Member's Statement of Disability

Jan 2017

HOOPP Healthcare of Ontario Pension Plan

Complete both pages of this form. Please print or type. Attach additional sheets if more space is required.
This form must be printed on 8½" × 14" (legal size) paper.

1. Member Information

first name: | last name: | middle initials:

SIN: | date of birth: (mm/dd/yyyy) | address:

phone: | city/town: | province: | postal code:

occupation: | employer:

I am applying for (choose one): ☐ free accrual ☐ disability pension
(If no option is chosen, HOOPP will process this as a free accrual application)

2. Medical Information

Briefly describe your present medical condition, its cause and history:

Date symptoms began: (mm/dd/yyyy)

Date your medical condition first prevented you from working: (whether or not you were scheduled to work) (mm/dd/yyyy)

Do you have any other health-related conditions or impairments? ☐ yes ☐ no

If yes, please describe:

Have you been hospitalized for your present medical condition? ☐ yes ☐ no

If yes, please explain when, where and for how long:

List all physicians you have seen for your present medical condition:

Physician's/specialist's name	Address	Treated from	To
		mm/dd/yyyy	mm/dd/yyyy

3. Disability Benefits

If you have applied for or are receiving any other disability, wage loss and/or retirement benefits, provide details below.

A. ☐ Workplace Safety & Insurance Board (WSIB) benefits

Application status: ☐ approved ☐ denied ☐ pending ☐ terminated

If approved, type of approval: ☐ total ☐ partial ☐ temporary

B. ☐ Long-term disability benefits

Application status: ☐ approved ☐ denied ☐ pending ☐ terminated

If approved, type of approval: ☐ own occupation ☐ any occupation

Name of disability insurance company: _____

C. ☐ Canada Pension Plan (CPP) benefits

Application status: ☐ approved ☐ denied ☐ pending ☐ terminated

If approved, effective date of approval: (mm/dd/yyyy)

Healthcare of Ontario Pension Plan

1 York Street, Suite 1900
Toronto, Ontario M5J 0B6

Tel: 416-646-6445
Toll-free: 1-877-43HOOPP (46677)
Fax: 416-369-0225

hoopp.com
clientservices@hoopp.com

- Send to HOOPP
- Keep a copy for your files

4. Observations

Does your disability prevent you from travelling to work? ☐ yes ☐ no

Are there aspects of your job you could do despite your disability? ☐ yes ☐ no

If yes, please explain:

Are there aspects of your job you can no longer do? ☐ yes ☐ no

If yes, please explain:

Are you doing any paid work? ☐ yes ☐ no

If yes, please explain:

Is there any type of work you could perform if it was available through your employer or retraining? ☐ yes ☐ no

If yes, please explain:

5. Functional Limitations

Do you have any problems or limitations in the following areas:

		yes	no		yes	no		yes	no
Special senses:	hearing	☐	☐	equilibrium	☐	☐	vision	☐	☐
Psychological:	mood changes	☐	☐	coping with stress	☐	☐	concentration	☐	☐
Cardiorespiratory:	breathing	☐	☐	exertion	☐	☐	stamina	☐	☐
Orthopedic:	joint motion	☐	☐	standing	☐	☐	lifting	☐	☐
Neurological:	coordination	☐	☐	memory/thinking	☐	☐	pain	☐	☐
Activities of daily living:	eating	☐	☐	dressing	☐	☐	driving	☐	☐

Can you use public transportation? ☐ yes ☐ no

Please explain any other problem:

6. Certification and Consent

I certify that the information provided on this form is, to the best of my knowledge, complete and true. I agree to notify the Healthcare of Ontario Pension Plan (HOOPP) of any changes that may affect my eligibility for benefits. This includes an improvement in my condition; a return to full-time, part-time, or volunteer work; or any trial period of work or rehabilitation.

I authorize any physician, practitioner, hospital, clinic, insurance company or organization to give full documentation of my medical condition to HOOPP, its medical consultants, or its legal representatives. I agree that a photocopy of this form is valid authorization for the release of any required information. I authorize HOOPP to collect, use and disclose my personal information for the purpose of assessing my disability application and administering my disability benefits, if applicable.

Signature of member: _____ Date: mm/dd/yyyy

Please return this form to HOOPP along with your completed Physician's Statement of Disability.