Return to HOOPP

HOOPP
Healthcare of Ontario Pension Plan

Disability Benefit Appeal Application

Please print clearly and review the form to ensure the information you provide is complete and accurate.

Section 1: Member Information

First Name

Last Name

SIN

Telephone Number

Email

Section 2: Member Declaration

I, _____ , wish to appeal HOOPP's decision to deny my application for disability benefits and this is my application to HOOPP for an appeal. I acknowledge and agree that as part of my appeal AssessMed, a third party independent medical examination service provider, will arrange an appointment for me with an impartial independent medical examiner; and that AssessMed is an independent contractor and, for purposes of my appeal and independent medical examination, is not an agent of HOOPP.

I authorize and direct (i) HOOPP to provide to AssessMed and (ii) AssessMed to provide to the independent medical examiner assigned to my case, all medical information it has on file with respect to my medical condition; I consent to such disclosure by both HOOPP and AssessMed of my personal information and personal health information; and I hereby waive any and all rights I may have to contest any such disclosure by HOOPP or AssessMed.

I understand that AssessMed will arrange the independent medical examination for me; that AssessMed will contact me to arrange the next steps in the appeal process, which will include booking an appointment for me with the independent medical examiner. I understand that HOOPP will be responsible for paying the costs of the independent medical examination, except if I fail to attend the appointment or if I cancel it. If AssessMed charges for my failure to attend or the cancellation of my appointment, I accept that I will be responsible for the payment of those costs. I will pay such costs immediately upon receipt from HOOPP of the AssessMed invoice. I also understand that HOOPP will not be responsible for paying for the cost of my travel expenses to and from the appointment. I accept that I will be responsible for payment of these costs.

I understand that the decision of the independent medical examiner shall be final and binding on HOOPP and me; and once the decision is made, I will have no more rights with respect to my pending application for HOOPP disability benefits.

By signing this disability benefit appeal application, I am acknowledging and agreeing that I understand and accept all of the terms and conditions that apply to my appeal, as set out above.

Member Name (please print)

Signature of Member

Date (MM / DD / YYYY)

Witness Name (please print)

Signature of Witness

Date (MM / DD / YYYY)

Address of Witness

City

Province

Postal Code

Please forward any additional medical evidence, which you have not yet provided to HOOPP, that you consider relevant to your claim along with this appeal application.

Healthcare of Ontario Pension Plan

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