OMERS

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.

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.

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

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.

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.

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

Group Number	Membership Number		Date of Birth (m/d/y)
◯ Mr. ◯ Mrs. ◯ Ms. ◯ Other:	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? ☐ Yes - Date of return (m/d/y) ☐ 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.

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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)