Application for Disability Benefits

To apply for disability benefits from the Healthcare of Ontario Pension Plan (HOOPP), please complete and submit Section 1 and provide **one** of the medical document options listed below.

Section 1: Member Disability Information

First Name

Last Name

Please choose one of the following options below to submit with your application:

Option 1: Approval for other disability benefits

☐ A copy of an approval letter or email for workplace disability benefits **or** a copy of your Notice of Entitlement for Canada Pension Plan (CPP) disability benefits.

Option 2: Completed application for other disability benefits

☐ A copy of the form your doctor, nurse practitioner or psychologist has completed to support your application for disability benefits, such as workplace or CPP disability benefits.

Option 3: Application filled out by your doctor, nurse practitioner or psychologist

☐ If you don't have any of the above documents, please have your doctor, nurse practitioner or psychologist complete **Section 2** of this application.

Member Consent

I certify that the information provided is to the best of my knowledge, complete and true. I agree to notify HOOPP of any changes that may affect my eligibility for disability benefits.

By completing this form I authorize HOOPP to collect and retain my personal and health information in support of this application and the ongoing administration of my disability benefits. I understand that this may include disclosing this information to a third party (such as a physician or an independent medical examiner) to assess my ongoing eligibility for disability benefits. I acknowledge that I am responsible for any charges or fees related to the completion of this application.

I understand that HOOPP may request additional information from me at any time, if required.

Signature

Date (DD/MM/YYYY)

See page 2 for Section 2: Medical Practitioner's Certification

Section 2: Medical Practitioner's Certification

Have your medical practitioner (doctor, nurse practitioner or psychologist) complete this section if you are **not** submitting one of the documents in Option 1 or Option 2 above and return this to HOOPP together with Section 1.

Please note that any changes in Section 2 must be initialed by the medical practitioner who signed it.

Member First Name

Member Last Name

Medical Practitioner's Name

Specialty (if any)

Telephone Number

I hereby certify that the HOOPP member named above meets the following definition of HOOPP disability: (Please check the appropriate box.)

- ☐ **Partial Disability** – A medical condition causing physical or mental impairment which **prevents a member from performing the duties of employment** in which the member was engaged prior to the impairment.
- ☐ **Total Disability** - A condition causing physical or mental impairment which **prevents a member from engaging in any employment** for which the member is reasonably suited by virtue of the member's education, training or experience.
- ☐ **Total and Permanent Disability** – A condition causing physical or mental impairment which **prevents a member from engaging in any employment** for which the member is reasonably suited by virtue of the member's education, training or experience, and **can reasonably be expected to continue for the remainder of the member's lifetime.**

Medical Practitioner's Signature

Date (MM/DD/YYYY)

Your privacy is important to us! At HOOPP, safeguarding the privacy of our members is a priority. We collect, use and disclose our members' personal information only for the purpose of administering the Plan; this refers primarily to administering pension benefits and paying pensions after retirement. For more information on HOOPP's privacy policies and practices, please visit **hoopp.com**.