OPTrust

OPSEU Pension Trust | Fiducie du régime de retraite du SEFPO

Member's Statement on Disability

OPSEU Pension Trust 1 Adelaide Street East, Suite 1200, Toronto, Ontario M5C 3A7
Telephone: 416-681-6100 Toll-free: 1-800-637-0024 Fax: 416-681-6175

1. IDENTIFICATION

Employee Last Name | **First Name and Initials** | Date of Birth (DD/MM/YYYY) D D M M Y Y Y Y | OPTrust ID Number

WIN Number | Home Address: Number and Street | Apt. No.

City/Town | Province | Postal Code | Telephone Number

2. WORK AND DISABILITY HISTORY

• Have you resigned from employment?

☐ Yes ☐ No If not, why?

What was your last day worked? (DD/MM/YYYY) D D M M Y Y Y Y

• Which ministry/agency are/were you currently employed by?

• What is/was your position title?

• What is/was your period of employment in your current position?

• Describe in your own words, your job position. Please include in your answer the following:

— complexity

— skill required

— responsibility

• When did your medical condition start?

• Please describe in your own words your current medical condition.

• How has your condition impacted on your regular:

— hours of work

— job duties

— job performance

— job satisfaction

• Are you able to perform the duties of a similar position in the same class and grade?

☐ Yes ☐ No If yes, give details.

• Have you been offered alternative employment by your Ministry/Agency?

• How has your employer offered to modify your current position in order to accommodate your condition?

Keep a copy of this form for your records.

• Have you sought assistance from the employee counselling services? If so, what has been the outcome?

• What is your counsellor's name and telephone number? Telephone Number

• Do you expect to return to active employment?

• What alternative work do you feel you are currently capable of performing?

3. STATUS OF APPLICANT

• Are you:

— still a member of the OPSEU Pension Plan? ☐ Yes ☐ No If no, give termination date: D D M M Y Y Y Y

— on leave of absence with pay? ☐ Yes ☐ No If yes, give start date: D D M M Y Y Y Y

— on leave of absence without pay ☐ Yes ☐ No If yes, give start date: D D M M Y Y Y Y

4. OTHER DISABILITY BENEFITS

• Have you applied for Long Term Income Protection (LTIP) benefits? ☐ Yes ☐ No

— Was your LTIP benefit application: ☐ Approved ☐ Denied Effective date: D D M M Y Y Y Y

— Provide LTIP claim number:

— What kind of LTIP benefits are you receiving? ☐ Stage 1 (1 to 2 years) ☐ Stage 2 (over 2 years)

— Have you made a claim under:

Worker's Compensation Plan: ☐ Yes ☐ No Date applied: D D M M Y Y Y Y Granted: ☐ Yes ☐ No

Canada Pension Plan: ☐ Yes ☐ No Date applied: D D M M Y Y Y Y Granted: ☐ Yes ☐ No

If no application was made, or claim was disallowed, please state reason. If you have supporting medical information regarding these benefits, please list below and attach the supporting information.

5. ADDITIONAL MEDICAL INFORMATION

IMPORTANT: Attach any consultation reports and test results relevant to this application. Also attach any additional medical information that is relevant to this application.

MEMBER'S AUTHORIZATION

I CERTIFY that the foregoing answers and information contained in other documents supporting this claim for benefits are to the best of my knowledge and belief, true full and complete.

I AUTHORIZE any physician, medical practitioner, employer representative, agency providing disability benefits, hospital, clinic, other medical or medically related facility or insurance company, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment or test of me, to give to OPTrust, its medical consultant, or its legal representative, any and all such information.

I AUTHORIZE the medical consultant to use this information to make a recommendation to OPTrust regarding my application for a pension.

I UNDERSTAND the information obtained by use of this authorization will be used by OPTrust in the evaluation of my claim for disability benefits only. Any information obtained will not be released by OPTrust EXCEPT to persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

This authorization or any photographic copy of it shall be valid during the continuation of the claim.

Signature of Applicant Date Signed (DD/MM/YYYY)

x Sign Here D D M M Y Y Y Y