Invalidity Pension

Under the Social Security Agreement between Malta and Canada

38, Ordnance Street, Valletta, VLT 1021
Email: social.security@gov.mt
Website: www.socialsecurity.gov.mt
International Calls: +356 21255153
Freephone: 153

* Indicates mandatory information

Application Received on _ _ / _ _ / _ _ _ _

Personal Details

Maltese Identity Card Nº: * _____ Maltese Social Security Nº: _____

Name: * _____ Surname: * _____

Date of Birth: **(DD/MM/YYYY)** _ _ / _ _ / _ _ _ _ Maiden Surname: _____
(in case of married female)

Canadian Insurance Nº: *(if known)* _____

Civil Status *

☐ Single ☐ Married ☐ Cohabitation ☐ Separated maintaining Spouse / Partner

☐ Civil Union ☐ Widow/er ☐ Divorced ☐ Separated not maintaining Spouse / Partner

Date of change in Civil Status **(DD/MM/YYYY)**: _ _ / _ _ / _ _ _ _

Contact Details *

Address

House Name / Number: _____ Locality: _____

Street: _____ Post Code: _____

Contact Number: _____ Email: _____

Spouse / Partner

The details requested are those of the other person forming part of this family unit

Maltese Identity Card Nº: * _____ Maltese Social Security Nº: _____

Name: * _____ Surname: * _____

Date of Birth: **(DD/MM/YYYY)** _ _ / _ _ / _ _ _ _ Maiden Surname: _____
(in case of married female)

Canadian Insurance Nº: (if known): _____

If spouses are legally separated, attach a legal copy of Court's Order

Pension Details

Are you receiving or expecting to receive a pension (other than the **Service Canada** pension) for services rendered to one or more of your former employers [1] (inside and outside Canada)? If YES please enter the information and comply with the instructions shown hereunder. ☐ Yes ☐ No

If Yes: From Where and Effective Date Where: _____ Date: _ _ / _ _ / _ _ _ _

Kindly attach documentation showing the amount as on the first payment date of pension you are receiving or expecting to receive.

[1] E.g.: A private pension, superannuation fund, retirement savings account, etc.

Employment History in Malta

Your last employment in Malta:

Employer / Company [2]	Grade / Designation	Year	Weekly Income [3]

Canadian Residence

Information required to support an application for benefits under a social security agreement

Account Number: _____ CAG: _____

A. **If born outside Canada provide*:***

Place of entry to Canada: _____ Date of entry to Canada: _ _ / _ _ / _ _ _ _

B. List the places where you have lived in Canada from age 18 to present:
(if required, please provide additional information on a separate sheet of paper and attach to this form)

From Month / Year	To Month / Year	City, Town or Village	Country or District	Province or Country

C. List all absences from Canada of more than 90 days during the periods of residence you have listed above
(if required, please provide additional information on a separate sheet of paper and attach to this form)

Departed DD/MM/YYYY	Country or Countries Visited	Returned DD/MM/YYYY
_ _ / _ _ / _ _ _ _		_ _ / _ _ / _ _ _ _
_ _ / _ _ / _ _ _ _		_ _ / _ _ / _ _ _ _
_ _ / _ _ / _ _ _ _		_ _ / _ _ / _ _ _ _
_ _ / _ _ / _ _ _ _		_ _ / _ _ / _ _ _ _

[2] If available, please attach any relevant documentation, e.g. letter of appointment / contract, termination of employment certificate, letter of reference by employer, statement of payee earnings, emoluments record.

[3] If you do not remember the basic salary leave empty

D. List names, addresses and contact numbers of at least two persons not related to you by blood or marriage, who can confirm the facts of your residence as stated above.
(if required, please provide additional information on a separate sheet of paper and attach to this form)

Name and Surname	Address	Contact Number

E. List names, addresses and contact numbers of your employers in Canada.
(if required, please provide additional information on a separate sheet of paper and attach to this form)

Name and Surname	Address	Contact Number

Declaration of Termination of Employment

I declare that employee terminated employment on _ _ / _ _ / _ _ _ _

Employer / Company Details

Name and Surname: _____

Address: _____

_____

Email: _____

_____ _____ _____

Employer's Signature | Employer's Designation | Employee's Signature

Medical Assessment Report

Part I – Current Assessment

The following section is to be completed by the certifying medical practitioner / consultant.
The information submitted shall guide the Medical Professionals to provide a recommendation to the Director of Social Security.

a. Date of Assessment: _ _ / _ _ / _ _ _ _

b. Applicant's Details:

Height (cm) _____ **Weight (kg)** _____ **Blood Pressure** _____

c. Additional information for this assessment:
This may include but is not restricted to:

i. the applicant's positive attitude and / or approach to health management;
ii. genetic treatment and / or other programmes which have been undertaken or are already in place to improve level of functioning;
iii. relevant educational, training or work history;
iv. important socio-cultural and / or psycho-social issues which affect level of functioning, etc.

Instructions for Medical Practitioner / Consultant
Please provide details of diagnosis and clinical features of current conditions. *You may need to attach a separate sheet.*

d. Clinical history and examination:
Include history, symptoms and their severity, examination findings, frequency and management of pain episodes (if applicable), treatment options, prognosis, and other features.

e. How does this condition affect the applicant's ability to function?:
Be specific and consider the effects due to the medical condition alone.

f. The function impact of this condition is: ☐ **Temporary** (Explain below)

This is an aggravation of an existing condition ☐ Yes ☐No

☐ **Permanent** (Explain below)

g. What treatment is given to the applicant?

h. Does the applicant have a medical history at a state hospital? ☐ Yes ☐No

Does the applicant have a medical history at a private hospital or clinic? ☐ Yes ☐No

If the answer is Yes, provide medical history

Part II – Capacity for work or training

Instructions for Medical Practitioner / Consultant

Part II is to provide a holistic summary of the applicant's current and potential capacity for work.

- Only those conditions identified as **Permanent** should be considered in assessing the applicant's work capacity
- Please rate how the applicant's medical condition would affect his / her capacity to work over the next two years
- Please tick one option for each question
- Please answer even if the applicant has not worked for some time

a. Indicate the applicant's current capacity to do any work without any intervention programmes:
E.g. vocational, prevocational and / or educational.

Number of hours per week	Current	Within 6 months	Between 6 and 12 months	More than 12 months
From 0 to 7				
From 8 to 14				
From 15 to 29				
More than 30				

Type of work

Suggested suitable work

Give reasons for work capacity and type of work recommendations

b. Indicate the applicant's capacity to do any work with educational training, vocational training or on-the- job training:
E.g.: Mainstreaming programmes not designed for people with physical, intellectual or psychiatric impairments.

Number of hours per week	Current	Within 6 months	Between 6 and 12 months	More than 12 months
From 0 to 7				
From 8 to 14				
From 15 to 29				
More than 30				

Type of work
Suggested suitable work

Give reasons for work capacity and type of work recommendations

c. Indicate the applicant's capacity to do any work with disability specific intervention:
E.g.: programmes designed specifically for people with physical, intellectual or psychiatric impairments (Like: Vocational rehabilitation, disability employment services.

Number of hours per week	Current	Within 6 months	Between 6 and 12 months	More than 12 months
From 0 to 7				
From 8 to 14				
From 15 to 29				
More than 30				

Type of work
Suggested suitable work

Give reasons for work capacity and type of work recommendations

d. What type/s of assistance would be best to enable the applicant to return to work?

No assistance Required	☐
Educational Training	☐
Vocational / Work Training and Rehabilitation	☐
On-the-job Training	☐
Voluntary Work	☐
Other means of assistance (give details)	☐
Would not benefit from participation in programmes	☐

→

e. Indicate the applicant's interest in pursuing assistance to return to work

☐ None ☐ Minimal ☐ Moderate ☐ Substantial

Give details

_____

_____

_____

_____

Part III (Medical Practitioner / Consultant's Details and Declaration)

I declare that to my knowledge all information given is true, complete and correct.

Name of Medical Practitioner / Consultant: _____

Medical Council Number: _____

Address: _____

_____

Telephone Number: _____

Mobile Number: _____

Email: _____

_____ _____

Signature Date

Rubber Stamp

Necessary Documents

- ☐ Marriage Certificate *
- ☐ Spouse's Birth Certificate *
- ☐ Official documentary evidence that allowance was provided if separated / divorced
- ☐ Detailed Medical Report

* Certificates of any births, marriages or deaths requested in this application, are to be attached only if they are not registered at the Public Registry of Malta.

Bank Account Details

Benefit should be deposited either in a Canadian or a Maltese Savings or Current Account but not in a Loan Account. The account should be in the name of the beneficiary.

If Bank is in Canada

Bank: _____

Account Number: | | | | | | | | | | | | | | | |

Account Name: _____

Transit Number: | | | | | | Bank Reference Number: | | | |

If Bank is in Malta

Bank: _____

IBAN: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Declaration

- I declare, that all information given is to my knowledge true, complete and correct. I understand that if the information given is false, I will be penalised as stipulated by Law and also lose the right for all or part of the benefit as stipulated by the Maltese Social Security Act (Cap. 318.)
- I authorise the Director (Benefits) Malta and Service Canada, to perform all the necessary investigations and to exchange any necessary information to determine the correct entitlement of this benefit.
- I bind myself to inform immediately the Director (Benefits) Malta, of any changes in circumstance as indicated in this form. (e.g.: if I start working again.)
- I am aware that if in the future it transpires that I had no right for Invalidity Pension, I will have to refund to the Department of Social Security Malta, such monies for which I was not entitled.

_____ _____

Name and Surname Identity Card Number

_____ _____

Signature Date

Data Protection Declaration:

The Department of Social Security collects all relevant personal information to provide its services to individuals who qualify for assistance, allowance or non-contributory pensions in accordance with the Social Security Act (Cap. 318.). The Department may verify the information submitted by you in line with article 133 (b) of the Social Security Act to ensure its accuracy in relation to the claim. Personal data may be disclosed to departments / third parties, who may also have access to your data as authorised by law. Personal information may also be exchanged with benefits institutions of other countries to combat and deter fraud, as provided for in international treaties or bilateral agreements to which Malta is a party. You will be informed in due course of the result of your claim after it has been assessed.

Pursuant to the General Data Protection Regulation (EU) 2016/679 (GDPR) and the Data Protection Act (Cap. 586.), we have a legal duty to respect and protect any personal information we collect from you and we will abide by such duty. We take all safeguards necessary to prevent unauthorised access and we do not pass on your details collected from you as a visitor and/or user, to any third party unless you give us your consent to do so or as authorised by law. You may request in writing to access information held about you, and eventually to rectify, and where applicable to erase incorrect information. Such a request is to be addressed to "The Data Controller", Department of Social Security, 38, Ordnance Street, Valletta VLT 1021 or by e-mail to dpsocialsecurity.dss@gov.mt and appropriate action would be taken at the earliest possible time. In making such a request, kindly quote your identity card number, social security number, your name and address and other relevant documentation to identify your case.