APPLICATION FOR DISABILITY PENSION

VESTCOR

☐ **NB Teachers' Pension Plan**

☐ ***Provincial Court Act***
Provincial Court Judges' Pension Act

(01/2021)

Are Workers' Compensation Benefits Payable? ☐ Yes ☐ No Have you applied for Disability Benefits from Canada or Quebec Pension? ☐ Yes ☐ No

Other Group, Association or Franchise? ☐ Yes ☐ No _____ _____
Name of Insurance Company **Group Policy Number**

Are you claiming or receiving disability benefits from other sources? ☐ Yes ☐ No If Yes, please name them _____

1. a) Name _____ b) Date of Birth _____

c) Social Insurance No _____ d) Latest Occupation _____

e) Employer _____

2. When did the illness begin that developed into present disability?

3. From what date has your disability prevented you from working?

4. Describe your present condition, its **CAUSE** and **HISTORY**.

				From	To
5. During this illness: a) were you confined to bed (other than hospital)?	☐ Yes	☐ No	If "Yes" give dates		
b) were you confined to your home?	☐ Yes	☐ No	If "yes" give dates		
c) where you a patient at a hospital or sanitarium?	☐ Yes	☐ No	If "Yes" give dates		

6. Name all physicians who have attended you during present disability and request consultation reports (if available)

Physician's Name	Address	Dates From	Dates To

7. a) What formal education have you had? _____ b) Date education completed _____

c) Briefly describe other jobs you have had

8. a) Are you now working? ☐ Yes ☐ No b) If working, give date of commencement _____

c) How many hours per week do you work? d) What kind of work are you doing?

9. If not now working, when do you expect to return to work?

CERTIFICATION AND AUTHORIZATION

I certify that the information in this form is true and complete. I understand the Claims Administrator may investigate this claim. I authorize my employer, physician, practitioner, health care professional, hospital, health care institution, medical organization, clinic and any other medically-related facility, insurance company, Worker's Compensation authority, Canada or Quebec Pension Plan, group plan administrator, employer-sponsored pension plan administrator, to release and exchange with the Claims Administrator and the Plan Administrator any medical or benefit payment information to process or manage my claim. I agree that a photocopy of this authorization shall be as valid as the original. I understand that any charges for having forms completed or medical reports are my responsibility.

Signature of Employee _____ Address _____

Telephone _____ Postal Code _____

Date _____

Please return completed form to:
Vestcor
P.O. Box 6000, Fredericton NB E3B 5H1

PLEASE USE A SEPARATE SHEET FOR ADDITIONAL COMMENTS