

**PROVINCE OF MANITOBA
CIVIL SERVICE SUPERANNUATION BOARD
APPLICATION FOR DISABILITY ALLOWANCE**

Full Name of Applicant _____ Employee # _____

Home Address: _____

City/Town _____ Postal Code _____

Phone Number _____ Medical Health Services # _____

Date of Birth _____ Date of Birth of Spouse _____

Employer _____ Department _____

Next of Kin _____ Relationship _____

Nature of Disability _____

Attending Physician _____ Phone Number _____

Address _____

_____ Postal Code _____

Specialist (if applicable) _____ Phone Number _____

Address _____

_____ Postal Code _____

Specialist (if applicable) _____ Phone Number _____

Address _____

_____ Postal Code _____

I hereby make application to the Civil Service Superannuation Board for a disability pension and I authorize the Board to obtain any medical report(s) relevant to my disability. I acknowledge that any medical report(s) relevant to my disability may be used for the purpose of supporting an application for waiver of insurance premiums. I understand that I may be examined by one or more doctors selected by the Superannuation Board who will submit medical reports to the Board.

DATE

SIGNATURE