



Disability Retirement Benefits Application Form

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Use this form to apply for a Provincial Judges and Applications Judges Registered and Unregistered Pension Plans (Judges Pension Plan) disability pension. Two types of disability pensions are available. A partial disability pension may be granted when medical evidence indicates that a member suffers from a physical or mental impairment that prevents them from performing the regular duties of their employment. A total disability pension may be granted when medical evidence indicates that a member suffers from a physical or mental impairment that can be reasonably expected to last for the rest of their lifetime and prevents them from engaging in the duties of a judge. The disability assessment will be based on a combination of medical evidence and pension legislation.

Please send this completed form and the *Confidential Medical Statement* (after completion by your physician(s)) to:
Judges Pension Plan, c/o Alberta Pensions Services Corporation (APS),
5103 Windermere Blvd. SW, Edmonton, AB T6W 0S9 Fax: 780-421-1652

1. Member Information

member's first name

member's middle name

member's last name

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member social insurance number

member's address

member's address effective date (YYYY/MM/DD)

city, town, village, etc.

province

postal code

country (if outside of Canada)

primary phone number

ext.

country code
(if outside
Canada/USA)

Work Home Cell

2. Definition of Pension Partner

"Pension partner" means

- (i) a person who, at the relevant time, was married to a participant or former participant and
 - (A) was not judicially or otherwise separated from him or her, or
 - (B) if so separated, was wholly or substantially dependent on him or her,
- (ii) if there is no person to whom subclause (i) applies, a person who, as at and up to the relevant time, had lived with the participant or former participant in a conjugal relationship
 - (A) for a continuous period of at least 3 years, or
 - (B) of some permanence, if there is a child of the relationship by birth or adoption,and was, during that period or that relationship, as the case may be, held out by the participant or former participant in the community in which they lived as being in that conjugal relationship, or
- (iii) if there is no person to whom subclause (i) or (ii) applies, a person who was married to but separated from the participant or former participant and not wholly or substantially dependent on him or her at the relevant time.

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

According to the definition above, I have a pension partner on the date that I am completing this form (please check one):

YES If YES, please complete section 3. *Pension Partner Information*

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



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3. Pension Partner Information

pension partner's first name

pension partner's middle name

pension partner's last name

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

marital status (married/common law)

Please check one:
female male

4. Pension Commencement Date

I want my pension to start on:

date (YYYY/MM/DD)

If the date you give is before you stop participating in the Plan, or before the Judges Pension Plan receives your application, your pension commencement date will be adjusted to the closest possible date allowed under the rules of the Plan. We will send you a *Retirement Benefit Statement* with your pension options. This statement will show the pension commencement date used to calculate those options.

5. Member Authorization

The information on this form is, to the best of my knowledge and belief, complete and accurate. I authorize my physician(s) to release to Judges Pension Plan, its representative(s) and/or consulting physician(s), any information relating to the medical condition(s) which is the cause of my disability. This information is to be used to evaluate my application for a disability pension only and permission is **NOT** granted for any other use or disclosure.

member's signature

member's name (please print)

date signed (YYYY/MM/DD)

Please note:

- You are responsible for the cost of obtaining any information relating to your medical condition.
- **This is an official record that must be signed to be valid.** Mailing and fax information is at the top of page 1. Keep a copy of the completed form for your records.
- If you have questions, please contact the Member Services Centre, toll free, at 1-800-358-0840.



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If you are participating in the Judges Pension Plan, your employer must complete the following section. If you are no longer participating in the Judges Pension Plan, completion of this section by your former employer is not required.

6. Employer Use Only

a) Please explain whether the member is incapable of performing the duties of his or her position.

b) Is the member receiving Long Term Disability Income Continuance Plan benefits?

7. Employer Certification

I certify that the information on this form is, to the best of my knowledge and belief, complete and accurate.

employer name

employer
number

member's termination date (YYYY/MM/DD)

name of authorized person
(please print)

phone number

ext.

signature of authorized person

date signed (YYYY/MM/DD)

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Confidential Medical Statement

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The information on this form will assist the Judges Pension Plan in determining eligibility for disability pension benefits for the patient. No information, in whole or in part, will be released to any unauthorized person(s) without the patient's prior written consent. This statement will be held in strictest confidence and used solely to enable an assessment of the patient's disability by an independent medical consultant. The information on this form must be completed by a physician and returned to the patient. Charges for the completion of this report, if any, are the responsibility of the patient.

1. Patient Information

patient's first name _____ patient's last name _____ pension plan identification number _____
address _____
city, town, village, etc. _____ province/territory _____ postal code _____

2. Physician Information

physician's full name _____ area code _____ phone number _____
address _____
city, town, village, etc. _____ province/territory _____ postal code _____

3. Medical Relationship

- a) How long have you been treating the patient? _____
- b) When did you start treating the patient for the medical condition(s)? _____
- c) When did you last examine the patient? _____

4. Medical Assessment

- 1. a) What medical condition(s) are preventing the patient from working?

b) What was the date of onset? _____

c) Please list all relevant symptoms



Confidential Medical Statement

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

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

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

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

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

7. a) Do you consider the patient has become incapable of effectively performing the regular duties of employment as a result of the physical or mental impairment? yes no

b) Do you consider the patient is suffering from a physical or mental impairment that can reasonably be expected to last for the remainder of the patient's lifetime and prevents the patient from engaging in any gainful occupation? yes no

8. The duration of the disability is:

Temporary (reasonable probability for recovery)
 Permanent (low probability for recovery)

9. Please provide any additional information.

5. Physician Certification

I certify that the information on this form is, to the best of my knowledge and belief, complete and accurate.

physician's signature

date (YYYY/MM/DD)