

Instructions

Employers should complete this form when an OPSEU Pension Plan ("the Plan") member is applying to OPTrust for a disability pension or a special disability refund due to being "totally and permanently disabled" as defined under the Plan. This form should be completed by a manager, supervisor, human resources representative or benefits advisor who has direct knowledge of the Member's employment situation. If you require additional space to respond, please attach additional sheets as needed. Once complete, this statement should be sent directly to OPTrust through the Secure Employer Portal.

A – Employer information

Name of employer (Ministry, Agency, Board or Commission)

Name of employer-representative completing this statement

Position / title

Phone number

B - Member information

Last name

First name and initials

OPTrust ID or Employee Number

C - Member employment information

1. What is the Member's position title, category, and class/grade (if applicable)?

Important: Please complete and attach a Physical Demand Analysis for this position

2. What is the Member's current status? Full-time Part-time Unclassified

3. What is the Member's current annual salary rate? (CAD / year)

4. When was the Member's last day at work? (Day-Month-Year)

5. Is the Member still employed with your organization? Yes No

If "No," date employment ended: (Day-Month-Year)

6. Is the Member currently on a leave of absence? Yes No

If "Yes," date leave started: (Day-Month-Year)

If "Yes," what is the type of the leave? (i.e. illness, LTIP, other etc.)

7. Member's hire date:

Current position start date:

8. Please provide a description of the Member's position with reference to its:

- a) Complexity:
- b) Skill required:
- c) Responsibility:

9. Describe your understanding of the Member's current ability to maintain their regular:

- a) Hours of work:
- b) Job duties:
- c) Job performance:

10. To address any impact on the Member's performance of their regular duties, were any accommodations considered or made and/or was reassignment explored? Answer yes or no, and explain below. Yes No

11. Please explain options for future workplace accommodation or reassignment:

12. In what other positions has the Member worked for this employer? If applicable list other positions and give dates:

D - Other disability benefits

13. Has the Member applied for Long Term Income Protection (LTIP) benefits? Yes No Unknown

If "yes," was the LTIP application (select all that apply):

Approved, effective: Denied Pending Under appeal Unknown

14. Has the Member applied for disability benefits from the Workplace Safety and Insurance Board (WSIB)?

Yes, full Yes, partial No Unknown

If "yes," was the WSIB application (select all that apply):

Approved, effective: Denied Pending Under appeal Unknown

E. Signature

The information provided in this statement is accurate and complete, to the best of my knowledge.

Name of employer-representative completing this statement (printed)

Signature

Date signed (Day-Month-Year)