Notice of rehabilitative work

This form is for employer use only. Use this form if a member will be returning, or has returned, to rehabilitative work. This work must be approved by OMERS if the member is to continue receiving a disability benefit.

Rehabilitative work is a transition period between total disability status and a return to normal work duties or to a new permanent occupation (either full-time or part-time). Rehabilitative work generally lasts weeks or months but not years.

Once you have completed and signed this form, send it to **OMERS, One University Avenue, Suite 700, Toronto, ON M5J 2P1** or fax: **416-369-9704,** toll-free fax: **1-877-369-9704**. If you fax it, be sure to write your group number and the member's social insurance number at the top of the second page, and **do not** mail the original.

Review the member's progress regularly and advise OMERS in writing when the member returns to regular duties and begins normal contributions. Be sure to include the date the member returned to work. You must also advise us immediately if the member stops rehabilitative work, or if the nature of the rehabilitative work changes.

Sections 1, 2, 3 and 4 are to be completed by the employer

1. MEMBER INFORMATION

Group number	Social insurance number		Birth date (yy/mm/dd)
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other:	Last name	First name	Middle name
Daytime telephone ( )	Name of present employer		Occupation prior to disability

2. REHABILITATIVE WORK INFORMATION

A member should **not** make contributions to the OMERS Pension Plan during an OMERS-approved rehabilitative work period. If the member made contributions during this period, please call us.

Rehabilitative work — Date work started (yy/mm/dd): ______ Employer's next scheduled rehabilitative review — Date (yy/mm/dd): ______

Has the member returned to regular work? ☐ Yes — Date of return (yy/mm/dd): ______ ☐ No — Expected return date (yy/mm/dd): ______

What type of rehabilitative work is the member involved in?

- ☐ a different occupation or a training program, *with no reduced hours*, to train for a new occupation
- ☐ a different occupation or a training program *with reduced hours*, to train for a new occupation
- ☐ a different occupation as a transition to resuming own occupation
- ☐ a different occupation *with reduced hours*, with the goal to resume own occupation
- ☐ own occupation for a trial period (*no reduced hours* or modifications to duties)
- ☐ own occupation with modifications to duties
- ☐ own occupation *with reduced hours*
- ☐ own occupation with modification to duties and *reduced hours*

Please describe the work in detail. For example, include the type of work the member is doing and the number of hours the member is working.

Group number (if faxing)	Member's social insurance or OMERS membership number (if faxing)

3. OTHER DISABILITY BENEFITS

Has the member applied for a Workplace Safety and Insurance Board benefit?

☐ Yes — Please complete the following:

☐ Approved | Monthly benefit amount $ | ☐ Total/full ☐ Partial ☐ Temporary | Temporary benefit end date (yy/mm/dd)

☐ Declined ☐ Under appeal ☐ Pending approval

☐ No — Please advise OMERS in writing if the member is approved for a WSIB benefit in the future.

Has the member applied for a benefit under your long-term disability plan?

☐ Yes — Please complete the following:

☐ Approved ☐ Receiving benefit ☐ Benefit stopped as of | Date (yy/mm/dd)

☐ Declined ☐ Under appeal ☐ Pending approval

☐ No — Please advise OMERS in writing if the member is approved for an LTD benefit in the future.

4. EMPLOYER AUTHORIZATION

Employer name	Contact (please print)	Title

Telephone number	Fax number	
( )	( )	By providing my e-mail address below, I authorize OMERS to contact me by e-mail to clarify information about this member.

Signature of authorized signing officer	Date (yy/mm/dd)	Contact's e-mail address

Sections 5 and 6 are to be completed by OMERS

5. TO BE COMPLETED BY A DOCTOR APPOINTED BY OMERS

Based on the information submitted to me, I recommend that the rehabilitative work be:

☐ Approved ☐ Declined | Next review date (yy/mm/dd)

Additional comments

Doctor's signature	Date (yy/mm/dd)	Disability code

6. APPROVAL

Based on the information provided, the member identified in section 1 is:

☐ Approved ☐ Not approved for rehabilitative work according to the *OMERS Act, 2006.*

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