Employer's Statement on Disability

Public Service Pension Plan (PSPP)

To provide information about the member/former member's disability, and how it affects their employment. Return completed form to the applicant for filing with OPB.

OPB client number

Employee information

OPB client last name (please print)

OPB client first name

Initials

1. Work and disability history (attach additional pages if needed)

Employer name

Attach a Physical Demands Analysis for this position

Suite number

Address

OPB client position

Position category

Position class/grade

Immediate supervisor's name

Contact telephone number

a) Has the applicant resigned from employment? ☐ Yes ☐ No

Last date of work (YYYYMMDD)

If no, explain why not

b) What is/was the applicant's period of employment in their position?

From (YYYYMMDD)

To (YYYYMMDD)

c) Describe the applicant's position with reference to the following:

Complexity

Skill required

Responsibility

d) How has the applicant's condition affected on their regular:

Hours of work

Job duties

Job performance

Job satisfaction

OPB client number

2. Work and disability history (continued)

e) When did the applicant's medical condition first appear to affect work performance?
Date (YYYYMMDD)

f) Do you feel the applicant is able to perform the essential duties of a similar position in the same class and grade? ☐ Yes ☐ No

g) Has the applicant been offered an alternate position in the same class and grade? ☐ Yes ☐ No
If yes, give details

h) What kind of job accommodations have you considered for this applicant?

i) Is the applicant a candidate for retraining? ☐ Yes ☐ No

3. Status

a) Applicant is still a member of the PSPP? ☐ Yes ☐ No If no, Termination date (YYYYMMDD)

b) Applicant is on leave of absence (LOA) with pay? ☐ Yes ☐ No If yes, LOA start date (YYYYMMDD)

c) Applicant on a LOA without pay? ☐ Yes ☐ No If yes, LOA start date (YYYYMMDD)

4. Other disability benefits

a) Has the applicant applied for Long Term Income Protection (LTIP) benefits? ☐ Yes ☐ No

b) Was the LTIP benefits application: ☐ Approved ☐ Denied Effective date, if approved (YYYYMMDD)

c) Is the applicant currently receiving LTIP benefits? ☐ Yes ☐ No

d) What kind of LTIP benefits is the applicant receiving? ☐ Stage 1 (up to 2 years) ☐ Stage 2 (over 2 years)

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4. Other disability benefits (continued)

e) Has the applicant made a claim under one of the following plans?

Workers Compensation: ☐ Yes ☐ No Granted? ☐ Yes ☐ No Effective date (yyyy/mm/dd)

Canada Pension Plan: ☐ Yes ☐ No Granted? ☐ Yes ☐ No Effective date (YYYYMMDD)

State reason if no application was made, or claim was disallowed.

Sign and date

Employer representative

Position title

Date signed (YYYYMMDD)

Contact telephone number

Employer representative signature

Employer representative must be in a Payroll/HR/Administrator role

The personal information on this form is collected under the authority of the *Public Service Pension Act* and will be used only to evaluate the applicant's claim for disability benefits, and to document/process disability applications or reviews. Questions about this collection should be directed to our Privacy Officer at:

Telephone 416-364-5035 or **toll-free** 1-800-668-6203 (Canada & USA) | **Fax:** 416-364-7578 | **OPB.ca**