OPSEU Guide to the Hospitals of Ontario Disability Income Plan (HOODIP)

OPSEU Membership Benefits Department
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1. Introduction

This booklet is for all OPSEU members who are covered by the Hospitals of Ontario Disability Income Program called HOODIP. It is designed to help you to access HOODIP and related sickness and disability programs when you need them and what you can do if you get denied benefits.

It is for OPSEU stewards to help members understand their rights, assist members with information on eligibility and applications for related government plan incomes and represent members with the grievance and appeals processes.

Health insurance is an important income protection for all workers in the event they are unable to work. We never know when we may become ill and access these vital income security plans.

Throughout the twentieth century, working people fought for union recognition as well as government health care and benefit programs so that everyone would have coverage. Hospital members negotiated for health benefits and programs above existing government programs and as a result, HOODIP was created in 1968 to provide uniform disability income protection for all members of participating employers.

The basic principles of HOODIP group insurance for members that belong to a specific HOODIP workplace are:
- actively at work,
- qualify for the benefits program and
- meet eligibility based on disability based on medical support.

If you are not covered by any insured benefit program, you are still eligible to receive coverage through the Employment Insurance program (EI) and through the Canada Pension Plan (CPP). This booklet also includes information about these two programs.

2. HOODIP and your Collective Agreement

OPSEU members are eligible to be plan members of HOODIP if their employer is a member of the Ontario Hospital Association and participates in HOODIP. This applies to all full-time employees. Some local employers do allow participation of regularly scheduled part-time employees in the plan.

If you change your job to another hospital where the employer does not participate in HOODIP, your coverage is terminated.

In general, the local Employer will contract with an insurance company or a third party administrator to assist in the adjudication of short term and long term HOODIP benefits.

The Central Collective Agreement specifies that employers may change the insurance carrier at any time. However, non-participating employers must guarantee equivalent and continuing benefits to members and claimants.

You have the right to grieve any dispute on whether you are entitled to short or long term benefits under the HOODIP plan (Article 15 of the Central Collective Agreement).

All benefit rights for HOODIP are laid out both in the Central and local collective agreements. It is always important to check your collective agreements for benefit rights you are entitled to and what you would like to bargain in the future.

It is highly recommended that you are aware of any time limits in your collective agreement and with the insurance carrier. Contact your union representative as soon as possible if you are denied benefits so you can meet these deadlines for grievance and help with your appeal.

3. The HOODIP Disability Plan

Overview

There are three distinct components to the disability coverage:

- Short Term Benefits - for the first fifteen weeks, a sick pay benefit called Part "A" of HOODIP; funded by the employer
- Employment Insurance - for the next fifteen weeks, Employment Insurance sickness benefits; funded by your contributions and your employers and paid by the Government of Canada; and
- Long Term Benefits - starting at the thirtieth week, a long term disability plan called Part "B" of HOODIP, funded by the employee's employer as an insured benefit; that means the insurance company – the carrier – signs a contract with the employer to provide the program for a certain cost.

The three benefits are separate plans, each with their own eligibility requirements and benefit levels. If you do not complete and submit the necessary forms for each benefit of the plan on time, you may experience interruptions of income.

Who is Covered?

Full-time employees are eligible for sick pay coverage only as long as your employer participates in HOODIP. Part time employees may be included if allowed by the local employer.

Remember also that in calculating when your coverage begins, you can count time with a previous employer who participates in HOODIP.

There is an initial three month waiting period for Short Term benefits and six months for LTD coverage before you are eligible for HOODIP.

The plan will pay benefits for medical conditions regardless of whether or not these conditions predated your employment with your employer.

Date of Disability

The date of disability is determined by the first day you cannot report to your regularly scheduled employment due to injury or illness.

Eligibility

Before being eligible, you must have completed 3 months of service with the same employer following your first day of active work. This is called the qualifying period.

Actively at Work

'Actively at work' is defined by the plan to mean that you are:

- fully capable of performing your regular duties; and
- either:
  - actually working at the employer's place of business or a place where the employer's business requires you to work; or,
  - absent from work due to vacation, weekends, statutory holidays, occasional educational days or union business.

The insurer does not consider you actively at work if you are on an extended leave of absence from work.

If you are sick on the effective date of your coverage beginning, your coverage is delayed for:

- full time employees who must work for seven consecutive working days before being covered
- part time employees whose coverage is delayed for ten calendar days

If you are not off sick but on an extended leave, your coverage will be effective on your return to work.

Pre-Existing Conditions

Members who have completed three months of service are eligible for coverage regardless of any pre-existing conditions.

Exclusions and Limitations

Exclusions and limitations under HOODIP are:

- disabilities resulting from intentionally self-inflicted injuries,
- injuries sustained during 'civil disorder' or war;
- committing or attempting to commit a criminal offence excluding operating a vehicle while your blood contains more than 80 milligrams of alcohol per 100 milliliters of blood
- not under the active and continuous care of a licensed physician and following the prescribed treatment for the disabilities
- elective or cosmetic surgery unless medically necessary
- If your illness is due to the use of alcohol or drugs, you must be receiving care from a rehab centre

- If you have a psychological illness, you must be under the appropriate professional for treatment

Some of these limitations may pose significant difficulty for workers; one example is that members who live in remote areas may not have access to the kind of professional treatment that they need. It can be difficult to obtain medical documentation in a timely manner.

Another example is where the insurer and your employer decide on treatment and rehabilitation programs for members based on medical reports. You risk termination of your benefits if you fail to undergo these programs. This is why it is important to work closely with medical professionals in order to protect your own interests and ensure that you receive good medical care and supporting and timely medical documentation.

Leave of Absences

If you take and approved leave of absence, your benefits will be continued for a period of 12 months by the employer. Premiums are not required while receiving for HOODIP LTIP during an approved leave. If you are unable to return to work due to being totally disabled, you will be considered disabled as of your scheduled return date.

4. Dealing with Medical Professionals

An essential part of any benefits claim – whether it is for Short term or long term disability – is your medical documentation. In short, your medical professionals – your family doctor, psychiatrist or specialist – can help you or hurt you, whatever medical assistance they give you.

It is critical that you know the benefit criteria for each plan so you are aware of what documentation is required to collect your benefits. You must communicate these definitions to your medical professional so they are aware at the time they completed medical documentation in support of your claim or appeal.

The insurer might also be asking for specific information from the doctor. The information needed is often listed in any denial of benefits letter.

Insurers have biases about the professionals whose opinions they would prefer to accept. They tend to prefer doctors over para-professionals and specialists over family doctors. They may also insist on an 'independent' medical assessment (or IME) if they are not satisfied with the medical documentation you have provided. Insurers have medical staff on retainer to perform these medical examinations and write medical opinions.

Effective medical information includes **all** doctors' reports, tests, examinations and clinical notes.

Most long term illnesses are a complex mixture of physical and psychiatric symptoms. Indeed, 75% of longer term disabilities are now psychiatric. This may make diagnosis and prognosis more difficult. Access to competent professionals is difficult unless you live in an urban centre.

If you grieve, your health records will have to be released for the arbitration process.

5. Part A: Sick Pay Benefit

Overview

Sick pay benefits cover the time you are off work when you are unable to perform the regular duties of your own job. Part "A" defines this as a *total disability* and …

> ……..state of incapacity as a result of bodily injury or disease which prevents the member from performing the regular duties of the occupation in which the member was engaged prior to the commencement of disability

How much will I get?

Here is the schedule for benefit payments, based on your years of service:

3mths to 1 year	66 2/3% of earnings
1 yr to less than 2 yrs	70% of earnings
2yrs to less than 3 yrs	80% of earnings
3 yrs to less than 4 yrs	90% of earnings
4yrs and up	100% of earnings

For how long can I collect sick pay?

You can receive up to 15 calendar weeks of benefit based on your regular work week. If you are sick over a statutory holiday, you can claim that day as a sick day.

How do I apply?

As soon as you are aware you will be off work, report to the appropriate employer contact at the worksite. Then seek medical attention as soon as possible. Be sure to ask your doctor for a medical certificate verifying that you will be off, how long you will be incapacitated, your inability to work or restrictions on your ability to work. Submit your certificate to the employer, or to the designated employer representative (i.e. the occupational health department). During the time you are medically incapacitated, you will be asked to provide additional information to support your ongoing time off.

Pregnancy and Parental Leave

If you are sick when on your leave, or just prior, your leave may commence on the agreed leave date or the date of birth or adoption whichever is the earliest. If you become totally disabled while on pregnancy/parental leave, you would be considered totally disabled on the date you were scheduled to return to work.

Plan Termination of Benefits

Your eligibility for benefits terminates on the earliest of the date of:

- termination of employment, retirement or death
- transfer to a group covered by the Plan
- the plan terminates or your employer terminates participation in the plan

If you are totally disabled on the date of the plan terminates, you will entitled to the benefit.

Recurrences

If you become further disabled while you are off on sick leave, you only have the remaining sick leave available to you.

If you return to work and then become ill again from the same or a related illness or injury within 3 regular work weeks or, if you are part-time, 21 calendar days, again, you will only be covered for the remainder of the 15 calendar weeks of your original sick leave.

If your sickness or injury is unrelated, to your original illness, your sick pay begins again for 15 calendar weeks.

Returning to Modified Work

The insurer and the employer will request information on your restrictions, limitations and prognosis to determine if there is accommodation is available at the workplace.

If you are able to return to work on a modified work program, please notify the employer. Your employer may also offer you modified work. It is important to remember that if you return to work on a modified work program (to accommodate your illness) within the 15-week short term benefit period, you are not considered to be ‘actively at work’. So the time spent on the program is all part of the 15 week period.

Failure to participate in such return-to-work programs that have been approved by your employer, the insurer and your physician may be grounds for suspension of your benefits. This is where it is essential that you work closely with your physicians so that they know what work is available and your capacity to perform it through the entire return to work process.

If you require accommodation assistance, please contact your union steward or your local OPSEU office.

Medical Certificates

If, under HOODIP you are required to provide a medical certificate, the hospital will pay the full cost. Under the sick pay benefit plan, employers may require proof of sickness if you are absent from work. Under the long term disability plan, the insurance company will require much more extensive medical documentation initially and during the life of your claim.

6. Workplace Safety and Insurance Benefits

Overview

If you are injured at work, you cannot collect benefits from HOODIP. However, it can take time to establish that your injury is work related. The central collective agreement provides for HOODIP benefits to be paid pending approval of your claim to the Workplace Safety and Insurance Board. Since local collective agreements can vary, check your own collective agreement for any specific provisions concerning Workplace Insurance payments or advances.

Reporting Accidents

If your injury or illness is possibly work-related, you must tell the employer immediately and it should be before the end of your work shift. The Employer is required to report the accident to the Board within 3 working days, using a Form 7 and provide you a copy of their report to the Board to you at the time of filing of the claim. You will need to seek medical attention as soon as possible and your physician will report the medical information to the WSIB using a Form 8.

The Employer is required to pay for the day of the accident directly. The Employer must allow you to attend for medical attention on the day of the accident and pay for any transportation to obtain medical attention on the day of the accident.

You may be asked by the WSIB to complete a Form 6, a Workers' Report of the accident. When a work-related injury is well reported and timely, you have a much greater chance of having your claim allowed quickly. More information including filing forms on workplace safety and insurance can be found at www.wsib.on.ca.

Injuries may be chance events where you fall or become injured while doing your work or they may be more gradual such as repetitive strain injuries, occupational illness resulting from exposure to workplace substances; they may recur and may have secondary symptoms; they may be as a result of assault from other workers or patients; they may also be a result of an aggravation of a pre-existing medical condition.

There are strict time limits for reporting accidents to the WSIB. Normally, it is no later than 6 months from the date of the accident and in the case of occupational diseases, 6 months of when you became aware of a potential claim. When in doubt, report the accident.

How much do I get?

While you are waiting for your claim to be approved, you may apply to the employer for the lesser amount of two options:

- The benefit you would receive from WSIB; or

- The benefit that you would receive from HOODIP

The employer must be satisfied that you will qualify for HOODIP benefits and you will required that you will repay the appropriate amount to the HOODIP plan if you become eligible for WSIB benefits.

Workplace Insurance benefits are based on the date of injury. All payments are tax free. A new and accepted WSI claim will pay a weekly rate of 85% net earnings called a Loss of Earnings payment. If you have a permanent impairment, you can also receive a separate pain and suffering award called a Non-Economic Loss Award.

Many members do not miss any time at all but still incurred health care costs. Health care costs related to the workplace injury and/or illness include payment for drugs, assistive devices, paramedical services and other medical services and equipment. The majority of the WSI claims involve payment only for health care benefits. It is important to file as some conditions worsen and may require lost time, further health care, rehabilitation and access to return to work.

If you receive WSI benefits, the WSIB will regularly request medical information from you in order to assess your continued qualification due to your medical condition.

You are required to co-operate in any return to work initiatives while on WSIB. The employer can request functional abilities information on restrictions, limitations and prognosis.

If there is any material change of circumstances in your health, ability to work and income, you must report this information to the WSIB within 10 days. Failure to report material change or co-operate in return to work can cause suspension of benefits.

If you missed more than the first day of work, have worked more than one year for the employer and claim WSI, you are entitled to re-employment rights for up to two years. You can find more information on re-employment rights, rehabilitation and material changes at www.wsib.on.ca

How do I appeal a WSI Denial?

If your claim for workplace insurance is denied, you have 6 months to appeal the WSI benefits denial to the WSIB. To appeal a WSI denial, you must write to the WSI caseworker listed in the WSIB denial letter, indicating that you wish to appeal the caseworker's decision to deny benefits. The WSIB will send you an appeal form along with a copy of your Board file. Once you have received the appeal form and a copy of your WSIB file, you can request the assistance with your appeal from of the OPSEU's Membership Benefits Department at 1-800-268-7373 ext.8662.

If you are denied by the WSI at their final level of appeal (Appeals Officer), you have 6 months to appeal to the Workplace Safety and Insurance Tribunal (WSIAT) in writing.

There are three reasons why it is important to appeal a denial of workers' compensation and, hopefully, receive WSIB:

- First, if the timing is right, you can avoid the gap (see below) since workers compensation will tide you over and you will not have to apply for employment insurance (EI).
- Second, workers' compensation is tax free. This means that you will pay less tax overall on your benefit.
- Third, you get a minimum $50 benefit before HOODIP deducts from your benefit.

If you already have workers' compensation, why would you apply for HOODIP? First, the premiums for benefit coverage are waived while you are receiving HOODIP, so if your workplace insurance is reduced, you have maintained your coverage with HOODIP. On both programs, you are required to submit regular supporting medical information.

7. Employment Insurance

Overview

For the next 15 weeks, the only income protection for members whose medical condition is longer term is Employment Insurance (EI) sickness benefits, unless your medical condition is covered by workers compensation. The normal two-week waiting period is waived and EI benefits will commence on the sixteenth week.

It takes 28 days to process an EI application so you also have to think ahead so that you have income for the 15 weeks after your short term sick leave elapses. Will your medical condition continue? If so, apply a month ahead of time.

How much do I get?

You will receive substantially less money. The basic benefit rate is 55% of your average insured earnings up to a yearly maximum insurable amount of $42,300. This means you can receive a maximum payment of $447 per week (as at November 2009). Your EI payment is also taxable.

You could receive a higher benefit rate if you are in a low-income family — an income of less than $25,921— with children and you or your spouse receive the Canada Child Tax Benefit (CCTB), you are entitled to a Family Supplement.

How do I apply?

To qualify for EI sickness benefits, you must have worked 600 hours of work in the last 52 weeks or since your last claim. You will need a record of employment from your employer confirming your hours and rate of pay. You also must get a medical certificate indicating how long your illness is expected to last. You will have to pay to get this medical certificate. To receive sickness benefits you must submit an EI application online or in person to your Service Canada Centre. For further information check http://www.servicecanada.gc.ca

When you apply for Employment Insurance sickness benefits, you will have to pay for medical certificates yourself.

How do I appeal the EI denial?

If your application is denied, you may appeal the denial. There is no cost to file an appeal, but there is a 30-day time limit for filing the appeal. For instructions on how to appeal, check http://www.ei.gc.ca for further information. You may need further medical information to support your case. You must tell your Service Canada Centre in writing that you want to appeal. You have 30 days after you receive the EI Commission decision to do this.

8. Part B: Long Term Disability

Overview

The HOODIP long term disability plan is an insured benefit plan.

Your employer pays 75% of the billed premium towards your coverage. You pay the remaining 25% of your coverage.

Premiums payments for members when including life insurance are not paid by the member in any full calendar month in which they receive Long Term Disability benefit payment. This is known as a waiver of premium.

To be eligible for long term disability (LTD), you must be a full-time employee and have completed six months of service following your first day of being ‘actively at work’. Coverage is compulsory for full-time workers regardless of any pre-existing medical conditions.

Only the long term disability plan of HOODIP is portable between employers who participate in HOODIP. If you terminate employment (or are laid off) with one employer and are subsequently employed within six months by another HOODIP employer, your coverage is effective on your first day you work for the new employer.

Long term benefits are payable after the 15 week short term sick pay benefits and the 15 week EI benefits are both exhausted. This 30-week period is called the ‘qualifying period’.

For the first phase of the HOODIP LTD plan, the plan provides for payment during the first two years of your absence if you are unable to do your own job and are totally disabled. The plan counts the two years from the commencement date of disability under the short term leave plan.

For the first two year period, the definition of ‘total disability’ is:

> *that you have a medically determinable physical or mental impairment due to injury or illness that prevents you from performing the regular duties of your own occupation.*

LTD benefits are payable for 17 months if you cannot do your own job. You must make sure any medical professionals you consult know this definition of disability and make their reports and written opinions in the light of this definition.

After 24 months of being on short and long term benefits, you must show due to your illness or injury that you are unable to participate in any gainful occupation for which you are, or may become fitted through training, education or experience.

It is essential that your treating physicians provide supporting medical documentation that supports that your illness or injury supports the new definition of total disability.

The insurer will normally ask that you apply for Canada Pension Plan (CPP) disability benefits within the first 24 months. CPP disability benefits have similar criteria in that you must show that you are totally disabled, cannot return to work for a prolonged period, are seriously ill and under regular medical care.

How much do I get?

The amount of income you receive depends upon your length of service:

Years of service	Regular earnings
After 6 months	65% of earnings
After 20 years	70% of earnings
After 30 years	80% of earnings

Remember that the LTD pay is offset or reduced by other sources of disability income for which the employer made contributions. This would include Canada Pension Plan CPP), Workplace Safety and Insurance, HOOPP pension plan payments and income while participating in rehabilitation programs.

How do I apply?

For long term benefits to start on time, you must apply once you have been off work for about 24 weeks, since it takes four to six weeks for your application to be processed. You must get the applications from your employer. The benefits are paid monthly and begin one month after your eligibility is confirmed. At the very latest, you must apply for HOODIP benefits within six months after the end of the qualifying period. HOODIP benefits are taxable.

Rehabilitation

The insurance carrier and the employer will encourage you to undergo rehabilitation programs with a view to returning to work. The insurance carrier reserves the right to develop and coordinate these programs by their own staff.

Rehabilitation programs include modified work programs, vocational retraining, educational programs and part-time work in a new or related field.

Your doctor will be expected to fill in Activities of Daily Living (ADL) questionnaires. You need to make sure that you work with your medical professionals so that the information is complete and realistic. The insurance carrier will be anxious to get you into any job. You need to be sure that this assessment is in your interests.

If you do participate in a rehabilitation program you will receive your monthly disability less 50% of the earnings you receive from your rehabilitative employment. At no point can you receive more than you received in your job before you were disabled.

Recurrence of Disability

If you have been collecting LTD benefits and return to full-time work and then get ill again with the same disability, your benefits will begin again immediately and you will not need to go through the qualifying period again as long as your disability re-occurs within six months.

However, if you have a different disability or the disability re-occurs after six months on the job, you will have to start all over again by completing the thirty week qualifying period of short term sick leave and EI benefits.

What happens if my employer switches carriers?

Insurance companies must hold a reserve fund that is guaranteed to cover all "liabilities" – in order to pay workers who are disabled while on the program. This is important to remember because if you are laid off or your employer switches to a new carrier, you still have a right to receive your long term disability benefits, as long as you provide any medical information that is necessary to make your case.

When do my benefits stop?

- when you are no longer totally disabled
- when you start working in any occupation except as permitted under the Rehabilitation Benefit
- when you stop getting medical care, or fail to provide medical proof of disability to the insurer
- when you refuse to participate in an approved rehabilitation program or a vocational assessment
- if you have reached age 65 and have less than ten years of service prior to becoming disabled
- you are imprisoned
- or if you die
- when you fail to submit to an Independent Medical Evaluation if requested by the insurance carrier

9. Disputing Denials of HOODIP Benefits

Any dispute which may arise concerning an employees' entitlement to short-term or long-term benefits under HOODIP may be subject to grievance and arbitration under the provisions of the central agreement (15.05(a)).

It is essential that you review your local collective agreement for time limits on grievances and appeals, since time limits may vary from hospital to hospital.

Sick Pay Benefits

For short term benefits, you have 7 days to grieve once you receive the written decision from the employer or carrier. Depending on your plan with your employer, you should check to see if there is an initial informal appeal process.

Long Term Disability Benefits

If you are denied long term benefits, you must comply with the insurer's medical appeal process before you file a grievance. For example, in the central collective agreement:

> If a claim for long term disability is denied, the employee must fully comply with the carrier's Medical Appeal Process prior to filing a grievance, provided that the Process is completed within sixty (60) days of its inception, unless that time is extended by mutual agreement of the Hospital and OPSEU (1505(b)):

Every insurer will have a different medical appeal process. If your claim is denied it must be in writing and the information concerning the medical appeal process and their time limits must be contained in the insurer letter.

Generally, the insurer, using their internal appeal process, will give you 3 months to appeal a written denial decision. As an example, one appeal process works as follows:

- you must submit new medical information within the three months.
- if you are denied after this review, you will be offered a Medical Appeals Process for final resolution of the claim. You will be asked to sign a form to continue on with the appeal process.
- then a physician will be appointed to act on your behalf (it may be one of your doctors). The insurer will designate the Medical Director of the insurer or a designate for the Medical Director. The two physicians will jointly choose a third independent physician to review all your medical and functional evidence.
- this medical panel may ask you to undergo additional tests or examinations as necessary.
- the decision of this medical panel is binding.
- However, once this internal appeal process is complete, you can grieve the final decision if you are covered by the Central Collective Agreement.

10. The Canada Pension Plan Disability Plan

Overview

The CPP disability benefit is available to people who have made enough contributions to the CPP, and whose disability prevents them from working at any job on a regular basis. The disability must be long lasting or likely to result in death.

The CPP legislation defines “disability” as a condition, physical and/or mental, that is “severe and prolonged”. “Severe” means that you have a mental or physical disability that regularly stops you from doing any type of work (full-time, part-time or seasonal). “Prolonged” means that your disability is likely to be long term, or is likely to result in your death.

How much do I get?

To be eligible for a CPP disability benefit, you must have made enough CPP contributions in at least four of the last six years, or you must have made valid CPP contributions for at least 25 years, including three of the last six years, prior to becoming disabled.

Workers receiving a CPP disability benefit in 2008 received, on average, about $799.14 each month. The benefit includes a fixed amount that everyone receives ($424.43 a month for 2009), plus an amount based on how much you contributed to the CPP during your entire working career. The most money you can receive from the disability benefit each month in 2009 is $1,105.99. Every January, there may be an increase to the CPP disability benefit to take into account any increase in the cost of living.

The CPP benefit is taxable.

Your dependent child under 18 years of age, or your child who is between 18 and 25 and who is attending school full time, can receive $213.99 a month in 2009 if you are approved for a disability benefit. Your child can only receive a benefit if at least one parent is receiving a CPP disability benefit.

Remember that CPP payments will be off-set against any HOODIP benefits and you must report your receipt of these benefits to the HOODIP carrier.

CPP payments are not deducted from HOOPP Disability Pensions.

Remember that if you are receiving CPP disability benefits, you do not make contributions to the CPP. But the time you are on CPP disability is deducted from your ‘contributory period’. This means that your pension is not reduced because you were disabled.

How do I apply?

If you think or know that your illness or injury will continue over a prolonged period or that it is terminal, you should apply separately for CPP disability benefits. The CPP disability benefit is administered by Service Canada on behalf of Human Resources and Skills Development Canada (HRSDC). You can complete your application on-line. Take care in completing the form as poorly completed forms are a major source of denial claims. You can find out more information and the application forms on the CPP website at http://www.hrsdc.gc.ca

Your doctor needs to complete a separate form and you will have to pay the physician for the cost of completing it.

In order to qualify and continue to qualify for HOODIP long term disability you must apply for CPP disability benefits. Otherwise, your benefit will be automatically reduced by the amount of CPP you would be eligible to receive. This is because your HOODIP benefit is reduced by any funds you receive from any government program.

It may take as long as three months for you to find out if your application for a disability benefit has been accepted. This time frame is much shorter for terminally ill applicants.

How do I appeal denial of CPP disability benefits?

If your application for a CPP disability benefit is not granted, there are three opportunities for review or reconsideration, in the following order:

- first, a request to Service Canada for reconsideration.
- second, an appeal to the Office of the Commissioner of Review Tribunals;
- third, a request for leave to appeal to the Pension Appeals Board.

All must be made within ninety days of the previous decision having been received.

11. Disability and the Healthcare of Ontario Pension Plan (HOOPP)

Overview

HOOPP offers two types of disability benefit - free accrual and a disability pension. The extent of your disability determines what you are eligible to receive from HOOPP.

HOOPP has different definitions for disability. Plan members can receive disability benefits from HOOPP if medical evidence shows you are:

Partially disabled	You have a medically-certifiable physical or mental impairment that HOOPP has determined currently prevents you from doing your own job.
Totally disabled	You have a medically-certifiable physical or mental impairment that HOOPP has determined currently prevents you from doing any job.
Totally and permanently disabled	You have a medically-certifiable physical or mental impairment that HOOPP has determined will prevent you, for your life, from doing any job.

Free Accrual

Free accrual is contributory service that is credited to disabled members by HOOPP. If you are disabled, you receive free accrual, which means that you accumulate contributory service without having to make any contributions; employers don't make contributions either. This means that you can continue to build pension service while off work.

Free accrual can cannot commence until after 15 weeks of health leave and continue for up to four years from the start of the health leave if you are partially disabled, and longer if you are either totally disabled or totally and permanently disabled.

Disability Pension

If you have been assessed as totally and permanently disabled, you can choose to receive free accrual or a HOOPP disability pension. A disability pension is an immediate, unreduced pension based on the contributory service (including free accrual) accrued before the members disability retirement date. Before you can collect a disability pension, you must terminate your employment. HOOPP disability pensions do not include early retirement benefits. Nor do they include a benefit package.

To qualify for a HOOPP disability pension, you must:

- have contributed to the Plan before the date of disability;
- be under age 65; and
- have less than 35 years of contributory service
- have two or more completed years of HOOPP service

How much will I get?

Your disability pension will be calculated based on the projected years of contributory service built up to age 65 or 35 years, whichever is first.

If your application is successful, you will receive a monthly lifetime pension; a spousal benefit is also available in the event you die before your spouse. Your spouse will receive a 60% spousal pension based on contributory service to the date of your death.

Check www.hoopp.com and call to find out the monthly amount you will receive.

Remember always to get financial advice on your pension options before you make a decision.

How do I apply?

You must apply for a 'health leave' and get a disability kit from your employer.

You will be required to provide medical evidence of your disability.

HOOPP does not require you to apply for a disability pension. You have the option to apply for a disability pension if you are currently disabled. If you meet the HOOPP definition of total and permanent disability, you can receive a disability pension or receive free accrual.

The employer and the insurance carrier may both encourage you to opt to terminate your employment and collect a pension. If you are found eligible, the insurance carrier may reduce your long term benefits equal to the HOOPP plan even if you choose the free accrual option. If you do not apply for the HOODIP disability plan, the insurance carrier will reduce your LTD payments by the eligible amount of the HOOPP plan.

Rehabilitation and Modified Work

If you on a health leave and are participating in a rehabilitation program with the employer, you need to have the program approved by HOOPP. If the program is approved, your health leave and free accrual may continue.

HOOPP will approve a rehabilitation plan if it:

- has an objective of enabling you to return to work
- has a specific, measurable goals which are time-dependent
- does not continue beyond the fourth year of a health leave, if you are partially disabled

To qualify, the employer submits a Notice of Participation form to HOOPP. If the program is less than three weeks, no form has to be submitted. If greater than three weeks, a form is required and it takes two to three weeks to hear back from HOOPP. If the program is approved, HOOPP will assume that you will return to work at the end of the program and the free accrual will stop at the end of the program. You can ask for extensions.

If you are partially disabled, receiving free accrual and reach the end of the fourth year of your health leave/extension while on a rehab program, you can continue on rehabilitation but you lose your free accrual.

How do I appeal a denial of HOOPP Disability Pension?

You can appeal the denial of HOOPP disability pension. It must be in writing to the decision maker with supporting medical information and a letter of explanation. You should review the denial letter carefully, to determine the information required and meet any deadlines. Failure to meet the deadlines may permanently prevent you from appealing further.

12. What can Local Union Representatives Do?

In order to be informed about benefits at the worksite, local representatives should:

- ask for the benefits booklet and the insurance plan text from the employer
- review the central and local collective agreements
- discuss with the employer informal appeal processes for short term benefits
- obtain insurer’s contact information
- contact the insurance carrier and review the medical appeal process for long term benefits

Local union representatives can assist members by:

- provide members with the benefits information at their workplaces
- assist member where possible with the application process for the various benefits
- help members with obtaining medical information to support the appeals
- ensure that members grieve and appeal any denials for HOODIP
- make referrals to the appropriate OPSEU staff for further assistance

www.opseu.org