OMERS

Medical report - OMERS total disability benefits

Use this form to provide OMERS with new or updated medical information.

Once OMERS receives the form, we will determine whether you qualify or continue to qualify for an OMERS total disability benefit. Your employer may be contacted to obtain any outstanding information regarding your leave period.

OMERS will also accept copies of medical forms or reports about the member's condition that the member's doctor has completed for other benefits. In that case, the doctor does not need to complete Section 3 of this form.

Note to members and doctors: OMERS is not responsible for any costs associated with either completing this form or providing medical documents to OMERS.

To help us serve you better, submit your documents quickly and securely using your myOMERS account. Go to My Communications, start a new conversation, attach your files, and submit.

Any personal information provided on this form may be used to update your membership profile.

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 member)

OMERS Membership Number*		Date of Birth (m/d/y)		
◯ Mr. ◯ Mrs ◯ Ms. ◯ Other:	First Name	Middle Name	Last Name	
Apt/Unit	Address	City	Province	Postal Code
Home Number	Mobile Number	Email		
Name of Current Employer		Occupation		

**Your membership number appears on your Pension Report or any personalized statement from OMERS.*

SECTION 2 - MEMBER ELECTION (to be completed by the member)

NOTE: Your signed election form is required for any disability claim reported by your employer. If you have already signed and submitted your election form to OMERS, you do not need to complete Section 2 of this form.

By signing and dating this form, you are requesting that OMERS process your application for a disability waiver benefit.

I understand that OMERS will conduct regular reviews including requesting new or updated medical information to determine whether you qualify or continue to qualify for an OMERS total disability benefit.

Your Signature _____ Date (m/d/y) _____

SECTION 3 - MEDICAL INFORMATION (to be completed by the member's doctor)

This section is to be completed by a medical doctor licensed to practice under the laws of a province of Canada or the place where the member resides.

OMERS will also accept copies of medical forms or reports about the member's condition that the member's doctor has completed for other benefits. In that case, the doctor does not need to complete this section.

Please provide the following details on the nature of the member's total disability (print clearly).

Date of total disability:	Date (m/d/y)	Date member's total disability affected their ability to work:	Date (m/d/y)

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Diagnosis

Subjective symptoms

Objective findings (results of x-rays or other tests, physical exam findings)

Prognosis

Other pertinent information

Disability waiver of contribution - first 24 months

*To qualify, the member must have a physical or mental incapacity **during** the first 24 months of the disability that wholly prevents them from performing the regular duties of the occupation they were engaged in immediately before the date of disability.*

Does the member have any restrictions and limitations that prevent them from their full regular duties? ☐ Yes ☐ No
If yes, provide restrictions and limitations, with associated timelines:

When do you estimate the member returning to full regular duties? Date (m/d/y)

Disability waiver of contribution - after 24 months (from the date of disability)

*To qualify, the member must have a physical or mental incapacity that wholly prevents them from doing **any** work for compensation or profit for which they are, or may reasonably become, qualified to do by education, training or experience.*

Does the member have any restrictions and limitations that prevent them from performing **any** work? ☐ Yes ☐ No
If yes, provide restrictions and limitations, with associated timelines:

When do you estimate the member being able to return to **any** work? Date (m/d/y)

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Disability pension

*To qualify, the member must have a physical or mental impairment that wholly prevents them from doing **any** work for compensation or profit for which they are, or may reasonably become, qualified to do by education, training or experience. This impairment is also reasonably expected to last for the remainder of their lifetime.*

Does the member have any restrictions and limitations that prevent them from performing **any** work? ☐ Yes ☐ No
If yes, provide restrictions and limitations, with associated timelines:

When do you estimate the member being able to return to **any** work? Date (m/d/y)

Doctor's Name			Phone	
Suite/Unit #	Address	City	Province	Postal Code

Doctor's Signature

Date (m/d/y)