OPERS DISABILITY BENEFIT REHABILITATIVE SERVICES SELECTION FORM

Ohio Public Employees Retirement System
277 East Town Street, Columbus, Ohio 43215-4642
1-800-222-PERS (7377)
www.opers.org

Managed Medical Review Organization

44090 W. 12 Mile Road, Novi, Michigan 48377
Phone 1-866-516-6676 Fax 1-248-530-7411
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MMRO

The purpose of Rehabilitative Services is to ensure OPERS benefit recipients receive appropriate treatment to improve functionality and to provide the tools and resources to assist the recipient with seeking employment in the competitive labor market. If you elect to participate in the Rehabilitative Services Program, the medical and vocational information acquired through the Rehabilitative Services Program may be used in the determination of your continued eligibility for a disability benefit.

This form is to be completed by the disability benefit recipient to make their selection whether to participate in Rehabilitative Services. Before making your selection below it is important for you to read and understand expectations of rehabilitative services. This information can be found in the *Disability Benefit* leaflet.

STEP 1: Member Personal Information

Social Security Number ___ — ___ — ____ **-OR-** OPERS ID

Date of Birth ___/___/____ Gender: ◯ Male ◯ Female

First Name MI Last Name

Address

City State ZIP Code

Home Phone Number ___ — ___ — ____ Work Phone Number ___ — ___ — ____

Cell Phone Number ___ — ___ — ____

E-mail Address

See next page

STEP 2: Rehabilitative Services Selection - Please choose one of the options below.

○ I choose to participate in Rehabilitative Services. I understand that by participating in Rehabilitative Services I will remain on a leave of absence from my last public employer and continue to be evaluated under the **own occupation** standard for up to five years following the effective date of my benefit. If at any time after my third benefit anniversary I stop participating in rehabilitative services, my disabling condition will be reviewed immediately under the **any occupation** standard. Furthermore, I understand that upon the expiration of my leave of absence period I will be evaluated under the **any occupation** standard.

○ I choose not to participate in Rehabilitative Services. I understand that by not participating in Rehabilitative Services my leave of absence from my last public employer will be **limited** to three years following the effective date of my benefit. Furthermore, I understand that upon the expiration of my leave of absence period I will be evaluated under the **any occupation** standard.

STEP 3: Member's Acknowledgment

I understand if I choose to participate in Rehabilitative Services, I agree to work with OPERS' third party administrator and to comply with my physician directed treatment plan.

I understand if I choose to participate in Rehabilitative Services, I agree to engage in a self-directed effort to maximize my employability. I understand if I elect to participate in the Rehabilitative Services Program, the medical and vocational information acquired through the Rehabilitative Services Program may be used in the determination of my continued eligibility for a disability benefit.

I understand if I choose to participate in Rehabilitative Services and become non-compliant prior to my third benefit anniversary, OPERS will suspend my benefit payments and my health care.

I understand if I choose to participate in Rehabilitative Services and, at any time following my third benefit anniversary, I stop participating in Rehabilitative Services, my disabling condition will be reviewed immediately under the **any occupation standard.**

I understand if I choose to participate in Rehabilitative Services, I must make my election no later than six months prior to my third benefit anniversary. If I elect to withdraw from Rehabilitative Services I understand that I will only have one additional opportunity to elect back into the program.

I understand if I choose not to participate in Rehabilitative Services, I may be required to engage in continued medical treatment. I further understand that I will be required to provided OPERS with physician statements completed by my physician at scheduled intervals.

I understand if I choose not to participate in Rehabilitative Services, my leave of absence from my last public employer will be limited to three years following the effective date of my disability benefit.

Member Signature _____ Today's Date ____/____/____

Do not print or type name