OPSEU Pension Trust

Fiducie du régime de retraite du SEFPO

Mail to:
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Toronto, ON M5C 3A7
Tel: (416) 681-6100 Fax: (416) 681-6175
Toll Free: 1-800-637-0024 www.optrust.com

MEMBER'S STATEMENT ON DISABILITY

1. Identification

Employee Last Name	First Name	Initial	Social Insurance Number — —
Home Address: No. and Street		Apt. No.	
City / Province / Postal Code / Phone			Date of Birth DD MM YY

2. Work and Disability History

2.1 Have you resigned from employment? YES NO If not, why?

2.2 What was your last day worked? DD MM YY

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

2.4 What is/was your position title?

2.5 What is/was your period of employment in your current position? DD MM YY TO DD MM YY

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

- complexity
- skill required
- responsibility

2.7 When did your medical condition originate?

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

2.9 How has your condition impacted on your regular:

a) hours of work

b) job duties

c) job performance

d) job satisfaction

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

2.11 Have you been offered alternative employment by your Ministry/Agency? YES NO If yes, give details:

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

2.13 Have you sought assistance from the Employee Counselling Services? If so, what has been the outcome? What is your counsellor's name and the telephone number?

2.14 Do you expect to return to active employment?

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

Keep a copy of this form for your records.

3. Status of Applicant

3.1 Are you				DD MM YY
a) still a member of the OPSEU Plan?	YES	NO	If no, give termination date	DD MM YY
b) on leave of absence with pay?	YES	NO	If yes, give start date	DD MM YY
c) on leave of absence without pay?	YES	NO	If yes, give start date	DD MM YY

4. Other Disability Benefits

a) Have you applied for Long Term Income Protection (LTIP) benefits?

YES NO

b) Was your LTIP Benefits Application: DD MM YY

APPROVED? DENIED? If approved give effective date?

Provide LTIP Claim Number

c) What kind of LTIP benefits are you receiving? STAGE 1 (1 to 2 years) or STAGE 2 (over 2 years)

d) Have you made a claim under:	WORKER'S COMPENSATION PLAN?	CANADA PENSION PLAN?
	YES NO	YES NO
If yes, please provide: Date applied	DD MM YY	DD MM YY
Granted	YES NO	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 the OPSEU Pension Trust, 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 the OPSEU Pension Trust regarding my application for a pesnion.

I UNDERSTAND the information obtained by use of this authorization will be used by the OPSEU Pension Trust in the evaluation of my claim for disability benefits only. Any information obtained will not be released by the OPSEU Pension Trust 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 ______________

Personal information is collected on this form under the authority of Article 14.1 of the Ontario Public Service Employees' Union Pension Plan, 1994. It will be used to determine eligibility for benefits and to document/process pension payments. Questions about this collection should be directed to the Director, Member and Pensioner Services, 12th Floor. 1 Adelaide Street East, Toronto, Ontario M5C 3A7, Telephone (416) 681-6100, Toll Free within Ontario 1-800-637-0024.

Keep a copy of this form for your records.