



OPSEU Pension Trust  
 Fiducie du régime de  
 retraite du SEFPO

Mail to:  
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 Toll Free: 1-800-637-0024 www.optrust.com

# EMPLOYER'S STATEMENT ON DISABILITY

## 1. Identification

Employee Last Name	First Name	Initial	Social Insurance Number — — —
Employer: Ministry or Agency, Board, Commission (ABC) Ministry or ABC Address			Ministry Phone Number:

## 2. Work and Disability History

2.1 What is the applicant's position title?			
2.2 Has the applicant resigned from employment?	YES	NO	If not, why?
			What was the last day worked? DD MM YY
2.3 What is the position category?	2.4 Please complete and attach a Physical Demand Analysis for this position.		
2.5 What is the position class/grade?			
2.6 Please provide a description of the applicant's position with reference to its:			
- complexity			
- skill required			
- responsibility			
2.7 What is the applicant's period of employment in his/her current position?	DD	MM	YY
			TO DD MM YY
2.8 Name of immediate supervisor?	Telephone No.		
2.9 How has the applicant's condition impacted on his/her regular:			
a) hours of work			
b) job duties			
c) job performance			
e) job satisfaction			
2.10 When did the applicant's medical condition first appear to affect work performance?			
2.11 Do you feel the applicant is able to perform the essential duties of a similar position in the same class and grade?			
2.12 Has the applicant been considered for an alternative position in the same class and grade? If so provide details.			
2.13 What kind of job accommodations have you considered for the applicant?			
2.14 Is the applicant a candidate for retraining?			

### 3. Status

3.1 Is the applicant 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

4.1 Has the applicant applied for Long Term Income Protection (LTIP) benefits?	YES	NO				
a) Was the applicant's LTIP Benefit Application:	APPROVED?	DENIED?	If approved give effective date?	DD	MM	YY
b) Is the applicant currently in receipt of LTIP Benefits?	YES	NO				
c) What kind of LTIP Benefits is the applicant receiving?	STAGE 1	or	STAGE 2			
d) Has the employee made 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						

### Signatures:

\_\_\_\_\_  
 Ministry/ABC Official (PLEASE PRINT NAME) Title Signature Date

Telephone No. (\_\_\_\_) \_\_\_\_\_

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.