Member's Statement of Continuing Disability

HOOPP Healthcare of Ontario Pension Plan

Jan 2017

Complete both pages of this form. Please print or type. Attach additional sheets if more space is required.

1. Member Information

first name: | last name: | middle initials:

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

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

former occupation: | former employer:

2. Medical Information

Has your medical condition changed since your last report to HOOPP? ☐ yes ☐ no

If yes, please explain:

Have you been hospitalized for your medical condition since your last report? ☐ yes ☐ no

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

Have you seen any physicians/specialists since your last report? ☐ yes ☐ no If yes, please list them below:

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

3. Disability Benefits

Since your last report, have you held any job for which you have been paid? ☐ yes ☐ no

If yes, please explain:

When, if ever, do you expect to return to your previous or any other job?

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:

4. Observations

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

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

If yes, please explain:

Are there aspects of your former 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 Continuing Disability.

Healthcare of Ontario Pension Plan

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- Send to HOOPP
- Keep a copy for your files