



Certificate of total disability

Use this form to provide OMERS with new or updated medical information.

Send the completed form to **OMERS, One University Avenue, Suite 700, Toronto, ON M5J 2P1** or fax: **416-369-9704**, toll-free fax: **1-877-369-9704**. If faxing, write your social insurance number or OMERS membership number at the top of the second page, and **do not** mail the original.

Once OMERS receives the form, we will determine whether you qualify or continue to qualify for an OMERS disability benefit.

OMERS will also accept copies of medical forms or reports about the member's condition that the member's doctor has completed for other benefits. In that case, the doctor does not need to complete Section 2 of this form.

FOR OMERS USE ONLY

Review date(yy/mm/dd)

Type of review: Initial Discretionary — before/after 24 months Required 24-month

Section 1 is to be completed by the member

1. MEMBER INFORMATION

Social insurance number		Birthdate (yy/mm/dd)		OMERS membership number	
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Last name		First name		Middle name
<input type="checkbox"/> Other:					
Address (street number and name)			City	Province	Postal code
Name of current employer			Occupation		

Personal information is collected for pension administration purposes under the authority of section 35 of the *OMERS Act, 2006*. If you have questions, please contact OMERS Client Services.

Section 2 is to be completed by the member's doctor

2. MEDICAL INFORMATION

This section is to be completed by a medical doctor licensed to practice under the laws of a province of Canada or the place where the member resides.

OMERS will also accept copies of medical forms or reports about the member's condition that the member's doctor has completed for other benefits. In that case, the doctor does not need to complete this section.

Please provide the following details on the nature of the member's disability (print clearly).

Date of disability (the last day the member worked)

Diagnosis

Subjective symptoms

Objective findings (results of x-rays or other tests, physical exam findings)

Prognosis

Other pertinent information

Social insurance number (if faxing)

OR OMERS membership/reference number (if faxing)

Which of the following definitions apply or do not apply to this member?

Disability waiver of contribution – first 24 months

To qualify, the member must have a physical or mental incapacity during the first 24 months of the disability that wholly prevents them from performing the regular duties of the occupation they were engaged in immediately prior to the date of disability.

Does the member meet the disability waiver of contribution definition? Yes No

Disability waiver of contribution – after 24 months (from the date of disability)

To qualify, the member must have a physical or mental incapacity that wholly prevents them from doing any work for compensation or profit for which they are, or may reasonably become, qualified to do by education, training or experience.

Does the member meet the disability waiver of contribution after 24 months definition? Yes No

Disability pension

To qualify, the member must have a physical or mental impairment that wholly prevents them from doing any work for compensation or profit for which they are, or may reasonably become, qualified to do by education, training or experience. This impairment is also reasonably expected to last for the remainder of their lifetime. (If the member was disabled before 1992, please call OMERS as this definition does not apply.)

Does the member meet the disability pension definition? Yes No

Form for Doctor's name, telephone number, address, city, province, postal code, signature, and date.

Sections 3 and 4 are to be completed by OMERS

3. TO BE COMPLETED BY A DOCTOR APPOINTED BY OMERS

Does the member meet one of the following definitions?

Disability waiver of contribution – first 24 months Yes No

Disability waiver of contribution – after 24 months Yes No

Disability pension Yes No

Is there a need for a further review? Yes Discretionary or 24 month Next review date (yy/mm/dd) No

Is this disability a recurrence? Yes No

Additional comments

Blank area for additional comments.

Form for Doctor's signature, date, and disability code.

4. APPROVAL

Based on the information provided and according to the OMERS Act, 2006, the member identified in Section 1 is:

- Approved for a disability pension / Not approved for a disability pension
Approved for a disability waiver of contribution / Not approved for a disability waiver of contribution

Form for Signature of authorized OMERS staff and Date (yy/mm/dd)