



# Notice of rehabilitative work

Use this form if you are an employer and have a member who will be returning, or has returned, to rehabilitative work. This work must be approved by OMERS if the member is to continue receiving a disability benefit.

Rehabilitative work is a transition period between total disability status and a return to normal work duties or to a new permanent occupation (either full-time or part-time). OMERS does not approve rehabilitative work beyond two years from initial date of return to work.

Mail/fax the completed and signed form to the contact information below. If you fax it, do not mail the original.

Providing OMERS with your personal information is considered consent for its use and disclosure for the purposes set out in our Privacy Statement, as amended from time to time. You can find out more about our collection, use, disclosure and retention of personal information by reviewing our Privacy Statement at [www.omers.com](http://www.omers.com).

## SECTION 1 - MEMBER INFORMATION (to be completed by the employer)

Group Number	Membership Number	Date of Birth (m/d/y)	
<input type="radio"/> Mr. <input type="radio"/> Mrs. <input type="radio"/> Ms. <input type="radio"/> Other:	First Name	Middle Name	Last Name
Phone	Name of Present Employer	Occupation Before Disability	

## SECTION 2 - REHABILITATIVE WORK INFORMATION (to be completed by the employer)

A member should **not** make contributions to the OMERS Pension Plan during an OMERS-approved rehabilitative work period. If the member made contributions during this period, please call us.

OMERS rehabilitative work may include any one of the following:

- a different occupation or a training program, with or without reduced hours, to train for a new occupation
- a different occupation, with or without reduced hours, as a transition to resuming own occupation, with the goal to resume own occupation
- own occupation with reduced hours, as a transition to resuming own occupation, with the goal to resume own occupation
- own occupation with modification to duties, as a transition to resuming own occupation, with the goal to resume own occupation

Based on the above description of rehabilitative work, when did the member return to rehabilitative work?

Date (m/d/y)
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## SECTION 3 - EMPLOYER AUTHORIZATION

Employer Name	Contact	
Phone	Fax	Email

Signature of Authorized Signing Officer

Date (m/d/y)