



Notice of rehabilitative work - Employer Certification

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

To help us serve you better, submit your documents quickly and securely using the e-access portal. Start a new conversation, attach your files, and submit.

An employer defines the rehabilitative work program that transitions a member from total disability to normal work duties or a new permanent occupation. For continuing OMERS disability benefits, this type of program last weeks or months but not years.

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.

The member should not make contributions to the OMERS Plan during an employer's approved rehabilitative work program period approved by OMERS.

SECTION 1 - MEMBER INFORMATION - to be completed by the employer

Group Number	Membership Number	Date of Birth (m/d/y)	
First Name	Middle Name	Last Name	
Phone	Name of Present Employer	Occupation Prior to Disability	

SECTION 2 - EMPLOYER REHABILITATIVE WORK PROGRAM INFORMATION - to be completed by the employer

The employer **must** provide a next scheduled review date and/or an expected return to work date for OMERS to consider the continuation of the disability waiver.

Rehabilitative work	Date work started (m/d/y)	Employer's next scheduled rehabilitative review	Date (m/d/y)
Has the member returned to regular work?	<input type="checkbox"/> Yes -	Date of return (m/d/y)	<input type="checkbox"/> No - Expected return date (m/d/y)

Use the boxes below to indicate the type of rehabilitative work program the employer is providing the member:

- a different occupation or a training program, *with no reduced hours*, to train for a new occupation
- a different occupation or a training program *with reduced hours*, to train for a new occupation
- a different occupation as a transition to resuming own occupation
- a different occupation *with reduced hours*, with the goal to resume own occupation
- own occupation for a trial period (*no reduced hours* or modifications to duties)
- own occupation with modifications to duties
- own occupation *with reduced hours*
- own occupation with modification to duties and *reduced hours*

Please describe the work in detail to support the type of rehabilitative work program indicated above. For example, include the type of work the member is doing and the number of hours the member is working.

Group Number

Membership Number

SECTION 3 - OTHER DISABILITY BENEFITS

Has the member applied for a Workplace Safety and Insurance Board benefit?

Yes - Please complete the following:

Approved

Monthly benefit amount

Total/full

Partial

Temporary

Temporary benefit end date (m/d/y)

Declined

Under appeal

Pending approval

No - Please advise OMERS in writing if the member is approved for a WSIB benefit in the future.

Has the member applied for a benefit under your long-term disability plan?

Yes - Please complete the following:

Approved

Receiving benefit

Benefit stopped as of

Date (m/d/y)

Declined

Under appeal

Pending approval

No - Please advise OMERS in writing if the member is approved for an LTD benefit in the future.

SECTION 4 - EMPLOYER CERTIFICATION

Contact

Phone

Fax

Email

Signature of Authorized Signing Officer

Date (m/d/y)