OPERS

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

Disability Benefit Termination Request Form

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

This form is to be completed by a disability benefit recipient who wishes to terminate his/her disability benefit. The recipient must be deemed no longer disabled for OPERS to terminate his/her benefit. The recipient must submit along with this form a completed Report of Physician form (DR-APS) and objective medical evidence supporting his/her claim.

Section 1 - Member'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 -

Home Phone Number

Work Phone Number

Cell Phone Number

Preferred Telephone Number for Contact: Home Work Cell

Preferred Time to Call: Morning Afternoon Evening

E-mail Address

Section 2 - Member's Acknowledgment

HIPAA DISCLOSURE:
I authorize any licensed physician, medical provider, medical facility, or provider of health care or similar entity to release any and all of the following information to OPERS or their third party administrators:

Medical information with respect to any physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, and mental health.

I understand the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, return to employment opportunities, and assessment of ongoing treatment. Any information obtained will not be released to any person or organization except OPERS and their third party administrators.

I agree that a photographic copy of this Authorization shall be as valid as the original.

I understand that I may request a copy of this Authorization. This Authorization shall become effective on the date appearing next to my signature below.

I understand I have the right to revoke this Authorization at any time by notifying OPERS.

I understand that revoking this Authorization may impair necessary processing of my request.

I am requesting that my disability benefits be terminated. I understand that for OPERS to evaluate my request I must undergo a medical review to determine if I am no longer disabled. I also understand that as part of the medical review process I may be required to supply additional medical evidence supporting my claim and undergo a medical examination. I further understand that if OPERS determines I am still disabled, OPERS will not terminate my disability benefits which I have a vested right to receive as long as I am disabled. If OPERS determines that I am no longer disabled, a recommendation will be made to the Retirement Board to terminate my disability benefits.

Important: Please include with this form your completed Report of Physician form (DR-APS) and objective medical evidence supporting your claim.

Member Signature_____ Month ☐☐ Day ☐☐ Year ☐☐☐☐

Do not print or type name