National Defence / Défense nationale

Statutory Declaration
Canadian Forces Superannuation Act (CFSA 302) - Administration

Benefit number

Note: This form is to BE COMPLETED ONLY IN CASES WHERE A RECIPIENT IS UNABLE TO MANAGE HIS/HER OWN AFFAIRS OR IS INCAPABLE OF MANAGING HIS/HER OWN AFFAIRS AND THERE IS NO PERSON ENTITLED BY LAW TO ACT AS HIS/HER COMMITTEE OR CURATOR. If there is a legal committee, please forward to the Director Canadian Forces Pensions Services, National Defence Headquarters, Ottawa, Ontario, K1A 0K2, a certified copy of the Court Order or other instrument appointing the committee.

In the matter of the *Canadian Forces Superannuation Act* and in the matter of _____ recipient.
(Full name of recipient)

TO WIT: I, _____ of _____ in _____
(Full name of declarant) *(Number and street)* *(City, town or village)*

in the County of _____ in the Province of _____

do solemnly declare as follows:

1. That I am the (Note 1) _____ of (Note 2) _____

2. That I am informed and verily believe that the said recipient is incapable of managing his/her own affairs for the reasons stated in the certificate of

   Dr. _____ marked Exhibit "A" to this my declaration.
   (Name of medical practitioner)

3. That no person is to my knowledge entitled by law to act as committee of the said recipient and if the moneys payable to the recipient are paid to me, I agree:

   a) to administer the moneys to the best of my ability for the maintenance and care of the said recipient and his/her dependants during the period he/she is unable or incapable of managing his/her own affairs;

   b) in consideration of the said payments being made to me to indemnify and save harmless Her Majesty the Queen in right of Canada from and against all claims, demands and losses which Her Majesty may sustain, incur or be liable to, for or in consequence of the said payments being made to me; and

   c) to notify the Director Canadian Forces Pensions Services, Department of National Defence, Ottawa, Ontario, K1A 0K2, immediately upon the said recipient becoming able or capable of managing his/her own affairs or immediately the said recipient dies.

4. Marked Exhibit "B" to this my declaration is a certificate from two responsible persons who recommend that I am a proper person to administer the payments due to the recipient under the *Canadian Forces Superannuation Act*.

   And I make this solemn declaration conscientiously believing it to be true and knowing that it is of the same force and effect as if made under oath and by virtue of the *Canada Evidence Act*.

Declared before me at _____
(City, town or village)

in the Province of _____ this _____ day of _____ _____
(Month) *(Year)*

_____ _____
(Signature of declarant) *(Justice of the Peace, Commissioner, Notary, etc.)*

Notes: 1. Mother, Father, Sister, Brother, Wife, Daughter, Son, position title within institution, if applicable, etc., if not immediate family give explanation on separate sheet of paper.

2. Insert full name of recipient or name of institution if applicable.

Formulaire disponible en français - DND 2945-F

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Canada

Exhibit "A" - Certificate of Medical Practitioner

I, _____ , a duly qualified medical practitioner, residing at _____
(Name of medical practitioner) *(City, town or village)*

in the Province of _____ , state that _____
(Full name of recipient)

is unable to manage his/her own affairs or is incapable of managing his/her own affairs on account of *(state reason(s))*:

Date: _____ Signed: _____

Note: The "Certificate of Responsible Persons" must be completed by two responsible persons, not related to either the recipient or the proposed payee, and not financially interested in the proposed designation. These persons should not include the medical practitioner who has certified incapacity, the person before whom the statutory declaration was sworn, or employees of any institution being proposed as payee.

Exhibit "B" - Certificate of Responsible Persons

We, the undersigned declare that we are well acquainted with the facts set out in this statement and to the best of our knowledge and ability recommend that _____ is the proper person to administer the benefit payable to _____ whom, we are informed and verily believe, is unable to manage his/her own affairs or is incapable of managing his/her own affairs.
(Full name of declarant) *(Full name of recipient)*

Date: _____

_____	_____	_____	_____
(Signature)	*(Title)*	*(Where employed)*	*(Telephone number)*
_____	_____	_____	_____
(Signature)	*(Title)*	*(Where employed)*	*(Telephone number)*