

Please print

**1. Consent (to be completed by the applicant)**

**1.1 Information about the applicant's identity**

Family name	Given name	Social insurance number		
Address (number, street, apartment)				
City	Province	Country	Postal Code	

**1.2 Applicant's consent**

I hereby give my consent to the Régie des rentes du Québec to reimburse to the administrator of my disability insurance plan, \_\_\_\_\_, the amounts paid to me by that plan while I was waiting to receive my disability pension under the Québec Pension Plan.

Administrator's name (insurer)

The reimbursement is limited to the months for which I was entitled both to the disability insurance benefit and to a disability pension under the Québec Pension Plan. For any given month, the reimbursement cannot exceed the amount of the Québec Pension Plan disability pension.

The reimbursement will be made by means of a lump-sum deduction from the retroactive payment of my disability pension under the Québec Pension Plan, once the Régie des rentes du Québec has received this duly signed consent form.

This consent is not valid unless the application for a disability pension is received at the Régie within 12 months following the date on which the consent is signed.

Signature \_\_\_\_\_ Date 

year	month	day
------	-------	-----

  
Applicant or applicant's legal representative

**1.3 Applicant's consent concerning the release of information**

I hereby give my consent to the Régie des rentes du Québec to release to the administrator of the disability insurance plan mentioned above information regarding the disability pension that will be paid to me under the Québec Pension Plan.

I also give my consent to the administrator of the disability insurance plan to release to the Régie des rentes du Québec information about the disability insurance benefits paid to me.

Signature \_\_\_\_\_ Date 

year	month	day
------	-------	-----

  
Applicant or applicant's legal representative

**The administrator must fill out part 2, on the back.**

**2. Guarantee (to be completed by the administrator of the disability insurance plan)**

**2.1 Information about the applicant's identity**

Family name	Given name	Social insurance number
-------------	------------	-------------------------

**2.2 Information about the administrator's identity**

Name	Applicant's file number (if applicable)
------	---

Address (number, street, office number)

City	Province	Country	Postal Code
------	----------	---------	-------------

Representative of the plan administrator

Telephone <small>area code</small>	Extension	Fax <small>area code</small>
------------------------------------	-----------	------------------------------

**2.3 Administrator's declaration**

In my capacity as representative of the administrator of the aforementioned disability insurance plan, I certify that this consent concerns the monthly disability insurance benefit that would not be paid under this plan because of integration with the disability pension paid under the Québec Pension Plan, for the months during which the person mentioned in Part 1 is entitled to both benefits.

Monthly disability insurance benefit<sup>1</sup> that is integrated: \_\_\_\_\_ \$

This amount is the lesser of the following amounts:

- the amount of the monthly benefit paid by the insurer;
- the maximum disability pension payable under the Québec Pension Plan during the year in question.

<sup>(1)</sup> Monthly disability insurance benefit equals weekly amount paid multiplied by 4,33 weeks per month

Beginning of the period covered by the disability insurance benefits 

year	month
------	-------

I certify that the information regarding this agreement cannot be communicated to any third party.

I also certify that this form is in complete conformity with the contractual agreements entered into by all the interested parties.

I agree to notify the Régie des rentes du Québec of any change in the benefit payment.

Signature \_\_\_\_\_ Date 

year	month	day
------	-------	-----

  
Representative of the plan administrator