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

Report of Employer for Disability Benefit Applicant

Important: Please note Managed Medical Review Organization (MMro) may be contacting you regarding this application for disability benefits.

NOTE: Failure to complete this form in its entirety, along with a submission of a formal written job description, could result in a delay in processing.

The employer must complete this form to initiate or supplement the employee's disability application. Please provide complete and accurate information to allow OPERS to properly evaluate the employee's disability application. If more space is needed, attach additional pages. Employers should contact the Employer Call Center at 1-888-400-0965 with questions.

Section 1 - Employee's Personal Information

Social Security Number | **Gender** Male Female | **Date of Birth** Month Day Year

First Name | **MI** | **Last Name** | **Suffix**

Street or Mailing Address | **Apt. Number**

City | **State** | **ZIP Code**

Section 2 - Certification by Department Head - *This Section is to be completed by the employee's supervisor or department head. **It is important to provide contact information.***

A FORMAL WRITTEN JOB DESCRIPTION INCLUDING PHYSICAL/MENTAL FUNCTIONAL RESPONSIBILITIES FOR THE EMPLOYEE MUST BE INCLUDED WITH THIS COMPLETED FORM. YOU MUST ALSO COMPLETE THE EMPLOYER REPORTED PHYSICAL JOBS DEMANDS SECTION OF THIS FORM.

1. Employee's Job Title (Employee's Job Title must match title on job description)

2. Who initiated the application for disability? Employee or Employer

Section 2 - Certification by Department Head *(continued).*

3. <u>This question is only for employees who are law enforcement officers.</u> Is the disabling condition the result of an on-duty illness or injury that occurred during or resulted from the performance of duties under the direct supervision of the employee's appointing authority? Yes ☐ No ☐

If "Yes", explain and provide the date the illness or injury occurred: _____

_____

_____

4. Employer Reported Physical Jobs Demands (this section must be completed by all applicants).

Employer Reported Member Physical Jobs Demands **Max = Maximum lifting/carrying/pushing/pulling capacity - (lbs.)*					
Please address all below if applicable:	**Max***	**Not Applicable**	**Occasional 0 to 2.6 hours/day**	**Frequent 2.7 to 5.3 hours/ day**	**Constant 5.4 to 8 hours/day**
Low Lift (floor to knuckle)		☐	☐	☐	☐
Mid Lift (knuckle to shoulder)		☐	☐	☐	☐
Full Lift (floor to shoulder)		☐	☐	☐	☐
Carrying		☐	☐	☐	☐
Pushing		☐	☐	☐	☐
Walking	N/A	☐	☐	☐	☐
Climbing	N/A	☐	☐	☐	☐
Balance	N/A	☐	☐	☐	☐
Stoop	N/A	☐	☐	☐	☐
Kneeling	N/A	☐	☐	☐	☐
Crouching	N/A	☐	☐	☐	☐
Crawling	N/A	☐	☐	☐	☐
Reaching (immediate)	N/A	☐	☐	☐	☐
Reaching (overhead)	N/A	☐	☐	☐	☐
Handling	N/A	☐	☐	☐	☐
Fingering	N/A	☐	☐	☐	☐
Feeling	N/A	☐	☐	☐	☐
Sitting	N/A	☐	☐	☐	☐
Standing	N/A	☐	☐	☐	☐

Section 2 - Certification by Department Head *(continued)* - *This Section is to be completed by the employee's supervisor or department head.* ***It is important to provide contact information.***

General remarks regarding additional physical/mental job demands:

Did you require the member attain any additional education, skills or certification since they were hired?

Yes ☐ **No** ☐

If yes, please list:

Department Head First Name **MI** **Last Name**

Title

Employer E-mail Address

Primary Office Contact

Primary Office Contact Phone Number **Primary Office Contact Fax Number**

Primary Office Contact E-mail Address

Office Hours: _____ **Preferred Time to Call:** _____

Preferred Method of Contact - **Phone** ☐ **Fax** ☐ **E-mail** ☐

Today's Date
Month **Day** **Year**

Signature _____

Do not print or type name

Section 3 - Certification by Fiscal Officer - *The employee's fiscal officer should complete this Section certifying the final date of compensation. A separate request will be sent to you for completion once the OPERS Board of Trustees has approved the employee's disability benefit application.* ***Employees must be removed from the employer's payroll by the end of the month following the month in which the Board's decision to approve the disability benefit application. If the employee stays on the employer's payroll past this time frame, their disability benefit will not be paid and they will be required to re-apply for a disability benefit if eligible.***

I certify that the applicant listed on the front of this form was/is an employee of:

Employer

Department/Division

Check ONLY one of the following and provide the date if applicable:

☐ **The final date for which this employee was/will be compensated is:** **Month** **Day** **Year**

☐ **The final date of compensation is not known. I certify the final date of compensation will be provided pending the OPERS Board of Trustees approval of the Application.**

Fiscal Officer Reporting to OPERS

First Name **MI** **Last Name**

Title

Department

Work Telephone Number

Today's Date
Month **Day** **Year**

Signature _____

Do not print or type name

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OPERS

MMro Managed Medical Review Organization

URAC ACCREDITED INDEPENDENT REVIEW ORGANIZATION: COMPREHENSIVE