheet of paper.

Effects of impairment: _____

_____

_____

_____

_____

_____

Diagnosis: _____

Duration

Has your patient's impairment lasted, or is it expected to last, for a continuous period of at least 12 months? For deceased patients, was the impairment expected to last for a continuous period of at least 12 months? Yes ☐ No ☐

If **yes**, has the impairment improved, or is it likely to improve, to such an extent that the patient would no longer be blind, markedly restricted, equivalent to markedly restricted due to the cumulative effect of significant restrictions, or in need of life-sustaining therapy? Yes ☐ No ☐ Unsure ☐

Note
Additional comments related to duration may be added to the "Effects of impairment" section.

If **yes**, enter the year that the improvement occurred or may be expected to occur. Year ☐☐☐☐

Certification

Tick the box that applies to you:

☐ Medical doctor ☐ Optometrist ☐ Occupational therapist ☐ Audiologist

☐ Physiotherapist ☐ Psychologist ☐ Speech-language pathologist

As a **qualified practitioner**, I certify that the information given in Part B of this form is, to the best of my knowledge, correct and complete and I understand that this information will be used by the Canada Revenue Agency (CRA) to determine if my patient is eligible for the disability tax credit or other related programs.

Sign here

_____
It is a serious offence to make a false statement.

Print your name _____

Date _____

Telephone _____

Address

Note
If more information is needed, the CRA may contact you.