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IMPORTANT NOTE

This course does not provide legal advice and is not intended to create local benefits experts that represent members on appeals with insurers.

The course is intended to provide information, increase awareness and develop skills of local leaders to help support members with their benefits appeal issues.

Note to Participants

Please refer to the brochure for your notes on the Land acknowledgement and Statement of Respect.

BPS Benefits and Appeals
Course goals and objectives

Goal

To provide BPS activists, who are without an internal appeals resolution system under their collective agreement, some tools to support their members in appealing the denial of benefits (primarily disability).

Objectives:

Know

- What benefits are?
- What benefits do the members have?
- How can members find out information on their benefit coverage?
- What are the member's obligations?
- What are your responsibilities as a union representative in helping members?
- What resources are available through OPSEU?

Feel

- Confident when speaking with members about their benefits issues
- Comfortable knowing where to go for information
- More comfort with difficult conversations

Do

- Provide basic information to members with benefits questions
- Support members in appealing a benefits denial directly to the insurance provider
- Support members' decisions in difficult situations

BPS Benefits and Appeals
Course at a glance

Day 1	Day 2

9:30 to 12:30
What are the issues/building the picture
 	
• Getting started
• What are benefits?
• Four sides of benefits - chart
• Sources of benefits
  ○ Government
  ○ Employer direct
  ○ Insurance
• Dealing with medical information
• Knowing about insurance companies
	9:00 to 12:00
	Moving forward
	
	• Improving the collective agreement
	• Defending the safety net
	• Taking it back to the local

12:30 to 1:30 Lunch	
1:30 to 4:30 **Working with the member** • Working with the member • Difficult conversations • Appeals • Medical documentation • Benefits quiz	

Guidelines for participation

Shut off electronic devices or use them respectfully (turn sound off, excuse yourself if you need to use your device)

Speak for yourself (use I statements)

Don't be afraid to make mistakes/take risks

Ensure everyone gets an opportunity to speak. If you are always contributing allow someone else the opportunity.

Limit side conversations; it takes 2 to talk

Listen to each other with respect; differences are helpful if we can suspend judgment (watch for inner critic as well)

Look after your needs, example: move as needed to be physically comfortable

Observe the no-fragrance policy

Keep other people's stories confidential. You can tell your story, but you do not have the right to tell someone else's.

Other?

Task sheet 1
Getting started

Pair up with someone in the class who you don't know or know the least.

In your pairs, take 5 to 10 minutes to interview your partner to find out the answers to the following 4 questions.

Be prepared to introduce your partner to the class and report back briefly to the rest of us the answers to the questions.

1. Your name, local number and any position you hold in the local.

2. Where do you work (location/work unit/your job duties etcetera)?

3. Have you ever supported a member that has had issues with their benefits? If so, what did you do?

4. What do you want to learn about benefits and the appeals process from this course?

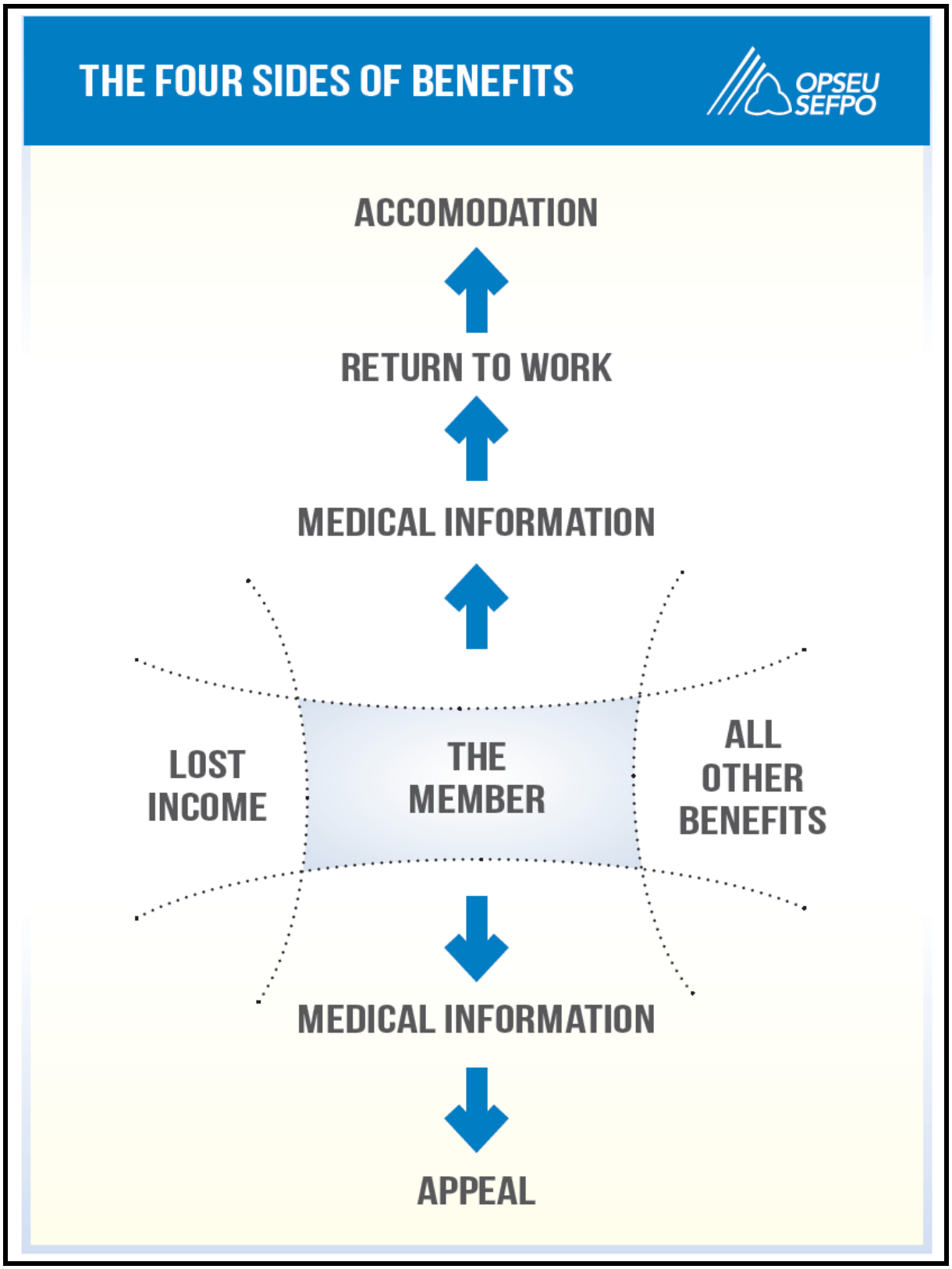
Task sheet 2
What are benefits?

In your small group, take 5 minutes discuss and record your answers to the following questions.

- Record your answers on the flipchart paper that is provided.
- Be prepared to report back to the class.

1. What are benefits?

2. How do you know what benefits you have?


THE FOUR SIDES OF BENEFITS
OPSEU SEFPO
ACCOMODATION
RETURN TO WORK
MEDICAL INFORMATION
LOST INCOME
THE MEMBER
ALL OTHER BENEFITS
MEDICAL INFORMATION
APPEAL

Task Sheet 3
Sources of benefits

In your group, write down as many benefits you can think of for the column of the chart that your group has been assigned.

Write down one benefit per sticky note and be prepared to report back your findings to the class.

Government	Insurance	Employer Direct

Arbitrability of insurance claims

Arbitrators have been divided as to whether the traditional Brown & Beatty "four categories" approach had been replaced by a new, expansive 'but for" test of arbitrability. In its decision in London Life v. Dubreuil , July 13, 2000 and the companion decisions of Honeywell and Longlac, the Court of Appeal has re-affirmed the Brown & Beatty "four categories" test of arbitrability and discarded the idea that there is any additional new right to litigate benefits claims. So, we are back to the original position, which is:

Brown & Beatty's four categories of insured benefits provisions

1. The collective agreement makes no reference to the insurance plan or the benefits provided under the plan – benefits not arbitrable.

2. The collective agreement provides for the provision of specific benefits – those benefits only are arbitrable.

3. The collective agreement provides only that the employer will be responsible for the payment of insurance premiums – benefits are not arbitrable.

4. The collective agreement incorporates the insurance plan – all benefits are arbitrable.

This certainly raises the possibility of bargaining towards number 4.

London Life v. Dubreuil Brothers Employees Association case link:
http://canlii.ca/en/on/onca/doc/2000/2000canlii5757/2000canlii5757.html
Longlac case link:
http://www.canlii.org/eliisa/highlight.do?text=Longlac+&language=en&searchTitle=Ontario&path=/en/on/onca/doc/2000/2000canlii4278/2000canlii4278.html
Weber v. Ontario Hydro case link:
http://www.canlii.org/en/ca/scc/doc/1995/1995canlii108/1995canlii108.html

Task sheet 4
Dealing with medical information

In your group, take a few minutes to discuss and answer the following questions:

What medical information is your employer entitled to?

What medical information is an insurance provider entitled to?

Are there any differences between the two? If so, what are they?

Knowing about insurance companies case study

You have just received a phone call from Marion, a member who has been off work for several weeks. Over the phone she sounds upset and is crying. She tells you that she has just been contacted by a very rude case worker from an insurance provider. The insurance provider wants more medical information including a diagnosis from her doctors and she is told that it is her responsibility to get the medical in before they will approve her sick leave benefits. Marion has been without an income for almost two months and is having trouble covering her bills. She feels that she is being harassed and does not want to co-operate because she has already provided medical information. You are unsure what to tell her and so you say that you need to look into things and will get back to her.

Review the case-law that is provided.

1. After reviewing the case-law, what information are you going to share with Marion about insurance providers?

2. Are there any resources to assist her?

3. What can you do to support her?

Re: Union policy grievance - Disclosure of medical information

The decision

It is important to emphasize the narrow issue in dispute in this case. The essential issue is whether the employer has the right to require employees to authorize the release of their medical information to a third party acting in the capacity of an administrator of a short-term salary continuation benefit under this collective agreement. This is not a case where the Union is questioning the extent of medical information being requested or where there is any challenge with regard to the employer's need for medical information in order to determine eligibility for the benefit.

The parties here agree and understand that no employer may release confidential medical information to any third party without an employee's specific consent (or pursuant to the exercise of subpoena powers which are not relevant in this case). The release would be contrary to the Personal Health Information Act, supra. However, that Act also provides that the information may be released when the individual consents: s. 29, supra. Since there is no suggestion that this employer has ever released medical information without specific consents being obtained, the only significant issue regarding "consent" is whether the employer may require that consent and then withhold sick benefits if the consent is not given.

The facts in this case are clear. The employer is presently providing employees who are making claims for sick pay with a consent form and advising them that failure to sign the release of their medical information may result in them not receiving the benefits they are claiming. This may not be an entirely agreeable or preferred course for employees. However, the requirement to provide the consent to the release of medical information is a well-recognized and legitimate exercise of management's right to administer income protection benefits. Arbitral case-law accepts that an employer may refuse entitlement to sick leave with pay to an employee until that employer is satisfied that the employee is suffering from a condition that renders him/her unable to perform duties because of illness or injury. See Telus Communications Co. and Telecommunications Workers Unit, supra. Therefore, requiring an employee to consent to the release of relevant medical information in the context of a claim for Sick Leave pay is entirely appropriate and justified. Nothing in this collective agreement limits or curtails that right.

This leaves the critical question of whether this employer has the right to ask employees to release their medical information to the third-party ASO that the employer has retained to assist in the administration of the sick leave benefits plan. The evidence establishes that this employer has elected to use Sun Life as an ASO for a number of reasons. The employer wants to preserve the trust and effectiveness of its 'on site' Employee Health Centre by shielding those medical professionals from any responsibility with respect to employees' sick pay benefit claims. Further, the employer believes that it is cost effective and more reliable to retain Sun Life for its expertise in this field. The employer has also shown that it has taken steps to ensure that Sun Life treats the medical information confidentially and has significant safeguards in place to preserve employees' privacy. It also cannot be forgotten that the Union does not challenge Sun Life's practices with regard to it receiving, adjudicating upon and paying out LTD claims. All these factors lead to the conclusion that there is nothing to suggest that there is anything wrong with the way Sun Life is receiving or storing the information and that there are rational operational reasons for it being retained by an organization outside of the bargaining unit. As Arbitrator MacDowell said about a similar arrangement in the case of Caledon (Town) (Deforest) v. Canadian Union of Public Employees, Local 966, supra, at para. 122: ..... whatever else may be said about the administrative process that the Employer has put in place in this case, the fact is, that process may be more effective and cost-efficient than a piece of litigation; it is probably more respectful of personal privacy as well.

In another case where the administration of a short-term and self-insured disability plan was being analyzed, Arbitrator Bruce concluded: Pursuant to the terms of the collective agreement the employer is contractually bound to pay short-term disability benefits to employees who are disabled within the meaning of the Plan. Further, the employer administers the plan as part of its right to manage the workplace. While the employer may engage third parties, such as London Life, to assist in the administration of the plan, it is ultimately responsible for all decisions under the plan including determinations of a claimant's entitlement to benefits. See Pacific Press and Communications, Energy & Paperworkers Union, Local 111-5, supra, at page 35.

Therefore, it must be concluded that the simple fact of engaging a third party with expertise and efficiencies to assist with contract administration has been widely recognized as a valid exercise of management rights. I have not

ignored the Union's assertion that the employer needs explicit contractual or statutory language to support such an arrangement. However, the contrary is the case. The employer has the management right and responsibility to administer the collective agreement, including the short-term benefits provision. Article 3.01 gives management "the exclusive function" of managing and "maintaining order and efficiency". Nothing in the contractual language limits that right. Since it has also been recognized that this employer has the right to expect employees to establish their entitlement to short term sick leave, it follows that the employer has the right to expect employees to sign authorization for the release of their medical information to the entity that the employer has chosen to assist with the administration of that benefit. Since it is accepted that appropriate information is being requested for the administration of the collective agreement and since there is no evidence or suggestion that there is any demonstrable reason to be concerned about bargaining unit members' privacy or confidentiality, it must be concluded that the Union has failed to establish any contractual or statutory violations.

Accordingly, this policy grievance is dismissed.

Dated at Toronto this 30th day of December, 2010.
Paula Knopf - Arbitrator

Task sheet 5
Helping the member

Read your assigned scenario (page 17) and the Disability denial letter (page 19)

Using your own experience and the resources provided:

For your assigned scenario, identify the steps you would provide. Your plan should include:

1. Preparing for the meeting

2. Your goals for the meeting: (what you would like to accomplish)

3. Follow-up plans

Resources:
OPSEU Disability Appeals Guide for the Broader Public Service (page 53)
Appeals Checklist (page 21)
Sample Letter to Doctor (page 23)

Scenarios

1. You are the Local president and receive a call from a member Kumail who is very upset. Kumail has just received a letter from the insurance company denying his disability insurance. He says the people from the insurance company want to know personal medical details that, he feels, they have no right to. After talking to Kumail you have convinced him to meet with you and he has brought his denial letter.

2. Elaine has called you to tell you that she has just received another denial of benefits letter from the insurance company. You are Elaine's steward and have been trying to help her maintain her disability benefits. You have been working with Elaine for the last several months but no matter what you do the insurance company continues to deny benefits. You feel that Elaine is justified in her claim. She wants to meet with you to discuss what to do next. Elaine has provided you with a copy of her denial letter.

3. You receive a call from Salihah, who has been off on long-term disability. She has informed you that the insurance company has sent her a letter denying her ongoing benefits. She says that she has been struggling to live on the funds she did have and now does not know she will do. As her local steward you agree to meet with Salihah to see what else can be done. She has provided you with a copy of her denial letter.

4. You have just received a call from Richard. Richard is a member who you have helped with submitting a claim for long term disability. Richard has complained about a number of physical concerns but lately has been talking about the manager being "out to get him". Your experience is that the manager has tried to be helpful. Richard has just received a letter from the insurance carrier denying his claim and requesting more medical information. Richard is very upset and is talking about "people being out to get him" and his doctor is part of the conspiracy. You have always had a good rapport with Richard. You agree to meet with him. He has left you a copy of his denial letter.

5. **Change in status:** Mary has been off work and in receipt of long term disability benefits for over 2 years now. She recently received a letter

from the insurance company indicating her benefits will be terminated in the near future. Mary does not understand why her benefits are being terminated. Her disability continues to prevent her from performing the essential duties of her position and her treating physicians have provided medical opinions to support this. You offer to meet with Mary to explain why her LTD benefits are now being terminated and what she can do to pursue further entitlement to LTD benefits?

Benefits denial letter

Big Bad Insurance Company pg. 1 of 3
123 Denial Way
Wawa, Ontario
October 30, 2012

Claimant
911 Happiness Avenue
Downsview, Ontario
Policy Number 1111 Claim Number 1234567

Dear Claimant:
A review of your application for Long Term Disability (LTD) Benefits has been completed and your application has been declined.

Policy Overview

In order to be eligible for Long Term Disability Benefits, you need to meet the definition of total disability or totally disabled as outlined in your group contract. The definition is:

“Restriction or lack of ability due to an illness or injury which prevents an Employee from performing the essential duties of:

a) his own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period; and

b) any occupation for which the Employee is qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified in part a) of this provision

The availability of work will not be considered by BBI Company in assessing the “Employee’s Disability.”

To determine whether or not you met the disability definition the following was considered:

- Medical examination findings, test results, and your symptoms and limitations

- Whether medical restrictions are supported by the medical
- information on file
- The physical and mental requirements of your occupation
- How your medical condition affects your ability to work in your own occupation

Summary overview

Assessment of the medical evidence does not support that you are disabled as defined in your group contract. Based upon review of the documentation currently in your file, you have the ability to perform the duties of your occupation with appropriate modifications. As you do not meet the contract definition of disability, your claim for Long Term Disability benefits is declined.

Appeal rights

If you disagree with this decision, you may request a review of your claim. Your written request should include the reasons for disagreement, and any medical information not previously submitted that you would like to be considered such as:

- Treating Physician's clinical notes from February 30th to Present
- Narrative consultation reports – specialist
- Pharmacy records
- Physiotherapist reports
- Occupational Therapist Reports
- Admission and/or Discharge reports from inpatient treatments
- Any medical test reports regarding your condition

Obtaining these reports and any accompanying charges are your responsibility.

Your request along with the additional information should be submitted within 60 days from the date of this letter.

It is important to note that BBI Company will not consider/review any appeals which are submitted after September 31st

Sincerely,

Nadda Chance
Disability Analyst

Appeals checklist

- ☐ Appeal Deadline Date Noted: (Date:_____)
- ☐ Copy of Collective Agreement Obtained
- ☐ Insured Benefit Provisions (if available) in Collective Agreement Reviewed
- ☐ Grievance Filed (check with OPSEU Staff Representative if grievable)
- ☐ Copy of Insurance Policy (if available) obtained
- ☐ Copy of Benefits Booklet obtained
- ☐ Definitions / criteria regarding insured benefit being appealed reviewed
- ☐ Insurer's letter denying benefits reviewed; rationale for denial noted;
- ☐ Required Medical Information Needed Identified
- ☐ Letter of Appeal completed and Faxed / Mailed to the Insurer (fax sent confirmation on file) on (date: _____); timelines met.
- ☐ List of Treating Physicians who can provide medical information
- ☐ Copies of Insurance Company's Denial letter and copies of any relevant policy definitions and criteria made for Doctors to review when producing a report
- ☐ Spoke and / or wrote to Doctors for additional medical information

Doctor's Name	Date of Letter / Discussion	Date Letter Received (Follow up if required)

- ☐ Letter to Doctor requesting additional medical information (see sample; Appendix B)
- ☐ Appeal letter and Additional Medical Information Submitted (Date:_____)
- ☐ 30 Day Follow up, decision not received
- ☐ Results of Appeal received (if decision is negative and additional medical information can be submitted, request reconsideration of a further appeal)
- ☐ Decision to pursue Civil Suit made
- ☐ Selection of Lawyer; case determined to have merit
- ☐ Application to Solidarity Fund Reserve Submitted

Sample Letter to Doctor

Date

Dr. Name
Address

Dear Dr. Name

Re: Your Name – Long Term Disability Appeal BBI
Policy #1111 – Claim #1234567

I am currently appealing a decision by my Insurance Carrier, (name of insurer), denying me entitlement to Long Term Disability (LTD) Benefits.

In order to qualify for benefits under my group plan I must be considered totally disabled from performing the essential duties of my position as a (position/job title).

The definition of disability under my group plan is:

“An employee will be considered totally disabled while he/she is continuously unable due to an illness to do the essential duties of his/her own occupation, during the elimination period and the following 24 months, and afterwards, while he/she is continuously unable due to illness to do any occupation for which he/she is or may become reasonably qualified by education, training or experience”.

I have enclosed a copy of the relevant provisions in my benefits booklet for your reference.

Please also find enclosed a copy of (insurer)’s decision letter denying me entitlement to benefits. This decision provides an overview of the rationale used to make this determination and outlines the steps involved in their appeals process. The decision-maker has also indicated what type of medical information would be most appropriate to support an appeal of their decision.

I would appreciate it if after reviewing the material I sent you as well as my medical charts; you would offer me your highly regarded medical opinion. Please include the following, particularly, as it relates to my employment:

- Diagnosis (including DSM IV Multi-Axial Evaluation for Psychiatric Conditions)
- Treatment program
- Tests undertaken and any follow up required
- Medications being taken
- Severity of symptoms
- Limitations and restrictions and how they prevent me from working
- Prognosis as it relates to employment
- Copies of Clinical Notes

In your opinion, could I return to work at my former job or an alternate job? Am I a likely candidate for retraining? Are there any restrictions or limitations with respect to the type of work I could likely perform?

I thank you in advance for responding to my request. I certainly appreciate how busy you are. Your kind attention to this matter is greatly appreciated.

Sincerely,

Your Name

Enclosures

Important note:

This template is provided as a sample only. Specifics regarding the issues under dispute, the period of your disability and type of medical evidence required are some factors that will need to be considered when generating your letter.

It may be more appropriate to make an appointment with your doctor to discuss your appeal and request a report from him/her at that time. Please

ensure you bring with you the insurer's denial letter and any available group insurance plan documentation.

The definition of disability in this template is a sample only. The definitions / criteria for total disability specific to your group plan can be found in your benefits booklet and /or group policy.

TALKING TO YOUR DOCTOR

You know more about your job, your work practices and your symptoms than anyone else. What should you tell your medical practitioner to help sort out the information that you need to provide to your employer.

Talk about your symptoms

- How you feel
- When your problem started
- When you got your symptoms
- Do you have your symptoms only at work? After work?
- Are the symptoms worse at the beginning of the week or at the end of the work week?
- Does it make any difference what time of day it is? What day of the week it is?
- Does the problem go away when you are on holidays?
- Do you notice the symptoms only when doing certain tasks at work or home?
- Did your symptoms start after changing a work procedure or work area?
- After using different equipment
- Whether or not your health problem caused you to miss time from work?
- Do any co-workers have the same symptoms?

Give information about your job

- Where you work
- What your employer makes or does
- What your regular job duties are
- When you started your present job
- What hours you work
- What days you work
- Provide a job spec if you have one

What hazards you may be exposed to

- Anything in your work that could be harmful to your health (dust, heat, noise, stress, conflict etc…)
- What supplies and equipment you work with
- Are there any hazards that have been brought to the attention of the Joint Health & Safety Committee
- What protective equipment you use – do you wear a mask, gloves, lab coat, coveralls or other protection if necessary
- Do you eat in your work area?
- Exposures you might have outside work - your personal habits – Do you smoke, take drugs/medications or consume alcohol
- What are your eating habits?
- Do you exercise?
- Do you work a second job, volunteer?
- What are your hobbies?

Information you should have on your doctors note to the employer

- Your name – the patient
- The doctors name, address and phone number
- The date of the medical examination
- Whether you were examined in person by the health care professional
- The date when you can return to work
- Specific restrictions which indicate the doctors knowledge of your job requirements
- How long (as specifically as possible) the restrictions will apply. Are the restrictions permanent?
- Are you're absences likely to be sporadic. Will there be flare-ups due to your condition
- When, if at all, you will be able to return to regular duties

Remember - the employer is **NOT** entitled to a diagnosis. They are entitled to a prognosis along with duration and specifics about your medical restrictions as they relate to your job. The employer is also not entitled to know what medications you are on – they are only entitled to know if the medication causes a restriction, eg. causes drowsiness.

Task sheet 6
Medical information and confidentiality

At the last Local Executive Committee it was decided that the members of the Local needed a better understanding of medical information in relation to benefits. Today is the first meeting of the group who volunteered to create a "Lunch and Learn" to address the LEC's concerns. In your group complete the chart below and then develop a poster/flyer to advertise your Lunch and Learn.

Lunch and Learn Plan

Title	
Target Audience	
Goal (What is the general purpose)	
Objectives (what specifically will the participants be able to do, know, or understand)	

Create a poster/flyer to advertise your Lunch and Learn

Be prepared to share your plan and poster/flyer with the rest of the group.

Five tips to maintaining privacy

1. Be careful who you share information with, know:
   - Who has what information?
   - Who on the employer's side is the health information custodian?

2. Don't speak out in the open.
   - Go to a private location or;
   - Wait until after hours to speak about the situation

3. Keep documents secure
   - Keep sensitive documents locked up in a secure drawer or filing cabinet
   - Keep documents at home if possible
   - If there is information on your computer, make sure the computer is password protected
   - Make sure to shred any sensitive materials after they are no longer needed

4. Watch what you do and say online
   - Refrain from commenting about a case online
   - Do not blog about a members' case or situation
   - Be careful what you put in your e-mail correspondence
   - Try to refrain from using the employers computer system
   - Know what your privacy settings are on Facebook etcetera.
   - Assume that if you post it on line it is available for anyone to see, including the employer

5. Don't be part of the rumour mill
   - Don't engage in idle chatter or speculate about someone in an open forum
   - Show respect for the member and their current situation

Benefits quiz

1. If a member gets cut-off of Long term disability benefits they no longer have a job?

   True___ False___

2. Insurance providers are entitled to know the diagnosis as well as any details of medications and treatment plans?

   True___ False___

3. If your condition is considered to be severe you may be entitled to Canada Pension Plan Disability benefits (CPP)?

   True___ False___

4. An insurance provider is entitled to know if any tests have been taken and if any follow-up tests are needed to be done?

   True___ False___

5. You must show proof of on-going total disability to get long term disability benefits?

   True___ False___

6. It is the member's responsibility to ensure that medical information and other changes of circumstances reported to the insurance company are accurate and up to date?

   True___ False___

7. If you run out of sick leave credits you can apply for Employment Insurance (E. I.)?

   True___ False___

8. Time limits for benefits appeals are usually flexible?

   True___ False___

9. You should immediately hire a lawyer to launch a benefits appeal?

   True___ False___

10. Members appealing a denial of benefits are automatically entitled to $5,000 dollars in support from the union

True___ False___

11. Each region of OPSEU has a hardship fund that could be used to assist members in benefits appeals?

True___ False___

12. Can the denial of benefits be grieved under the collective agreement?

True___ False___

Know the players

In the blank boxes below put the name, job title/contact info and OPSEU support you contact (who would be most helpful) if you had an issue with in the following areas:

Benefits local resource

Area	Name	Title/ How to contact	OPSEU Support
Short term sick leave			
LTD			
WSIB			
Return to work			
Duty to Accommodate			
Pension			
Human Rights			
Health Benefits			

Collective agreement guidelines

There is no such thing as a Master Agreement that will cover the many different workplaces where OPSEU represents members. There are just too many variables: example: full-time vs. part-time, 24/7 operations vs. weekdays only, on call, shift premiums, travel requirements etcetera.

Collective Agreements have to be tailored for each specific bargaining unit and the work which is performed. Negotiators, staff representatives and others must adhere to OPSEU's Standard Operational Procedures (SOP) and the Principles of Collective Bargaining when negotiating collective agreements.

There are three major components to a collective agreement:

1. The governing relationship between the parties
2. The procedures for policing and revising the collective agreement
3. The substance of the agreement: a) Working Conditions
   b) Fringe Benefits

The governing relationship and procedures lend themselves more readily to standardized language while the substantive clauses of an agreement will require more specialized language reflective of the diversity of work performed by our members and industry (sector) norms and standards .

The overriding consideration in selecting or writing language that must always be kept in mind is:

> "A Collective Agreement is negotiated in the shadow of arbitral jurisprudence and, indeed, it is the arbitral jurisprudence which gives meaning and certainty to the words and phrases which appear in the Collective Agreement"
>
> Kevin Burkett
> Arbitrator

Article Sample

SICK LEAVE PROVISIONS

Employers are most likely to try to ensure employees have very little accessibility to their sick entitlements by implementing attendance programs, enforcing discipline, etc.
Employer's goal is to minimize paid time off and force employees to provide medical evidence such as doctor's notes or medical exams.

Ensure the language allows for continuation of income between sick leave, short term leave and possible long term disability. Seek for improvements such as compensation during the EI waiting period.

U1-24.01

24.01 All employees shall be entitled to sick leave credits. Sick leave credits shall accumulate on the basis of _____days for each calendar month.

M1 – 24.01

Employer will counter language to restrict probationary employees from accessing vacation entitlements, like the language below:

24.01Non-Probationary permanent full-time employees shall be entitled to sick leave credits. Sick leave credits shall accumulate at the rate of _____ days per month.

U1-24.0

24.02Unused sick credits will be carried forward from one year of employment to the next.
Employer's will counter language to ensure there is no carry over and they will argue that such a carry-over is a big liability for their operations. As well, they will ensure sick credits have no cash value upon termination of employment.

24.03 Sick leave may be utilized for reasons of personal illness or medical appointments for her/his immediate family as defined under Article- Bereavement Leave.

24.04 Sick Leave credits will continue to accrue during periods of illness.

M1- **Sick Leave**

Employer's will argue and insist to include different qualifiers into sick leaves provisions. They may counter language that reads:

Sick leave credits may only be utilized for reasons of personal illness or medical appointments.

Employees who are absent from work due to illness must submit a medical certificate from their treating physician confirming their inability to carry out their work duties and the length of such absence.
In addition, The Employer may require an employee to provide a medical certificate for absences if: (i) there is a pattern of sick leave usage such as Fridays, Mondays, or a specific day each month, (ii) the Employer suspects that the employee is not sick, or (iii) the employee advises the Employer that he/she is sick for a period (or part of a period) for which his/her vacation request was denied.

Article
Sample

INSURED BENEFITS

In 1996 OPSEU's Executive Board adopted as a mandatory item The OPSEU Joint Trusteed Benefit Fund as part of collective bargaining. As with other mandatory items, this means that staff reps/negotiators and bargaining teams are required to propose it in bargaining (where the employer has not already agreed to it).

The agreement may possible (depending on the language) give the employer the unilateral right to change carriers. If so, is important to be mindful of obstacles that could arise as a result of the change and the impact it may have on the members, especially those on long term disability, etcetera.

25.01 The Employer shall provide to all employees a group insurance benefit plan which will be insured through the OPSEU Joint Trusteed Benefit Fund.

25.02 Insure benefits will include:

- Basic Group Life (define amount)
- Accidental Death and Dismemberment (define amount)
- Dependent Group Insurance (define amount)
- Long Term Disability (define amount)
- Short Term Disability (define amount)
- Semi-Private Hospital room
- Extended Health Insurance:
  - Prescribed drugs (define amount)
  - Hearing Aids (define amount)
  - Paramedical Services (define amount)
- Vision Care (define amount)
- Dental Benefits (define amount)

25.03 All premiums for the list benefits will be paid 100% paid by the Employer.

Article
Sample

EXPENSES

Ensure the language allows for employees to be compensated for any expenses incurred while under the employ of the employer, such as: mileage, travel time, meals, etcetera.

U1- Article 26

Mileage

Employee's required to use their vehicle for work purposes shall be reimbursed _____ cents per kilometre and all parking expenses.

Car Insurance Coverage

The Employer shall compensate those employees who transport clients for the additional liability cost _____ dollars per year for business car insurance, if the insurance is required.

Transportation

An employee who chooses to uses public transit (TTC) due to client services or on CTYS business will be reimbursed the cost of a TTC travel pass.

Meal expenses

Employees will be reimbursed for any approved out-of-pocket expenses

Article Sample

WORKERPLACE SAFETY AND INSURANCE

When incorporating language regarding Workplace Safety and Insurance is important to ensure employees are able to maintain benefit coverage and compensation until their claim is approve.

Should also include language that allows for the accumulation of vacation and seniority during the absent period.

U1- 27.01

27.01Where an employee is absent by reason of an illness or injury for which a claim is made to the WSIB, her/his salary shall continue to be paid to. If an award is made, any amounts paid by employer shall be reimbursed to the employer by the employee.

27.02 Where an employee receives an award from the WSIB, the Employer agrees to maintain premium coverage for insured benefits provided in the Collective Agreement and shall maintain participation in the pension plan.

27.03 The employee shall continue to accumulate seniority during the period covered by the award.

The example below is more detailed language an emphasis in the employer's obligation as well as ensure confidentiality during the process.

U2

Workplace Safety and Insurance

All injured and disabled workers shall be treated in compliance with the Ontario Human Rights Code, the Occupational Health and Safety Act, Workplace Safety and Insurance Act, the collective agreement and other relevant legislation. The parties will endeavour to provide fair and consistent practices to accommodate employees who are ill, injured or permanently disabled.

An employee who is unable to work as a result of an accident, injury or illness sustained while on duty in the service of the employer within the meaning of the Workplace Safety and Insurance Act, shall continue to receive her regular salary and benefits from the employer, less regular deductions, provided she assigns over to the employer her compensation payments due from the Board for time lost as a result of the accident.

All accidents must be reported as soon as reasonably possible by the employee, in writing, to her Supervisor who will complete an accident report. The employee will be provided with a copy of the report.

Employees are required to provide the employer, as far in advance as possible, with a written notice of readiness to return to work.

The employer is committed to make every effort to create an adaptive work environment for employees who sustain injuries at work. To this end employees shall be placed on a Work Accommodation Program. Every effort will be made by the employer to provide the employee with suitable employment up to the point of undue hardship. An employee may request the presence of a union steward of her choice at any meeting related to work accommodation and/or return to work programs provided that such meeting shall not be delayed as a result.

Work shall be modified in accordance with occupational health and safety principles in an effort to adapt the workplace to promote the highest degree of emotional and physical well-being of the injured worker.

The parties recognize the confidentiality of medical information and shall only disclose information regarding an employee’s medical abilities and/or

limitations to the extent necessary to implement and assess a return to work or workplace accommodation plan.
Employers may counter similar language such as:

M1
Should the employee's claim be disallowed by the Workplace Safety and Insurance Board, then any monies paid by the employer shall be either charged against the employee's accumulated sick leave credits or if the employee has no sick leave credits, the amount so paid shall be recovered from the employee. Thereafter the employee shall be governed by the sick leave provisions of the collective agreement.

Employer will often seek for loss of seniority as well as non-accrual of benefits and ultimately seek the employee's termination. The language could be presented as follows:

Or tabled language that will seek to "termination" of employment as a result of unable or unfit to return to work.

M2

An employee who has been on staff for more than one (1) year, and is declared unfit to perform the essential duties of her regular job shall lose her seniority and employment two (2) years after the date of the accident or one (1) year after the Notice of Fitness of Essential Duties from the Workplace Safety and Insurance Board has been received when all attempts to accommodate the worker or to provide alternate work have failed. Seniority and employment shall also be lost on the date as of which the employee is certified fit to return to work and she fails to do so or in the case of employees who are hired for a definite term of employment, upon expiration of such term. In the case of employees who have been on staff for less than one (1) year, the employee may be terminated on the date she is declared unfit to perform the essential duties of her regular job.
The language presented above makes reference to Return to Work and Accommodation. However, there is an increase of bad practices regarding the issue of Return to Work protocols and the Employers views that union participation may not be necessary. The Letter of Understanding below could be used as a guide as to what elements could be incorporated in to a RTW protocol.

Re: Return to Work of Disabled Workers

The parties are committed to a consistent, fair approach to meeting the needs of disabled workers, to restoring them to work which is meaningful for them and valuable to the employer, and as required under the law.

The parties agree to cooperate in facilitating the return to work of disabled employees.

(a) A joint Return to Work Committee (RWC) comprised of an equal number of representatives (union and non-union) will be established. The Committee will meet at least four (4) times each year.

(b) The employer will provide an updated list of information to the (RWC) before each quarterly meeting including the following:

i) employees absent from work because of disability who are in receipt of Workplace Safety Insurance Board benefits;

ii) employees absent from work because of disability who are in receipt Long Term Disability benefits;

iii) employees who have been absent from work because of disability for more than 23 months;

iv) employees who are currently on a temporary modified work program;

v) employees who are currently permanently accommodated in the workplace;

vi) employees who require temporary modified work; and,

vii) employees who require permanent accommodation in the workplace;

(c) A disabled employee who is ready to return to work will provide the Occupational Health Service with medical verification of her ability to return to work including information regarding any restrictions.

(d) When a returning employee is in need of a permanent accommodation the Employer will notify the RWC co-chairs and will provide to them the information obtained under (c) above.

(e) As soon as practicable the co-chairs or their designates will meet with the affected employee and the manager to create and recommend a return to work plan.

(f) In creating a return to work plan, the committee and the manager will examine the disabled employee's abilities and accommodation needs to determine if the employee can return to her:

i) original position;

ii) original unit;

iii) original unit/position with modifications to the work area and/or equipment and/or the work arrangement; or,

iv) alternate positions outside the original unit.

(g) In creating a return to work plan, the committee will consider the employee's abilities and accommodation needs, and if she is unable to return to work in accordance with article (f) above, the committee will identify any positions in the employer in which the employee may be accommodated.

(h) An employee in need of permanent accommodation may be temporarily accommodated until a permanent arrangement is established. Such an employee will remain on the list of employees requiring permanent accommodation provided under article (b) (vii) above.

(i) The parties recognize that more than one employee requiring accommodation may be suitable for a particular position or arrangement. In such cases the parties agree that in complying with articles (f) and (g) and (h) above, they must balance additional factors including in no particular order:

i) skills, ability, and experience;

ii) ability to acquire skills;

iii) path of least disruption in the workplace;

iv) the principle that more should be done to provide work to someone who otherwise would remain outside the active workforce; and,

v) seniority

(j) When more than one employee is deemed by the committee to be suitable for a particular position or arrangement, and the factors set our in articles (f), (g), (h) and (i) are relatively equal, seniority shall govern.

(k) The committee will monitor the status of accommodated employees and the status of employees awaiting accommodation.

(l) The committee will develop and recommend strategies for:

i) integrating accommodated workers back into the workplace; and,

ii) educating employees about the legal, personal, organizational aspects of returning disabled workers to work

Alternative Placements

i) Before posting, the parties will examine all potential vacancies to determine if they can be used to accommodate a disabled employee who requires accommodation but cannot return to her home unit in accordance with article (f).

ii) If a vacancy is identified as suitable for accommodation purposes, the parties may recommend holding the posting and convene a meeting of the RWC as soon as possible to determine:

- whether the unit, after considering all factors including the number of accommodated employees in the unit, the operational needs of the unit, safety of employees working in the unit, alternative resources, can reasonably accommodate a employee

- whether the posting of the position under the collective agreement between the parties may be waived

- whether a position outside the bargaining unit may be an appropriate position for accommodating a employee

iii) When the parties agree to a permanent accommodation whether or not a job posting is waived, and whether or not the position is inside the bargaining unit, the parties will sign an agreement containing the details of the accommodation.

iv) The parties may agree to a written agreement for temporary accommodations of extended duration.

v) The home position of an employee requiring permanent accommodation may be posted under the following circumstances:

A) The employee is permanently accommodated in another position or arrangement

B) the weight of the medical evidence establishes that there is no reasonable prospect of a return to her original position in the foreseeable future

C) the employer may elect to fill the disabled employee's home position by posting a temporary to permanent vacancy

1) In so electing, the position will be filled in accordance with the job posting provisions of the collective agreement

2) If and when it is confirmed that the disabled employee cannot return to her original position, the position may be offered to the incumbent on a permanent basis

3) When a job offer is made for the vacancy, the successful applicant will be clearly advised of the temporary status of the position and of its potential permanency.

D) Filling of a disabled employee's home position does not remove the Employer's duty to accommodate that employee.

Task sheet 7
supporting the local

In your group, develop a plan to improve the aspect of your local that you have chosen. If you want, you may create a scenario for your plan to address. Be as inventive as you want. Use your experience and the resources in your participant manual to assist you in developing your plan. Use the chart below to begin your planning process.

Supporting the Local Plan

Strategy	
Who needs to be involved	
Resources	
Steps involved	

You may present your plan in any way you think would be appropriate. (Flipchart presentation, skit, song, dance)

Presentations should be no longer than 5 minutes

Harper government's changes to Employment Insurance come into effect

The changes legislated by the Conservative government of Prime Minister Stephen Harper to the $17-billion employment-insurance program come into force on January 6, 2013. From that date, EI recipients will be expected to commute as much as an hour or more for a job and to accept work that, depending on their EI history, may pay as little as 70 percent of their previous employment income.

The changes to the EI legislation, contained in the Harper government's omnibus budget legislation, Bill C-38, short-titled the Jobs, Growth and Long-term Prosperity Act, removed key sections of the Employment Insurance Act that relate to the type of jobs that EI recipients can refuse as unsuitable. Instead, new rules have been introduced by regulation after the Bill received Royal Assent on June 29, 2012.

Human Resources Minister Diane Finley indicated, while the legislation was before Parliament, that the type of work and hourly wages that unemployed workers will be expected to accept as suitable will vary depending both on how long a person has been claiming EI benefits and how often he or she has claimed them in the past. She said that the government intended to divide claimants into three categories: long-tenured workers who have paid into the EI program for seven of the past 10 years, and over the last five years have collected benefits for 35 weeks or less; occasional claimants, who have more but still limited experience with being unemployed; and frequent claimants who have had three or more claims for a total of more than 60 weeks in the past five years.

Under this new scheme, according to Finley, long-tenured workers will be required after collecting EI benefits for 18 weeks to expand their job search to jobs considered similar to their previous job and to accept wages at 80 percent of their previous hourly wage. Occasional EI claimants will be able to limit their job search to their usual occupation and wage for the first six weeks, and then have to expand their search and be willing to accept work for which they are qualified and accept a lower salary. After 18 weeks, they will be required to accept wages starting at 70 percent of their previous earnings but not lower than minimum wage.

Finley said at the time that claimants will be assessed based on their job search activities, the intensity and frequency of their efforts, the type of work they are looking for and the evidence they have to prove their efforts. They will also be expected to be willing to commute up to an hour each way for work.

On December 13, Finley announced that the government's definition of "suitable employment" will be based on six criteria: personal circumstances (poor health, physically incapable of working, family obligations and limited transportation); working conditions (job offered is not vacant due directly to a strike, lockout or other labour dispute); hours of work (all available hours of work, including hours per day and availability outside the previous work schedule, will be deemed suitable for employment); commuting time (workplace is within a one-hour commute from home, although it could be higher, taking into account previous commuting history and a community's average commuting time); type of work (responsibilities, tasks, qualifications and experience); and wages. For a job to be considered "suitable employment," EI claimants must be better off financially accepting the position than receiving EI regular or fishing benefits.

Financial costs associated with accepting a job – such as child care and transportation costs – will be considered by Service Canada officials when determining whether the work is suitable. As previously announced, the pay levels and type of work deemed "suitable" for EI claimants will be based on a person's EI history and the duration of the claim.

As of January 6, the "reasonable job search" that claimants are required to conduct in order to qualify for EI benefits will have to include researching job opportunities, preparing a resume, registering for job banks, attending job fairs, applying for jobs, and undergoing competency evaluations.

At the time that the legislation permitting these changes was before Parliament, Canadian Labour Congress President Ken Georgetti criticized the EI changes as "ridiculous economic policy." He said that "[i]t's short-term thinking and it's political football with the people that are the most vulnerable in our society. People who are unemployed don't want to be unemployed. This government would have you believe that they're sitting there and surfing

off the shores of Nova Scotia or skiing in the mountains of British Columbia ... it's not true."

NDP finance critic Peggy Nash accused Finley of "scapegoating unemployed Canadians, that they're not trying hard enough to find work," and said that more pressure should be put on employers to create more jobs in order to reduce the unemployment level. Liberal Party human resources critic Rodger Cuzner said that his party is concerned that the proposed rules will force people to take low-skilled, low-paying jobs and will jeopardize the economic security of communities that rely on seasonal industries.

Adapted from: http://gordiecanuk.blogspot.ca/2009/02/harper-dismantling-nanny-state.html

Monday, February 9, 2009

Harper - Dismantling the Nanny State

It’s no secret that Stephen Harper is not a big fan of Canada's social safety net, in fact its a matter of public record. A previous entry here made note of several Harper quotes, available on line via CTV. Among them were a couple of gems:

- Canada is a Northern European welfare state in the worst sense of the term, and very proud of it.
- In terms of the unemployed, of which we have over a million-and-a-half, don't feel particularly bad for many of these people. They don't feel bad about it themselves, as long as they're receiving generous social assistance and unemployment insurance.

A welfare state? Okay...I guess, depending on one's perspective. Personally, like many other Canadians, I am proud that our country attempts to look after its citizens through socialized programs like Health Care, Employment Insurance and the Canada Pension Plan...among many others. That doesn't mean I don't understand those who share Harper's view. There are many in this country who find our social safety net cumbersome, expensive and ultimately a barrier to greater prosperity. It’s not a view I share however, and I suspect even Stephen Harper realizes that to campaign on a plan to dismantle our social programs would give him zero hope of ever attaining a mandate strong enough to begin acting on his true agenda.

The Toronto Sun recently published excerpts from soon to be published memoirs by Gerry Nicholls, a colleague of Harper's from his days with Canada's **National Citizens Coalition** (some coalitions are okay), the title "**Loyal To The Core: Stephen Harper, Me, and the NCC**". Included is this little snippet wherein Nicholls writes of Harper's decision to go back into politics and the reason why:

- “Because I don’t want my kids to grow up in a socialist country.”

But how do you dismantle social programs that took years to establish? Pierre Trudeau is largely credited with establishing and/or strengthening our national social programs. But it didn't happen overnight, and it didn't come cheaply. Canadians carry a substantial tax burden, the cost of looking after the weakest and most vulnerable members of society, and ensuring a minimum base standard for all Canadians.

That doesn't mean Harper and company haven't been working at eroding the foundation however, and that foundation is our system of taxation which funds our social programs. By lowering the GST by 2 points the Conservatives have weakened the national treasury to the tune of billions of dollars. Individually it only adds up to a penny or two saved here and there...unless you're regularly making purchases in the tens of thousands of dollars. I know there are some out there who do buy new cars worth $50,000 or more every year among other luxury items.

Were I lucky enough to be in that economic strata I might like Harper's plan. Nah...my social conscience and morals would still get in the way. But if I were self-centered to such an extent that I only cared about myself and viewed others as leeching off of my prosperity...you get the idea.

By wiping out the surpluses previous Liberal governments had operated on, Harper has undercut our national government's ability to even maintain the national programs on which so many Canadians rely, programs upon which many of us base our national identity...We're not the United States, we look after **all** of our citizens! Yes I know it ain't perfect, but it sure as hell beats a user pay system with no minimum standards.

The current economic crisis has allowed Harper to further pursue his agenda. By instituting tax-cuts in the most recent budget the Tories are

further hamstringing Ottawa's ability to play an active role in the social welfare of the Canadian people. We'll be racking up over $100 billion in deficit spending over the next 5 years, a lot more if Flaherty's record of forecasting is any indication...and when this crisis is over we're going to be left with one hell of a bill.

Every tax dollar that is spent on servicing the national debt is a tax dollar lost that could be used to fund programs like Health Care, Education, Welfare, Disability, Old Age Supplement...it’s a long list. And therein lies Harper's chance at success in fulfilling his mission, seeing that his children don't grow up in 'socialist country'. If Canadians ever give Stephen and his Conservatives a majority none of our children will be growing up with the social programs relied upon by all. Better hope those tax cuts can fill the void in a new User-Pay Canada.

Harper's welfare state for Canadian workers

BY
GERRY CAPLAN
| JUNE 4, 2012

Despite slurs to the contrary, the welfare state is alive and well and living in Harperland. Appropriately enough, its benefits are available largely to those who have earned them. Call them Real Canadians, call them Conservatives. Whatever. These admirable citizens are treated to all the advantages bestowed by Stephen Harper's personal social safety net.

Say, for example, these Conservatives lose their jobs. Say -- just to take a random notion -- they run for office and get whupped. Soon on the very verge of the deep depression, demoralization and self-loathing that so commonly accompanies being laid off, the Prime Minister suddenly reaches down and throws them a golden lifeline.

In fact, according to Postmedia News, almost a quarter of all the Prime Minister's defeated candidates in last year's election have received what the Ottawa Citizen calls "a taxpayer-funded federal job."

"A Postmedia News **analysis** reveals that 35 of the 141 Conservative candidates who lost at the polls received jobs in places such as the Prime Minister's Office, Health Canada, ministers' offices or on boards and agencies." Mr. Harper (who as opposition leader couldn't condemn patronage appointments fervently enough), explained through a spokesperson that "each one of the candidates identified ... was qualified for their position and earned their job based on merit." Who might have thought otherwise?

Of course there are jobs and there are jobs. Not all Conservative welfare dished out to failed Conservative candidates is created equal. There's only one Canadian ambassador to France, for example, and former Foreign Affairs minister Lawrence Cannon is the **lucky winner** of up to $221,800 annually for five years plus benefits plus one of the poshest digs in Paris. When he was in cabinet he was pulling in about $230,000 a year plus car allowance plus plenty of benefits, so he must make do with (slightly) less.

Then there's former Veterans Affairs and Revenue minister Jean-Pierre Blackburn whose rejection by the voters earned him the **agreeable post** of Canadian representative to UNESCO. It too, happily, is based in the heart of Paris, with an annual salary of up to $195,300 and with duties not easy to pinpoint.

That both men "earned their job based on merit" goes without saying.
As for the four failed Conservative candidates who were appointed to the Senate, with a base salary of $132,000 plus expense accounts plus free air travel plus pensions, one can only respond with a heartfelt "well done and godspeed!" Heaven knows they deserve every penny, especially the two who had already been senators, resigned to run in the election, were repudiated by the voters, and were then reappointed to the Senate (which Stephen Harper wants elected).
Of course we need to be realistic here. There are, after all, only so many ambassadorships and Senate seats available for the jobless in Canada, who number at least 1.4 million souls. It's true there's something called Employment Insurance, but only 40 per cent of the jobless actually get EI -- when they finally get it at all. Because the government slashed staff at Service Canada, workers have waited for months for their meager benefits, especially over Christmas. And when it finally comes, this lucky minority gets a max of 55 per cent of their average earnings. That means over 850,000 of those who lose their jobs get exactly nothing.

As well, since the vast majority of those laid off hadn't exactly been bringing home 1-per-cent-level earnings, it is, to say the least, no picnic to live either on EI or off it.

In a rational world, the high level of unemployment and the huge numbers of Canadians who get either no or modest help adds up to a national crisis. The Harper government agrees there's a crisis, but it sees a rather different one. As Human Resources Minister Diane Finley once declared, "We do not want to make it lucrative for them to stay home and get paid for it." As it happens, the minister's husband, who was campaign manager for the Conservative Party in both the 2006 and 2008 elections, was appointed to the Senate by Stephen Harper.

So the government has chosen to fix its invented crisis of shiftless, duplicitous swindlers rather than the country's real crisis. It's making it even tougher for the jobless to keep their EI payments, while forcing some recipients to accept wages starting at 70 per cent of their previous income. And you know how astronomical their previous income must have been, especially when wages have barely been keeping up with inflation.

Now there's a pretty clear pattern here. This is the third time the Harper government has forced workers to work for less. Recent changes to the Temporary Foreign Workers Program has permitted employers to pay migrant workers up to 15 per cent less than regular workers. And in the process of ending last year's labour dispute at Canada Post, the government took an extra kick at the workers by imposing a wage increase which was actually lower than the Crown corporation's offer. For those who envy the cushy job of a postal worker, make sure you too demand the lush $48,000 that letter carriers, postal clerks and mail handlers all make.

So when unions accuse the government of forcing a race to the bottom on wages in order to provide Canadian businesses with a pool of low-paid employees, when they insist these measures will exert "a terrible downward pressure" on the wages of all Canadian workers, they're not provoking a class war. They're describing the one workers are badly losing.

Add to the picture that this week marked the fifth time the Harper government has subverted the collective bargaining process by legislating workers back to work. These repeated tactics constitute an obvious attempt to wound an already battered trade union movement. Seen together with forcing workers to accept lower wages, it's part of a conscious Conservative strategy to undercut the wages and employment conditions of all workers.

And when we recall that the federal corporate tax rate is now just 15 per cent, down from 28 per cent a decade ago, while environmental protection for energy projects is being gutted, the larger pattern becomes clear.

Incrementally, perhaps, but steadily and consistently, Stephen Harper is delivering on the age-old business dream of a Corporate Utopia -- a trifecta of minimal government regulation, weak trade unions and paltry taxes on business and the rich.

And the next election is not for three more years.
This article was first published in the **Globe and Mail**.

HELPFUL RESOURCE MATERIALS

Legal Update

Medical Consent Form violates privacy legislation, collective agreement.
Hamilton Health Sciences and ONA (Surdykowski) (2007), 167 LAC (4th) 122,
http://www.canlii.org/en/on/onla/doc/2007/2007canlii73923/2007canlii73923.pdf

Summary
The Hospital hired a private company to administer its short-term disability plan under the collective agreement. Employees were required to complete a medical consent form that included extensive medical information in order to access sick benefits under HOODIP.

The Union filed policy grievances to challenge the scope of the medical consent form. The consent allowed any person involved in the employees' treatment to disclose confidential medical information to the administrator. The information disclosed could include diagnosis, medical history, symptoms and treatment. The administrator conceded at arbitration that no-one had reviewed HOODIP or the collective agreement when preparing the medical form.

The Arbitrator emphasized that Canadian society recognizes medical confidentiality as a legally protected privacy right. Except as permitted by a collective agreement, or as consented to by employees, an employer is entitled to only limited medical information as necessary to verify the entitlement to benefits.

For example, pursuant to the 1992 HOODIP, an employee is entitled to benefits if he or she is medically unable to perform regular duties, is under active, continuous and medically appropriate care, and is following the prescribed treatment. Generally, a medical certificate indicating that the employee is unable to work for a period of time will satisfy these requirements. An employer is not entitled to a medical diagnosis, history, specifics of medical tests ordered, treatment or prognosis unless there is an objectively reasonable basis to doubt the accuracy of the information provided.

The Arbitrator concluded that the medical consent form relied upon by the administrator was too intrusive, in violation of the collective agreement and the Personal Health Information Protection Act. He ordered that the Administrator cease using the form immediately.
The decision offers guidelines for medical consent forms:

- Consent requested must be limited to what the employer would otherwise be entitled to under the collective agreement or benefits plan.
- Consent forms should refer to a single health care professional. An employer cannot rely on one consent form to gather information from other people or agencies without the knowledge of the employee.
- Consent forms should not permit ongoing direct contact between a health care professional and the employer. Every contact should be with the employee's knowledge and specific consent.

Implications

This decision will help unions address intrusive procedures or forms under many short-term disability plans. Where there is any concern, medical consent forms and medical disclosure should be reviewed carefully against the principles set out in the decision. The specifics of what medical information is required will depend on the facts of each case.

Additional considerations will apply where medical information is requested in other contexts. For example, further disclosure of medical information may be necessary to support a workplace accommodation, a return to work from extended absence, or to access benefits under a long-term disability plan.

Medical information fact sheet

General Consensus among arbitrators that when assessing a request for short term disability or illness:

Employer is entitled to:

- General information as to the nature of the illness or disability
- General description of the work the employee can or cannot do.
- The expected date of return of the employee.

In Ontario Nurses Association v. Hamilton Health Sciences (2008) the arbitrator stated that the employer is entitled to the reason for the incapacity in the form of a "general statement" of the nature of the … illness or injury, that the employee has and is following a treatment plan (but not the plan itself), the expected return to work date, and what work the employee can or cannot do

Employer is not entitled to:

- Specific diagnosis
- Symptoms
- Treatment plan
- Medical history
- Prospective consent to contact the employee's doctor

In one case an Arbitrator went as far as to rule that medical information request forms supplied by the employer must make clear that diagnosis and symptoms are not to be provided. Ontario Nurses Association v. Brant Community Healthcare System (2008)

For more lengthy or complicated medical leaves some arbitrators have supported employer's requests for additional medical information such as:

- Information about prognosis
- Functional limitations
- Medical follow-up
- Expected return to work date
- General course of treatment

CUPE, Local 728 v. Surrey School District No. 36 (2006)

OPSEU SEFPO Ontario Public Service Employees Union
Syndicat des employés de la fonction publique de l'Ontario

A Guide to Appealing Disability Benefits in the Broader Public Service (BPS)

OPSEU Pensions and Benefits Unit
November 2012

Introduction

This guide was created to provide an overview of the appeals process and the steps involved when appealing the denial or termination of insured benefits in the Broader Public Service (BPS). The content contained is offered as a reference tool that can be used by members who have been denied disability benefits or by others who are assisting them. To avoid any liability, members assisting other members should not go on record as the claimant's representative with the insurance carrier. Any communication regarding the appeal should remain between the member claiming benefits (claimant) and the insurance company.

The information contained in this material should be used as a general guide only. It does not provide legal advice. Keep in mind that the appeals process will vary depending on the insurance company and the issues of each individual claim. The content provided is not intended to replace professional legal advice. If you have any questions or concerns regarding your group insurance contract, the appeals process or your claim, you should contact a lawyer.

Overview

When you have been away from work due to injury or illness for a specified period of time – depending on your workplace – you may be advised to apply for long-term disability (LTD) benefits. LTD benefits are usually administered and paid by an insurance company (the carrier) to which you and/or your employer pay premiums.

If you wish to receive the benefits, you must complete the carrier's application process and provide the carrier with medical opinions and evidence to show the injury or illness has made you disabled as per the terms of the insurance policy. This usually means that you are unable to work at your own occupation (at the first stage) or at any occupation (after you have been away from work for another specified period). However, all insurance contracts are different and you will need to check your benefit booklet for a complete description of what totally disabled means under your insurance contract.

Prior to the commencement of Short and Long Term Disability payments there is a waiting period. This period may also be referred to as the

"qualifying" or the "elimination" period. This is the period that a claimant must be disabled for to qualify for the benefit. Each plan will have a different waiting period for insured short and long term disability benefits.

You must also comply with a number of conditions set out in the insurance policy and your Collective Agreement. The policy is a legal document that determines, among other things, what your obligations are when you are applying for or receiving LTD benefits. Your Collective Agreement is a legal contract that may contain provisions with respect to insured benefits specific to your workplace.

When the carrier denies or terminates your benefits it may be due to insufficient information in your application, the carrier may simply ask you to supply more, or it may deny or "decline" your claim. It may also advise you of your right to appeal its decision.

If you are already in receipt of benefits, the carrier will continue to monitor your medical status and your compliance with the requirements of the policy. At some point, the carrier may conclude you are no longer entitled to benefits. Again, the carrier may notify you of its decision and advise you of your right to appeal.

Insurance Carriers set time limits for appealing the denial or termination of benefits. It is important to act quickly to ensure any time limits to appeal are met.

The appeals process can be onerous, stressful and time-consuming. You will need to be knowledgeable about your insured benefits policies, persistent and patient while fighting for the benefits you deserve.

Know and meet the deadline(s) for your appeal

Deadlines are critical in any legal process. Missing a deadline can have serious consequences, including forfeiture of your right to appeal. The deadline for filing an appeal should be included in the insurer's denial letter.

Write an appeal letter

Immediately notify the insurance company's Disability Case Manager in writing that you do not agree with their decision and you are appealing it.

Indicate in your letter that this is to formally notify them of your appeal. If you have additional medical information, enclose it with your letter and detail in your letter what documents you have attached and how they support your appeal. If you do not have additional medical information, advise in your letter that you are appealing the decision to deny benefits and that you are working on obtaining additional medical information and will forward it to them as soon as you receive it.

It is best to fax this appeal letter and keep a copy of the transmittal confirmation as proof that you have sent the letter.

Obtain copies of your collective agreement, benefits booklet & insurance policy

Copies of your collective agreement and benefits booklet will outline coverage and any rules, criteria and guidelines pertaining to your benefits. Benefit booklets are a condensed version of the insurance policy. They are created to summarize your coverage in a more user friendly and easier to read format. The actual insurance policy (sometimes called contract) between your employer and the insurance company is most likely not widely distributed to the employees. Some collective agreements may have provisions allowing you to grieve the benefit denial. Some group policies have a Medical Appeals Process (MAP) available to claimants. The benefit criteria and definition of total disability is information that will be useful for your treating physician when he/she is preparing a medical report. Please see Appendix A at the end of this booklet for a checklist of the documents important to your insured benefit appeal.

To be informed about benefits at your workplace; you should:

- ask for the benefits booklet and the insurance policy 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 appeal process for long term benefits

Understand why your claim was denied

The letter you received denying or terminating your benefits should include the specific reasons for the denial, the specific policy provisions on which the determination was made and any further information you can submit that may allow your claim. The letter should also include the steps of the appeals process and may include any other rules, guidelines or criteria involved in making the decision. You should read the letter carefully and if you don't understand something, call the Case Manager and ask for an explanation. He/she may also offer suggestions as to what would be helpful in your appeal.

Some common reasons for denials are missing or incomplete medical records; uncertainty on the part of the insurer that you are unable to perform your work; or lack of sufficient proof concerning your symptoms. Quite often the insurance company will suggest in their decision letter the type of information that would be helpful in supporting your appeal.

Obtain the evidence that supports your inability to work

One of the most important steps in winning your appeal is to obtain the medical evidence that supports your inability to work. It is critical to 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 to ensure they are aware when completing any medical documentation in support of your claim or appeal.

Insurance carriers often outline in their denial letter the specific type of information required to allow your claim. In some cases they may also include the benefit criteria, if not; this information can usually be found in your benefits booklet. You should provide a copy of this letter to your doctor(s) when requesting additional medical information. Doctors will quite often be in a position to provide you with the information the insurer is looking for.

Insurers have biases about the professionals whose opinions they would prefer to accept. They tend to prefer doctors over para-professionals (ie Physiotherapists) and specialists over family doctors. More weight will be put

on a specialist's report and these reports become more important the longer you are unable to work.

Effective medical information includes all doctors' reports, diagnostic tests, examinations and clinical notes. You should also ask your Doctor to include a detailed letter explaining in medical terms why you are unable to perform your job.

Depending on your particular case, Insurance companies will often want to know the following from your doctors:

- Diagnosis (for Psychiatric Conditions include DSM IV Multi-Axial Evaluation)
- Treatment program
- Tests undertaken and any follow up required
- Medications being taken
- Severity of symptoms
- Limitations and restrictions and how they prevent you from working
- Prognosis as it relates to employment (when will you be able to return to work)
- Copies of Clinical Notes

Insurers may also insist on an 'independent' medical assessment (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.

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 your appeal depending on the medical opinions they provide. If you are unable to see your Doctor in a timely manner you may opt to write to them for a report to assist with your appeal. Please see Appendix B at the end of this booklet for a sample letter to assist you in requesting medical information from your treating physician(s).

Submit your new evidence

Once you have obtained additional evidence to support your total disability another letter should be written to your insurance company indicating that

you are enclosing further evidence to support your on-going total disability. Write a brief overview of your position and explain how this additional evidence shows that you are disabled as defined by your insurance policy. Outline the dates and types of documentation you are providing and how it supports your disability. If the insurance company made any factually incorrect statements in their denial / termination letter, ensure that you address them in this letter.

Appeal denied

You can ask your insurer to consider another appeal if your appeal has been denied. This should be done if you believe there is additional medical information you can obtain that has not already been submitted that may change the insurer's mind. If there is no further medical evidence to be submitted you can contact the Insurance Ombudsman office. Before you can use OLHI's independent dispute resolution services, you must first try to resolve your complaint directly with your insurance company. All OLHI member companies are required to have a complaints resolution process and to provide consumers with a copy of this process upon request. This is, however, a complaint process and the Ombudsman cannot rule on any medical evidence and has no binding authority.

If you have exhausted your appeals process and your claim hasn't been approved you can take your claim to court. A suit against your insurer can be filed in an attempt to have the denial of your claim overturned. OPSEU members, in limited situations, can apply to the Solidarity Reserve Fund for financial assistance with legal costs.

Solidarity reserve fund

Provided your contract does not permit proceedings within your collective agreement to obtain benefits and the insurer's appeals process has been exhausted, you may be eligible for a maximum of up to $5000 from the Solidarity Reserve Fund to sue your insurance carrier. Before applying for funding, members should seek the advice of their local executive or Staff Representative to confirm if any avenues are available within the collective agreement.

Applications to the Solidarity Reserve Fund are decided by the OPSEU Executive Committee at regular meetings. To apply for funding members should submit in writing a letter to Eric O'Brien, General Counsel, 100 Lesmill Road, Toronto, Ontario M3B 3P8. Such letter should:

- Indicate that you are a member of OPSEU and requesting assistance through the Solidarity Reserve Fund in order to pursue a claim for LTD benefits;
- Provide some background about your denial, the issue in your claim and why you want to take action (attaching a copy of the Insurance Carrier's denial letter is helpful);
- Confirm the status of your claim with the insurer, such as whether you have an internal appeal that is still available or are waiting for a decision;
- Confirm whether there is a grievance or appeal procedure within your collective agreement;
- State you remain disabled and unable to work in your own position and/or any other position;
- State whether you have retained a lawyer yet, and whether you have paid any legal fees for your claim against the Insurance Company.

Sources of income replacement

While you are appealing the denial or termination of your disability benefits you will need income. There are limited sources of income replacement under these circumstances. The following are some common sources of help during these difficult economic circumstances.

Employment Insurance (EI) Sick Benefits

Some plans make the member apply and use up the EI sickness benefits before receiving any insured benefits. In some cases, the only income protection for members appealing denials is Employment Insurance (EI) Sick Benefits. If you were on an employer sponsored sick leave program before applying and being denied disability benefits, you can ask EI to waive the usual two week waiting period. EI will also expect you to pay them back should you win your disability appeal.

To be eligible to receive EI sickness benefits, you need to have paid EI premiums. These are premiums your employer deducts from your wages or salary. There is no minimum or maximum age for paying EI premiums. You need to pay EI premiums on all your earnings up to a maximum amount. In 2012, for every $100 you earn, your employer will deduct $1.83, until your annual earnings reach the maximum yearly insurable amount of $45,900. The maximum amount of premiums to be paid in 2012 is therefore $839.97.

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. Please see Appendix C for a list of helpful website addresses.

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.

The Canada Pension Plan Disability Plan

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 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.

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.

How much do I get?

People receiving a CPP disability benefit in 2010 received, on average, about $807.81 each month. The benefit includes a fixed amount that everyone receives ($433.37 a month for 2011), 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 2011 is $1,153.37. 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 $218.50 a month in 2011 if you are approved for a disability benefit. Applications for children's benefits are included in the application kit. Your child can only receive a benefit if at least one parent is receiving a CPP disability benefit.

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

How do I apply?

The Application for Disability Benefits is now available online. Or, contact us to have a kit mailed to you. You must apply for a disability benefit in writing.

If you prefer, someone else (a family member or friend) can complete the kit for you (but please make sure that you sign the application form for your benefit).

The kit contains information and instructions, including:

- application forms related to you and your dependent children;
- a questionnaire for details of your work history and medical condition;
- a medical report to be completed by your doctor. If you have more than one doctor, choose the one who knows the most about your main medical condition;
- a consent form that Service Canada staff may need to get additional information from other parties; and,
- a Child Rearing Provision form to complete if you stopped working, or reduced the number of hours you worked while you took care of your children when they were under the age of seven. If this provision applies to you, this may help you meet the contributory requirements or increase the amount of the benefit you are eligible to receive.

Use the applications checklist to ensure the application is complete.

How do I appeal the denial of CPP disability benefits?

If the decision is that you were not eligible for a CPP disability benefit, you have the right to request a review of the decision.
There are three opportunities to request a review of your disability application. These must occur in the following order. They are:

- Step 1. A request to Service Canada for reconsideration.
  If you are dissatisfied with this decision:
- Step 2.
  An appeal to the Office of the Commissioner of Review Tribunals.
  If you are dissatisfied with this decision:
- Step 3.
  An appeal to the Pension Appeals Board.

At every level, you must make your request in writing within specific time limits. Time limits of **90 days** are generally applicable to each step listed above. Please refer to the CPP Disability website to confirm the deadlines.

You can request a review of any decision made on your application, including, for example:

- the denial of a benefit,
- the amount of a benefit payment,
- the date the benefit payment begins, or
- the date of the cancellation of your benefit.

Ontario Disability Support Program (ODSP)

The Ontario Disability Support Program is one of Ontario's social assistance programs that provide financial help for people with disabilities who are in need. It can help pay for living expenses, like food and housing. If you qualify for Income Support, the amount of Income Support you receive will depend on your family size, income, assets and housing costs. You and your family may also qualify for other benefits, such as drug, dental, vision care, hearing aids, diabetic supplies; help with transportation costs to medical appointments, wheelchair/mobility device repairs and batteries, help to support your guide dog and help with work-related expenses.

How to Apply

There are three ways you can apply for Ontario Disability Support Program (ODSP) Income Support: online; in person and by phone. There are two parts to the application process. Part one looks at your financial situation and part two looks at your disability status.

Applying online

The Online Application for Social Assistance allows residents of Ontario to find out if they might be eligible for ODSP Income Support, and start the application process. You will be required to meet with an ODSP caseworker after the online application is completed. A caseworker will contact you directly to set up an appointment. Online applications can be access at: http://www.mcss.gov.on.ca/en/mcss/programs/social/apply_online.aspx

Applying in person

To begin the application process, contact your local Ontario Disability Support Program office and ask to set up a meeting. If you can't get to the local office for the appointment, they can arrange to meet with you at another location. If you have special needs, such as sign or language interpretation, or Braille or large-print forms, they can help. Just let them know ahead of time so arrangements can be made.

Before your appointment, the office will send you a letter confirming the day and time of the appointment. They will also include a list of all the things you need to bring to the appointment.

Applying by phone

Call your local Ontario Disability Support Program office to complete the application over the phone.

Part 1 – Financial Status Meeting

The purpose of the meeting is to look at your financial situation. The meeting will take about 1-1/2 hours. You will need to bring the following documents (as applicable) for you and your family members:

- birth certificates
- immigration papers (such as Record of Landing, Sponsorship Agreement or Permanent Resident Card)
- social insurance numbers
- Ontario health card numbers (OHIP)
- information about your housing costs (such as rent receipts, mortgage statements, or utility and heating bills)
- information about your assets (such as bank books or statements)
- information about your income (such as pay stubs or support orders)
- information about your job or training program
- evidence of trusteeship or power of attorney.

Together, you and the caseworker will go over in detail how much money you have and how many bills you have to pay. When they look at your financial situation, they will take into account many things, such as:

- how many people there are in your family
- how many children you have and how old they are
- if you have a spouse or adult dependants
- your income and assets
- if you are entitled to other sources of income
- where you live.

After the meeting, your caseworker will tell you whether or not you qualify financially for Income Support. If you qualify financially for Income Support you will then go on to part two of the application process, your disability status. This involves looking at your disability status to see if you meet the definition of "a person with a disability" as defined in the Ontario Disability Support Program Act.

If your caseworker tells you that you do not qualify financially for Income Support, you can ask to have the decision reviewed. This is first step in the appeal process and is called an Internal Review. While the review takes place, you may continue with part two of the application process, your disability status.

Part 2 – Disability Status

If you qualify financially, the next step is to see whether or not you meet the definition of "a person with a disability" as defined in the Ontario Disability Support Program Act. This is called the Disability Determination Process.

You will be provided with a Disability Determination Package that contains:

- a Health Status Report and Activities of Daily Living form
- a Consent to Release Medical Information form
- a Self-Report form, and
- instructions on how to complete the forms.

Some people do not have to complete these forms. For example, you will not have to complete these forms if you:

- receive disability benefits from the Canada Pension Plan (CPP) or the Quebec Pension Plan (QPP)
- are 65 or older but do not qualify Old Age Security (OAS)

- live in a certain type of institution, such as a mental health facility or a home for people with developmental disabilities.

If one of these applies to you, your local Ontario Disability Support Program office will tell you what information you need to provide.

Once all the forms in your Disability Determination Package are complete, you (or the health professional) have to return them to the Disability Adjudication Unit of the Ministry of Community and Social Services. An envelope with the return address should be included with your package. If not, the address is:

Ontario Disability Support Program
Disability Adjudication Unit
Box B18
Toronto ON M7A 1R3
Fax: 416-326-3374

Please note that the completed forms must be returned within **90 days** from the date that you received the package.

Ontario Works

It can take from a few weeks up to a few months to find out if you are eligible to receive Ontario Disability Support Program Income Support. If you need financial help right away you can apply for financial assistance under Ontario Works. If you qualify, Ontario Works staff will be able to help you right away. They will also help you apply for Ontario Disability Support Program Income Support.

How to Apply

There are three ways you can apply for Ontario Works; online, in person or by phone.

Applying online

The Online Application for Social Assistance allows residents of Ontario to find out if they might be eligible for Ontario Works and start the application

process. The link to the online application is:
http://www.mcss.gov.on.ca/en/mcss/programs/social/apply_online.aspx

Applying in person

To begin the application process, contact your local Ontario Works office to talk about your situation.

If you decide to complete an application, you will be given a time to meet with them. This meeting usually takes place at the Ontario Works office. If it is difficult for you to go to the Ontario Works office, the meeting can be held in your home or somewhere in your community.

You will need to bring certain documents to the meeting. When you make your appointment, Ontario Works staff will tell you what documents you need to bring. Here are some examples:

- proof of your Social Insurance Number
- Health Card
- proof of identity, such as your birth certificate
- recent bank statement for all your bank accounts
- copy of your mortgage or rental agreement
- Record of Employment and/or your most recent pay stubs
- copy of your Canada Child Tax Benefit statement (if you have children under 18 years of age)
- information about other money you may be receiving, such as a pension
- information about assets you may own, such as a Registered Retirement Savings Plan, and
- proof of immigration status, if required.

They will look at all this information to decide if you are eligible for Ontario Works.

Applying by phone

Call your local Ontario Works office to complete the application over the phone.

Your Pension Plan's Disability Pension

Depending on the severity of your condition, your age and your chances of returning to the workforce, you may be eligible for a disability pension through your workplace pension plan. This could be a very viable option; however, there can be significant consequences in choosing to start a disability pension. Firstly, collecting a disability pension from your plan would entail terminating employment with your employer. Any termination or limitations of insured benefits (health, dental etc.) applicable upon retirement that is specific to your workplace would apply when receiving a disability pension. It is also important to note that the amount received in a disability pension will likely be deducted from the amount received from the insurance company should your disability claim subsequently be allowed. Finally, if your plan is a "defined benefit" plan, it may have provisions that allow you to continue to accrue service while you are off work due to a disability. These provisions allow your pension to continue to grow. If you start collecting the pension under the disability provision it will likely be based only on the years of service you have contributed thus far. Therefore you are likely to receive an amount less than what you would have received if you had continued to accrue pensionable service in the plan.

For information regarding the disability pension provisions in your plan, consult your pension plan administrator. We strongly recommend you seek financial and/or legal advice prior to applying for any disability pension that may be available to you.

OPSEU Regional Hardship Fund

Each Region of OPSEU has an OPSEU Regional Hardship Fund available to members who are in financial distress. An application form can be downloaded from the OPSEU Website. Please see Appendix C for a list of helpful website addresses.

Helpful website addresses

Employment Insurance (EI) Sick Benefits
http://www.servicecanada.gc.ca/eng/sc/ei/benefits/sickness.shtml

Social Assistance
http://www.mcss.gov.on.ca/en/mcss/programs/social/odsp/income_Support/part_One.aspx

Ontario Works / Ontario Disability Support Program Online Applications
http://www.mcss.gov.on.ca/en/mcss/programs/social/apply_online.aspx

CPP Disability
http://www.servicecanada.gc.ca/eng/isp/cpp/applicant.shtml

OPSEU Regional Hardship Fund Application
http://opseu.org/sites/default/files/regional_hardship_fund_application_form_-_revised_2013.pdf

OmbudService for Life & Health Insurance
http://www.olhi.ca/complaint_process.html

Privacy fact sheet

What case law says about privacy	Where to learn more
Employers are prohibited from trying to gain access to a worker's medical records without the workers consent	"No employer shall seek to gain access, except by an order of the court or other tribunal or in order to comply with another statute, to a health record concerning a worker without the worker's written consent." **Ontario Occupational Health and Safety Act s.63(2)**
Unless agreed to (by the parties or statute), employers cannot discipline an employee for refusing to provide the employer with personal medical information.	Discipline quashed for refusal to provide medical certificate to employer. **Canadian Union of Public Employees, Local 1253 v. New Brunswick (Department of Edu)**
Employers cannot require an employee to submit to an examination by a doctor but if the employer has reasonable cause they may refuse to permit the employee to work until adequate medical documentation is provided	Discharge for resisting medical assessment by employer's doctor overturned. **Loyer v. Canada (2004) C.P.S.R.B. No. 21 (QL)**

Health Information Custodians

The legislation applies to defined "health information custodians" where they collect, use or disclose personal health information.

A health information custodian includes doctors, other health care practitioners, hospitals, and long-term care facilities. It also includes health care clinics, laboratories, pharmacies, the Ministry of Health and Long-Term Care, and other health-related organizations.

The legislation also applies to individuals and organizations outside the health system that receive personal health information from the health care system, such

as insurance companies, employers, and schools. The legislation applies to everyone regarding the collection, use or disclosure of OHIP numbers. http://www.health.gov.on.ca/english/providers/legislation/priv_legislation/priv_legislation.html

Safeguarding Personal Health Information

The Personal Health Information Protection Act, 2004 (the Act) requires health information custodians (custodians) to protect personal health information in their custody or control and to ensure that records are retained, transferred and disposed of in a secure manner.

The purpose of this fact sheet is to highlight some important safeguards for protecting personal health information. Custodians should also consult additional resources such as the Physician Privacy Toolkit and the Hospital Privacy Toolkit (the Toolkits), which set out these requirements in detail, and may be adapted to all custodians.

Storage of Personal Health Information

Custodians must take reasonable steps to keep personal health information securely stored. What is reasonable varies depending on the sensitivity of the information and the risks to which it is exposed. The size of an organization is also a factor to consider. For instance, large organizations dealing with significant amounts of sensitive personal health information will need different security than small offices. Custodians must therefore scale security measures to fit their own circumstances. Steps to ensure safe storage of personal health information should address physical security, technological security and administrative controls.

Physical security includes:

• Locked filing cabinets; and

• Restricted office access and alarm systems.

Technological security includes the use of:

• Passwords, user IDs;

• Encryption[2]; and

• Firewalls and virus scanners.

Administrative controls include:

• A concise written set of security rules;

• Appointment of a staff member with overall responsibility for security;

• Staff training;

• Security clearances;

• Access restrictions;

• Regular audits of actual practices for compliance with security policies; and

• Confidentiality agreements.

Where electronic health records are kept, custodians should ensure that they:

• Use features such as passwords to prevent unauthorized access;

• Install automatic back-up for file recovery to protect records from loss or damage; and

• Keep an audit trail that, at a minimum:

  · Records the date and time of each entry for each patient;
  · Shows any changes in the record; and
  · Preserves the original content when a record is changed, updated or corrected.

  Note: Where a record is corrected under the *Act*, particular items may be struck out in a way that does not obliterate the record, or the content may be severed and stored separately with a link that enables a person to trace the incorrect information.

A person who provides services to enable a custodian to collect, use and disclose information electronically must comply with the privacy protections set out in the regulations under the *Act*.

Privacy breaches

Custodians must notify individuals whose personal health information has been stolen, lost or accessed by an unauthorized person.

Retention of personal health information

The *Act* requires personal health records be kept for as long as needed to allow an individual to exhaust any legal recourse regarding a request for access.

As a best practice, personal health records should be retained for their minimum retention periods.

The *Act* does not establish specific retention periods for personal health information. However, custodians should refer to their governing legislation and regulatory procedures to determine what record retention requirements apply in their circumstances.

The *Toolkits* include a summary of retention periods set by other authorities for health records, OHIP records, and research records.

Transfer of personal health information

Records may be transferred to facilities, other custodians or successors.

Custodians must securely transfer records, and refer to their governing legislation and regulatory procedures to determine appropriate transfer requirements.

The *Act* requires custodians to make reasonable efforts to notify patients before transferring records to a successor, or if that is not reasonably possible, as soon as possible after the transfer.

Disposal of personal health information

Custodians must have procedures to securely dispose of personal health records so that the personal health information cannot be retrieved.

For hard copy records, secure disposal may mean shredding or burning them; and

For electronic records, secure disposal may include either physically destroying the media they are stored on (such as a CD) or magnetically erasing or overwriting the information in such a way that the information cannot be recovered.

Custodians should keep a record of disposal dates and the names of individuals whose records were disposed of.

Great care should also be taken to secure personal health information when moving offices. Files should not be left behind or tossed in the garbage without first being securely destroyed. If computers are to be sold, all personal health information must first be erased in such a way that it cannot be recovered.

Resources and links

This fact sheet has set out some of the basic requirements under the *Act* in relation to safeguarding, retaining, transferring and disposing of personal health information Custodians are encouraged to consult additional resources in order to ensure full compliance with these requirements.

Here are links to the *Physician Privacy Toolkit* and the *Hospital Privacy Toolkit*.

As well as a number of publications specifically addressing the *Personal Health Information Protection Act*, a general IPC privacy publication may also be useful in managing personal health information:

- *Moving Information: Privacy and Security Guidelines*

Other health privacy materials available from the IPC include:

- Frequently Asked Questions: *Personal Health Information Protection Act*;
- A *Guide to the Personal Health Information Protection Act*;
- *The Personal Health Information Protection Act and Your Privacy*;
- *Frequently Asked Questions: Health Cards and Health Numbers*;
- *Your Health Information: Your Rights*;
- *Collection, Use, Disclosure and Other Complaints: Personal Health Information Protection Act*; and
- *Access and Correction Complaints: Personal Health Information Protection Act*

For more information, please call, write or e-mail:

Information and Privacy Commissioner of Ontario
2 Bloor Street East, Suite 1400
Toronto, Ontario
CANADA
M4W 1A8
Telephone: 416-326-3333 or 1-800-387-0073
Facsimile: 416-325-9195
TTY: 416-325-7539
Website: www.ipc.on.ca
Email address: info@ipc.on.ca

Guidelines for difficult conversations

Your role as a local activist does not include counseling. (This is true even if you are a counselor by employment). Below are some general guidelines for when you are faced with difficult conversations.

- Be empathetic: Listen to the individual's problem in an objective but supportive way. Being a good listener is sometimes all a person wants.

- Model calmness: Difficult conversations can be very emotional for both the effected person and the one listening. By appearing calm, even if you are not, it can lower the emotional tension.

- Be safe: Safety for yourself is the most important thing. You can't help someone if you are not safe.
  - Meet in public areas
  - Bring another person along
  - End the conversation if you are feeling uncomfortable

- Set Limits: Make clear to the individual involved what your role is and isn't. If you need, end the meeting or set another time to meet.

- Provide resources: Employee Assistance Programs (EAP) family doctors, or community supports are appropriate places to refer individuals who are experiencing difficulties. Have a list of community resources or use the resource list provided in these materials.

- Follow up with the individual regarding any agreed to plans of action.

- Keep notes of your meetings. These will be helpful in reminding you of conversations if there are follow-up investigations.

- If you are concerned that the person may harm themselves or others calling the police is appropriate.

- When in doubt about your responsibility or what to do, contact your staff representative.

The above information is based on crisis intervention training including the Crisis Prevention Institute's Nonviolent Crisis Intervention training program®

Community Resources for your Members

You may already have a current list of community resources of use to your members. If you don't here's a start.

Addiction

DART (Drug and Alcohol Registry of Treatment): 1-800-565-8603

Gambling Help Line: 1- 888-230-3505

Crisis/Mental Health

Mental Health Service Information Ontario: 1- 866-531-2600

Disability and Accessibility

Accessibility For Ontarians With Disabilities Act (AODA)
Service Ontario, Contact Centre
Toll free: 1-866-515-2025 TTY: 416-325-3408 Toll free TTY: 1-800-268-7095
Fax: 416-325-3407

Adaptive Technology Resource Centre
Faculty of Information Studies, University of Toronto
Phone: 416-978-4360 Fax: 416-971-2629
E-mail: general.atrc@utoronto.ca
Internet: www.atrc.utoronto.ca
Online resources, consultation and accommodation support for employers hiring, retraining, advancing and retaining persons with disabilities.

ALDERCENTRE (Adult Learning Disabilities Employment Resource Centre)
Phone: 416-693-2922 Fax: 416-698-0038
E-mail: ld@aldercentre.org
Internet: www.aldercentre.org

ARCH: A Legal Resource Centre for Persons with Disabilities
Phone: 416-482-8255
Outside Toronto: 1-866-482-2724
TTY: 416-482-1254 Fax: 416-482-2981
E-mail: archlib@lao.on.ca
Internet: www.archlegalclinic.ca

Assistive Devices Industry Office
Industry Canada
Phone: 613-990-4316 or 613-990-4297
TTY: 613-998-3288 Fax: 613-998-5923
E-mail: adio@crc.ca Internet: www.at-links.gc.ca/as
Information on assistive technologies and programs and services related to technical accommodations.

Canadian Association of the Deaf
Phone: 613-565-2882 TTY: 613-565-8882
Fax: 613-565-1207 E-mail: cad@cad.ca
Internet: www.cad.ca

Canadian Council on Rehabilitation and Work
Phone: 416-260-3060 Toll free: 1-800-664-0925 TTY: 416-260-9223
Internet: www.ccrw.org
CCRW is a "one-stop shop" for disability and employment resources. The CCRW provides a number of hands-on services to employers, including partnerships, workplace assessments and training on a number of disability-related subjects including return to work processes for injured workers and how to implement an accommodation process in the workplace.

The Job Accommodation Network
Phone (V/TTY): 1-304-293-7186
E-mail: jan@jan.wvu.edu
Internet: www.jan.wvu.edu
Practical approaches to accommodation strategies for persons with disabilities.

Learning Disabilities Association of Canada (National Office)
Phone: 613-238-5721 Fax: 613-235-5391
Toll Free: 1-877-238-5322
E-mail: information@ldac-taac.ca
Internet: www.ldac-taac.ca

Learning Disabilities Association of Ontario
Phone: 416-929-4311 Fax: 416-929-3905
Internet: www.ldao.ca
Information on learning disabilities including a brochure for employers called "Learning Disabilities on the Job."

Link Up Employment Services Phone: 416-413-4922 Fax: 416-413-4927
TTY: 416-413-4926
E-mail: info@linkup.ca Internet: www.linkup.ca
This charitable, not-for-profit employment services agency assesses and provides supports to persons with disabilities. It also offers services aimed at helping employers hire persons with disabilities.

WORKink
(Canadian Council on Rehabilitation and Work) E-mail: workink@ccrw.org
Internet: www.workink.com
Offers services for employers to post jobs and review resumes from qualified candidates with disabilities.

Distress Centers—Ontario

Brampton
Distress Line: 905-459-7777

Cambridge
Distress Line: 519-658-6805

Durham County
Distress Line: 905-430-2522; 1-800-452-0688

The Farm Line Support Service
Distress Line: 1-888-451-2903

Kingston
Distress Line: 613-544-1771

Lanark, Leeds and Grenville Counties
Distress Line: 1-800-465-4442

London & District
Distress Line: 519-667-6711
Seniors Helpline (SHL): 519-667-6600

Niagara Region
Distress Line: 905-688-3711

North Halton
Distress Line: 905-877-1211

Oakville
Distress Line: 905-849-4541

Ottawa & Region
Distress Line: 613-238-3311
Crisis Line: 613-722-6914 or 1-866-996-0991

Peel Region
Distress Line: 905-278-7208
Mobile Crisis Line: 905-278-9036 or 1-800-363-0971

Sarnia & Lambton County
Distress Line: 519-336-3000 or 1-888-347-8737

Toronto
Distress Line: 416-408-4357
Survivor Support Program: 416-595-1716

Waterloo Region
Distress Line: 519-745-1166

Wellington and Dufferin Counties
Distress Line: 519-821-3760 or 1-888-821-3760
Crisis Line: 519-821-0140 or 1-877-822-0140

Windsor & Essex County
Distress Line: 519-256-5000

Emergency Crisis Lines

Abused Women's Help Line:
1-800-265-1576

Assaulted Women's Help Line:
For Bell, Rogers, Fido, Telus #SAFE or #7233)
1-866-863-0511/ TTY Crisis Line: 1-866-863-7876

At^lohsa Native Healing Services Crisis Line: 1-800-605-7477

Femaide (phone line that supports Francophone women in violent situations): 1-877-336-2433; 1-866-860-7082 (TTY)

Victim Support Line: 1-888-579-2888/Phone: 416-314-2447

Health
TeleHealth: 1-866-797-0007

Human Rights and Employment Issues

A Commitment to Training and Employment for Women (ACETW)
Tel: 416-599-3590 Fax: 416-599-2043
E-mail: info@actew.org
Internet: www.actew.org

Canadian Information Centre for International Credentials
Internet: www.cicic.ca
Services to support recognition of international credentials.

Career Edge
Phone: 416-977-3343 Toll Free: 1-888-507-3343 Fax: 416-977-4090
Internet: http://overview.careeredge.ca/
E-mail: info@careeredge.ca
Internship programs for people with disabilities, recent graduates and internationally qualified professionals.

Centre for Canadian Language Benchmarks (CCLB)
Phone: 613-230-7729 Fax: 613-230-9305
E-mail: info@language.ca
Internet: www.language.ca
See Resource Kit for Counseling and Hiring Immigrants
Practical supports for hiring and training newcomers.

City of Toronto – Human Rights Office
Phone: 416-392-8383 Fax: 416-392-3920 or 416-392-4686 TTY: 416-397-7332
E-mail: humanrights@toronto.ca
Internet: www.toronto.ca

COSTI Immigrant Services
Phone: 416.658.1600 Fax: 416.658.8537
E-mail: info@costi.org
Internet: www.costi.org
Offers employment, educational, settlement and social services to all immigrant communities, new Canadians and individuals in need of assistance.

Human Rights Tribunal of Ontario
Human Rights Tribunal of Ontario
Tel: 416-314-8419 Toll Free: 1-800-668-3946 TTY: 416-314-2379 TTY Toll Free: 1-800-424-1168 Fax: 416-314-8743

E-mail: hrto.registrar@ontario.ca
Internet: www.hrto.ca

Human Rights Legal Support Centre
Tel: (416) 314-6266 Toll Free: 1-866-625-5179 TTY: (416) 314-6651 TTY Toll Free: 1-866 612-8627
Fax: 1-866-625-5180 or 416-314-6202
E-mail: HRLSC@Ontario.ca
Internet: http//www.hrlsc.on.ca

Industrial Accident Prevention Association (IAPA) – Information Centre
Phone: 905-614-4272 ext. 2298 or ext. 2387 Toll free in Ontario: 1-800-406-4272 ext. 2298 or ext. 2387 Fax: 905-614-1414
E-mail: infocentre@iapa.ca
Internet: www.IAPA.ca
Website features wide variety of resources on occupational health and safety, and on creating and maintaining healthy workplaces, including resources on workplace violence.

Job Start – The Centre for Advancement in Work and Living
Phone: 416-231-2295 TTY: 416-253-2726 Fax: 416-253-2700
E-mail: info@jobstart-cawl.org Internet: www.jobstart-cawl.org
Community-based, not-for-profit agency helping experienced workers, newcomers to Canada and youth overcome challenges to reach their employment goals.

Miziwe Biik Aboriginal Employment Training
Phone: 416-591-2310 Fax: 416-591-3602
E-mail: info@miziwebiik.com
Internet: www.miziwebiik.com
Offers employer services including targeted wage subsidies.

Ocasi
Phone: 416-322-4950 Fax: 416-322-8084
E-mail: generalmail@ocasi.org
Internet: www.ocasi.org
A council of over 170 community-based agencies which serve the immigrant communities of Ontario.

Ontario Federation of Indian Friendship Centres
Phone: 416-956-7575 Toll Free: 1-800-772-9291 Fax: 416-956-7577
E-mail: ofifc@ofifc.org Internet: www.ofifc.org
Has an Employment Unit that delivers programs aimed at linking Indigenous people with employment opportunities.
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National Association of Women and the Law
Phone: 613-241-7570 Fax: 613-241-4657
E-mail: info@nawl.ca Internet: www.nawl.ca
Non-profit organization working to promote equality rights of all women in Canada.
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Ontario Association of Youth Employment Centres
Internet: www.oayec.org/youth/resources
Links to online resources.

St. Stephen's Employment and Training Centre
Phone: 416-531-4631 Fax: 416-531-2680
Internet: www.ststephenshouse.com
Provides services to employers such as free job postings, hosting a job fair on an employer's behalf, or wage subsidies as part of its youth employment program.

Legal Help Lines

Justice for Children and Youth
(Toronto): 1-866-999-JFCY (5329)

ARCH Disability Law Centre (Ontario):
1-866-482-ARCH (2724)
1-866-482-2728 (TTY)

Legal Aid Ontario
(legal services for low-income communities; website lists local community legal clinics in Ontario)1-800-668-8258
1-866-641-8867 (TTY)

Lawyer Referral Service, Law Society of Upper Canada
(referrals to lawyers who provide a free consultation of up to 30 minutes; $6 a call, unless caller is incarcerated, institutionalized, calling about child protection matters, or are in situations of domestic abuse); 1-900-565-4577/1-800-268-8326 (special crisis line)

Family Law Education for Women (FLEW)
(information about family law issues that affect women; information in multiple languages)www.onefamilylaw.ca

Ontario Human Rights Commission
416-314-4500

Lgbttq

Lesbian, Gay, Bi, Trans Youth Crisis Line: 1-800-268-9688

Mental Health Organizations

Across Boundaries, An Ethnoracial Mental Health Organization
Phone: 416-787-3007 Fax: 416-787-4421
E-mail: info@acrossboundaries.ca
Internet: www.acrossboundaries.ca

Canadian Mental Health Association (CMHA), Ontario
Phone: 416-977-5580 Toll Free: 1-800-875-6213 Fax 416-977-2813
E-mail info@ontario.cmha.ca
Internet: www.ontario.cmha.ca
Comprehensive resource on mental health. Can link an employer to services such as counselling or support for employees with mental illness. See "Stigma and Discrimination"
http://www.ontario.cmha.ca/about_mental_health.asp?cID=7599

The Canadian Psychiatric Association
Phone: 613-234-2815 Fax: 613-234-9857
E-mail: cpa@cpa-apc.org
Internet: www.cpa-apc.org

Canadian Psychiatric Research Foundation
Phone: 416-351-7757 Toll Free: 1-800-915-2773 Fax: 416-351-7765
E-mail: admin@cprf.ca Internet: www.cprf.ca

Centre for Addiction and Mental Health
Phone: 416-595-6111 Toll free: 1-800-463-6273 Internet: www.camh.net
E-mail: mmclaughlininformation@camh.net
Provides reliable information and active assistance for people seeking services or support about mental health and addictions. The CAMH website also has a wide range of information and resources

Community Resource Connections of Toronto
Phone: 416-482-4103 Fax: 416-482-5237
E-mail: crct@crct.org Internet: www.crct.org
See Navigating Mental Health Services in Toronto: A Guide for Newcomer Communities

Fact sheet #1- Employment insurance benefits

What is employment insurance benefits?

Employment insurance benefits (EI) provides temporary financial assistance to Canadians who are unemployed or have lost their job through no fault of their own (example: mass layoff, seasonal work)

There are several types of EI benefits available. The different benefits are:

- Employment Insurance Regular Benefits – available to individuals who lose their jobs through no fault of their own and who are available and capable to work but are unable to find a job.
- Employment Insurance Maternity and Parental Benefits – provide support to individuals who are pregnant, have recently given birth, are adopting a child, or caring for a newborn.
- Employment Insurance Sickness Benefits – available to individuals who are unable to work due to sickness or injury.
- Employment Insurance Compassionate Care Benefits – for individuals who have been temporarily away from work to provide care or support to a family member who is gravely ill with a significant risk of death.
- Employment Insurance Fishing Benefits – provide support to qualifying, self-employed fishers who are actively seeking work.

Please refer to the Employment Insurance Facts Sheets for more information on individual Employment Insurance benefits.

For additional information regarding Employment Insurance Benefits, please contact Service Canada by telephone at 1- 800-O-Canada (1- 800-622 - 6232) TTY 1- 800 - 926 - 9105 or the website at www.servicecanada.gc.ca.

If you wish to contact the Pensions and Benefits unit, please email us at pensionsandbenefits@opseu.org

OPSEU does not represent members in EI benefit appeals. This publication contains general information and is intended as a reference only. It is not intended as a substitute for independent legal advice regarding your particular situation

Fact Sheet #2

Employment insurance regular benefits

Am I eligible for Employment Insurance Regular Benefits?

You may be entitled to receive EI regular benefits if you**:**

- have paid premiums into the EI Account;
- lost your employment through no fault of your own;
- have been without work and without pay for at least seven consecutive days in the last 52 weeks;
- have worked for the required number of insurable hours in the last 52 weeks or since the start of your last EI claim, whichever is shorter;
- are ready, willing, and capable of working each day; and,
- are actively looking for work (you must keep a written record of employers you contact, including when you contacted them).

You may not be entitled to receive EI regular benefits if you:

- voluntarily left your employment without just cause;
- were dismissed for misconduct; or,

Do I need to apply to receive Employment Insurance Regular Benefits?

Yes, you need to apply for EI benefits, because Service Canada first needs to determine whether you are entitled to benefits.

When should I apply?

You should apply as soon as possible once you have stopped working, even if your employer has not issued your Record of Employment (ROE) yet. You should know that if you delay applying for benefits beyond four weeks after your last day of work, you risk losing benefits.

How do I apply for Employment Insurance Regular Benefits?

You can apply in person at a Service Canada Centre or online at www.servicecanada.ca. To locate a Service Canada Centre where you live, call 1-800-622-6232.

What documentation do I need to apply for Employment Insurance Regular Benefits?

- Social insurance card
- A second piece of identification, with your photo (example: passport, driver's licence)

- Your record of employment (ROE) from every place you have worked in the past twelve months; pay stubs; and, T-4 slips.

When will I start to receive Employment Insurance Regular Benefits?
If all the received information is submitted and you are entitled to receive EI benefits, your first payment should be issued within 28 days of the date your application for benefits is received.

How much will I get?
The basic rate for calculating EI benefits is 55% of your average insurable weekly earnings. As of January 1, 2011, the maximum yearly insurable amount is $44,200. This means that you can receive a maximum amount of $468 per week.

What is the two week waiting period?
Before you start receiving EI benefits, there are two weeks for which you will not be paid. The waiting period is like the deductible that you must pay for other types of insurance. You usually serve the waiting period at the very beginning of a benefit period, unless you receive earnings during this two-week period. In that case, the waiting period will start during the first week for which you would otherwise be entitled to benefits.

For how long will I receive Employment Insurance Regular Benefits?
You may receive EI regular benefits for a period ranging from 14 to 45 weeks. The number of weeks of benefits depends on the unemployment rate in your region and on the number of hours of insurable employment that you accumulated during your qualifying period, which is usually the last 52 weeks before the start date of your claim.

What are my ongoing responsibilities once I begin to receive Employment Insurance Regular Benefits?
After you apply for EI benefits, you must complete and submit EI reports to get the benefits you are entitled to receive. During the period your EI claim is active, you have to submit reports to Service Canada every two weeks that show you are still entitled to receive EI benefits.
For additional information regarding Employment Insurance Regular Benefits contact Service Canada at 1-800-622-6232 or online at www.servicecanada.ca

If you wish to contact the Pensions and Benefits unit, please email us at pensionsandbenefits@opseu.org

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Fact sheet #3

Employment insurance maternity benefits

What are Employment Insurance (EI) Maternity Benefits?

EI Maternity Benefits are benefits that are payable to the birth mother or surrogate mother of a child through Employment Insurance.

What are my eligibility criteria for EI Maternity Benefits?

To be entitled to maternity, parental or sickness benefits you must show that:

- your regular weekly earnings have been decreased by more than 40%; and
- you have accumulated 600 insured hours in the last 52 weeks or since your last claim. This period is called the qualifying period.

What information do I need to apply for Employment Insurance Maternity Benefits?

You can submit an application online at www.servicecanada.ca or in person to Service Canada.

You should have the following information when applying:

- your social insurance number
- your record of employment (ROE)
- personal identification – such as a driver's licence, birth certificate or passport
- your banking information for direct deposit
- the expected or actual date of your child's birth

How long can I receive EI Maternity Benefits for?

You are eligible to receive EI Maternity Benefits for a maximum of 15 weeks. You are able to begin collecting EI Maternity Benefits either up to eight (8) weeks before your expected due date or within 17 weeks of the actual expected week of birth. The date you file your claim is very important in order that you may receive the maximum maternity benefits you are entitled to

Special Note:

When a pregnancy terminates within the first 19 weeks of pregnancy, EI considers this an illness. Therefore, sickness benefits may be paid for as long as all of the conditions for receiving sickness benefits continue to be met.

When a pregnancy terminates after 19 weeks of pregnancy, the claim for benefits can be considered for maternity benefits as long as the conditions for maternity benefits are met.

What if my child is hospitalized after birth?

If your child is hospitalized after birth, then the 17 week limit can be extended for every week your child is in the hospital up to 52 weeks – following the week of your child's birth. You are still eligible to receive benefits for a maximum of 15 weeks, but payments can be delayed until your child is home. For more information on how to extend payments up to 52 weeks, please contact Service Canada at 1-800-206-7218.

When will I start receiving my EI Maternity Benefits?

If you have all the required information and you qualify for EI Maternity Benefits, you will start receiving payments within approximately 28 days from the date of filing your claim.

Do I need to serve a two week waiting period to receive EI Maternity Benefits?

Yes, you must serve a two week waiting period before you begin to receive your benefits payments.

How long can I receive EI Maternity Benefits if my spouse is receiving Employment Insurance Parental Benefits?

If you are receiving a combination of maternity and parental leave benefits, you may qualify to receive payments for a combined maximum of 50 weeks. For more information on combined benefit payments, please contact Service Canada.

For additional information regarding Employment Insurance Maternity Benefits contact Service Canada at 1-800-622-6232 or online at www.servicecanada.ca

If you wish to contact the Pensions and Benefits unit, please email us at pensionsandbenefits@opseu.org

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Fact Sheet number 1 Canada pension plan changes

Changes to the current Canada Pension will be gradually introduced from 2011 to 2016. The changes are especially important to those applying for benefits before age 65, those who want to retire, but work part-time, or anyone who entered the workforce late or was out of the workforce for extended times.

Note: these are administrative changes only to the CPP benefits. They are not related to the call for an expansion of CPP for all Canadians.

If you already receive CPP or expect to start collecting before the changes come into force, you won't be affected by the new rules.

What are the changes being made to the CPP?

- Your monthly CPP retirement pension amount will increase by a larger percentage if you take it after age 65.
- Your monthly CPP retirement pension amount will decrease by a larger percentage if you take it before age 65.
- If you are under 65 and you work while receiving your CPP retirement pension, you and your employer will have to make CPP contributions. These contributions will increase your CPP retirement benefits.
- If you are age 65 to 70 and you work while receiving your CPP retirement pension, you can choose to make CPP contributions. These contributions will increase your CPP retirement benefits.
- The number of years of low or zero earnings that are automatically dropped from the calculation of your CPP pension will increase.
- You will be able to begin receiving your CPP retirement pension without any work interruption.

Your monthly CPP retirement pension amount will decrease by a larger percentage if you take it before age 65.

Before the changes, your CPP retirement pension was reduced by 0.5% for each month before age 65 that you began receiving it. This meant that, if you started receiving your CPP pension at 60, your pension amount was 30% less than it would have been if you had waited to take it at 65.

From 2012 to 2016, the Government will gradually change this early pension reduction from 0.5% to 0.6% per month. This means that, by 2016, if you start receiving your CPP pension at the age of 60, your pension amount will be 36% less than it would have been if you had taken it at 65, an additional 6% reduction.

Your monthly CPP retirement pension amount will increase by a larger percentage if you take it after age 65.

Before the changes, your CPP retirement pension increased by 0.5% for each month after age 65 (and up to age 70) that you delayed receiving it. This meant that, if you started receiving your CPP pension at 70, your pension amount was 30% more than it would have been if you had taken it at 65.

From 2011 to 2013, the Government of Canada will gradually increase this percentage from 0.5% per month (6% per year) to 0.7% per month (8.4% per year). This means that, by 2013, if you start receiving your CPP pension at the age of 70, your pension amount will be 42% more than it would have been if you had taken it at 65, an additional 12% increase.

Are you affected by the changes?
These changes will affect you if you:

- contribute to the CPP, whether you are just starting your career or you are planning to retire soon; or
- are between the ages of 60 and 70 and you work while receiving your CPP retirement pension (or if you work outside of Quebec while receiving a QPP retirement pension)

You will not be affected by these changes if you started receiving a CPP retirement pension before December 31, 2010, and you remain out of the work force.

Note: The changes also affect employers who are required to match your contributions to the CPP.

If you are under age 65 and you work while receiving your CPP retirement pension, you and your employer will have to make CPP contributions. These contributions will increase your CPP retirement benefits.

Before the change, if you were receiving a CPP retirement pension and working, regardless of your age you did not pay CPP, contributions.

Starting in 2012, if you are under age 65 and you work while receiving your CPP retirement pension, you and your employer will have to make mandatory CPP contributions. These contributions go towards the new Post-Retirement Benefit (PRB), which is effective January 1 of the year following your PRB contribution. This additional benefit will be added to your current retirement benefit, gradually increasing your retirement income.

If you are age 65 to 70 and you work while receiving your CPP retirement pension, you can choose to make CPP contributions. These contributions will increase your CPP retirement benefits.

Before the change, if you were receiving a CPP retirement pension and working, regardless of your age, you did not pay CPP contributions.

Starting in 2012, if you are age 65 to 70 and you work while receiving your CPP retirement pension, you can either choose to make CPP contributions or you can opt out of making these contributions. If you decide to make the contributions, your employer will also have to make CPP contributions. These contributions will allow you to continue to build your CPP Post-Retirement Benefit, even if you are already receiving the maximum CPP pension amount.

The number of years of low or zero earnings that are automatically dropped from the calculation of your CPP pension will increase.

Before the changes, when Service Canada calculated your average earnings over your contributory period, 15% of your lowest earnings were automatically dropped. This is called the "general drop-out provision." Under this provision, up to 7 years of your lowest earnings were automatically dropped from the calculation of your average earnings.

Starting in 2012, the percentage of low earnings will increase to 16%, allowing up to 7.5 years of your lowest earnings to be dropped from the calculation, which will likely increase your benefit amount. In 2014, the percentage will increase again to 17%, allowing up to 8 years of your lowest earnings to be dropped from the calculation.

Note: This change benefits all CPP contributors who are eligible for CPP benefits in 2012 or later.

Planning for your retirement

These changes to the CPP may affect your retirement planning, including when you decide to apply for your CPP retirement pension. How the changes to the CPP affect you will depend on your age, your work history, and when you plan to retire.

The CPP, which is designed to replace about 25% of your average pre-retirement employment earnings up to a maximum amount, is one part of your retirement plan. The other components of retirement income include the Government of Canada's Old Age Security (OAS) pension, employer pension plans, and personal savings and investments.

You will be able to begin receiving your CPP retirement pension without any work interruption.

Before the change, if you decided to take your CPP retirement pension before age 65, you had to either stop working or significantly reduce your earnings for at least two months. This requirement was called the "work cessation test." After this two-month period, you could return to work or start earning more.

Starting in 2012, the work cessation test will no longer apply. This means that you will be able to take your CPP retirement pension as early as age 60 without having to stop working or reduce your earnings.

Need more information?

For additional general information regarding Canada Pension Plan, contact Service Canada at www.servicecanada.ca or by telephoning Toll-free in Canada and the United States**: 1-800-277-9914** If you have a hearing or speech impairment and use a teletypewriter **(TTY): 1-800-255-4786** From outside Canada and the United States (collect calls accepted): **613-990-2244**

If you wish to contact the Pensions and Benefits unit, please email us at pensionsandbenefits@opseu.org

OPSEU does not represent members in CPP appeals. This publication contains general information and is intended as a reference only. It is not intended as a substitute for independent legal advice regarding your particular situation.

Fact sheet #2

Canada pension plan disability benefits

What is the CPP Disability Benefit?

Canada Pension Plan (CPP) Disability Benefits provide a monthly taxable benefit to contributors who are disabled and to their dependent children. You should apply if you develop a severe and prolonged illness or disability that prevents you from working at any other job. The disability must be long lasting or may result in death.

The CPP Disability Benefit is available to people who have made enough contributions to the CPP. There is a provision in the CPP legislation which allows a period of time to be removed or "dropped out" when calculating your contributions to the CPP. Excluding this period of low or no earnings can help you become eligible for a CPP disability benefit. It can also increase the amount of your benefit.

How do I qualify for CPP Disability Benefits?

To qualify you must be under age 65; contribute into the CPP at least four of the last six years, or paid into the CPP for at least 25 years and made valid contributions to the Plan in three of the last six years.

If you are applying for a CPP disability benefit, but stopped working so long ago that you no longer have CPP contributions in four of the last six years but you meet all the other conditions of eligibility, you may still be eligible. This is called the late applicant provision. As long as you had enough years of CPP contributions when you first became severely disabled, and as long as you are considered to be continuously disabled from that date up to the present time, you may be eligible.

You must show through supporting medical documentation that you have a severe and prolonged disability as defined by the CPP legislation.

For information regarding whether you have sufficient contributions, you can contact Service Canada by telephone at 1- 800- 622- 6232 or email www.servicecanada.gc.ca for your Statement of Contributions.

Your benefits start four months from the date of your disability. If you apply late, you may be entitled to benefits dating back a maximum of one year from the date you apply. To remain eligible, you must continue to have a disability according to the CPP legislation.

How do I apply for the CPP Disability Benefit?

You must complete an application available from Service Canada. The application will include:

- A questionnaire about your work history and medical condition;
- A medical report form to be completed by your doctor.
- A consent form to give Service Canada permission to get additional information to process your application; and
- A form to complete if you reduced your working hours or stopped working to care for your children under the age of seven.

How long does it take for my Application for Disability Benefits to be approved?

It may take as long as three months for you to find out if your application for a disability benefits has been accepted. This time frame is much shorter for terminally ill applicants. It is important to submit as much supporting medical documentation at the time the application is made.

What are my responsibilities once I start receiving CPP Disability Benefits?

Service Canada will occasionally review the health and work status of claimants receiving a CPP disability benefit, to ensure that they continue to be eligible.

What are my options if my application for CPP Disability Benefits is denied?

If your application for a CPP disability benefit is not granted, there are three opportunities for you to have your application reviewed or reconsidered.

- A request to Service Canada for reconsideration in writing to say that you want to have the decision reconsidered. This must be done within 90 days of receiving a decision letter.
- An appeal to the Office of the Commissioner of Review Tribunals within 90 days of receiving a decision letter.
- An appeal to the Pension Appeals Board within 90 days of receiving the OCRT decision letter.

For additional information regarding CPP Disability Benefits; how to have a decision reconsidered; or, how to appeal a decision, please contact Service Canada by telephone: **1-800-O-Canada (1-800-622-6232), TTY: 1-800-926-9105** or at their Website www.servicecanada.gc.ca.
If you wish to contact the Pensions and Benefits unit, please email us at

pensionsandbenefits@opseu.org

OPSEU does not represent members in CPP appeals. This publication contains general information and is intended as a reference only. It is not a substitute for independent legal advice regarding your particular situation.

Fact sheet #3

Canadian pension plan retirement pension

What is the Canadian Pension Plan (CPP) Retirement Pension?

A CPP retirement pension is a monthly benefit paid to individuals who contribute to the Canada Pension Plan.

The CPP pension is designed to replace about 25% of a person's earnings from employment, up to a maximum amount. For 2011, the maximum amount is $960.00 per month.

How do I qualify for the CPP Retirement Pension?

To qualify, you must make at least one valid contribution (payment) to the Plan and meet the CPP earnings and contributions requirements. The normal retirement date is 65 years but you can retire as early as age 60 onwards with a reduced pension.

How do I apply?

You must apply for the CPP Retirement pension by completing the application available from Service Canada. Application forms are available on-line at servicecanada.gc.ca or call Service Canada at 1-800-622-6232. If you are already receiving a CPP disability benefit, you will need to apply for the CPP Retirement benefit when you turn 65. You should apply approximately 6 months before you intend to receive the benefits.

How is my CPP Retirement Pension calculated?

Your CPP retirement pension is based on how much, and for how long you contributed to the CPP, or to both the CPP and the Quebec Pension Plan (QPP).

The age at which you choose to retire also affects the amount you receive.

The CPP protects your pension by making certain adjustments before calculating 25% of the earnings you contributed over your working life. Some low-earning periods during your career (i.e. child rearing), may be "dropped out," so they do not reduce the amount of your pension. You can contact Service Canada directly and check if you are eligible to receive any "drop out" provisions.

How does my age affect the amount of my pension?

Although your CPP retirement pension usually starts the month after your 65th birthday, you can begin receiving your CPP retirement pension any time after age 60.

Your monthly payment is smaller if you begin receiving it before age 65, and larger if you take it after. The CPP offers you flexibility with respect to the age you retire. You can take your pension as early as age 60 or receive a larger pension if you wait until you turn 65 to begin receiving it.

When does my pension begin?

From Age 60 to 65

You can start receiving your retirement pension the month after you stop working or after you earn less than the allowable maximum pension payment for two consecutive months ($960.00 as of January 1, 2011).

- If you apply to receive your retirement pension once you turn 60, your pension will start the month after your 60th birthday.
- If you apply to receive your retirement pension after you turn 60 but before you turn 65, your pension will start the month after we receive your application is received (or at a later date if you specify one).

From Age 65

You can start receiving your pension the month after your 65th birthday (or at a later date if you specify one). You can choose to have your pension paid back to a maximum of 11 months from the date we receive your application, but no earlier than the month after your 65th birthday.

When do payments stop?

The last payment is for the month in which the contributor dies.

For additional general information regarding Canada Pension Plan, contact Service Canada at www.servicecanada.ca or by telephoning Toll-free in Canada and the United States: **1-800-277-9914** If you have a hearing or speech impairment and use a teletypewriter **(TTY): 1-800-255-4786** From outside Canada and the United States (collect calls accepted): **613-990-2244**

If you wish to contact the Pensions and Benefits unit, please email us at pensionsandbenefits@opseu.org

OPSEU does not represent members in CPP appeals. This publication contains general information and is intended as a reference only. It is not intended as a substitute for independent legal advice regarding your particular situation.

Fact sheet number 4

Canada pension plan and old age security rates 2012

CANADA PENSION PLAN PAYMENT RATES		
Type of Benefit	New Benefits Max. Amount 2012	Amounts Paid October 2011(in millions)
Retirement (at age 65)	$986.67	$2,053.0
Disability	$1,185.50	$267.8
Survivor - younger than 65	$543.82	$87.8
Survivor- 65 and older	$592.00	$241.5
Children of disabled contributor	$224.62	$16.9
Children of deceased contributor	$224.62	$13.7
Death (maximum one-time payment)	$2500	$23.7
Combined survivor/retirement (retirement at 65)	$986.67	$522.7
Combined survivor/disability	$1,185.50	$13.9

Source: Service Canada 2012

OLD AGE SECURITY BENEFIT PAYMENT RATES JANUARY to MARCH 2012				
Type of Benefit	Maximum Amount[1]	Income Level cut-off[2]	Income Level Cut-off for top-ups[2]	Amount Paid (In millions)
Old Age Security Pension3	$540.12	N/A		$2,508.6
Guaranteed Income Supplement				
▪ Single	$732.36	$16,368	$4,448	$448.10
▪ Spouse/common-law partner of someone who:				
✓ Does not receive OAS pension	$732.36	$39,264	$8,896	$38.5
✓ Receives as OAS pension	$485.61	$21,648	$7,456	$163.3
✓ Is an allowance recipient	$485.61	$39,264[4]	$7,456	$24.6
Allowance	$1,025.73	$30,336	$7,456	$25.7
Allowance for the Survivor	$1,148.35	$22,080	$4,448	$16.6

[1]The maximum amount includes the new top-ups for the GIS and the allowances effective July 1, 2011

[2]The income level cut-offs do not include the OAS pension and the first $3,500 of employment income

[3]The OAS pension repayment range in 2012 is from $69,562 to $112,772

[4]The Allowance stops being paid at $30,336, while the GIS stops being paid at $39,264

Source: Service Canada 2012

If you wish to contact the Pensions and Benefits unit, please email us at pensionsandbenefits@opseu.org

Fact sheet number 1

Reporting and filing workplace accidents

When should you report an accident/injury?

A work related accident/injury should be reported immediately, but if that is not possible, it should be reported to your supervisor before leaving the workplace on the day of the injury. Accidents must be reported to the Workplace Safety and Insurance Board (WSIB) no later than 6 months from the date of the accident. Occupational illness must be reported no later than 6 months from when the member learns that they suffer an occupational illness.

If there is any doubt whether your injury/illness is work related, file a claim immediately. Workers who do not report workplace accidents may lose the protection of the Workplace Safety Act. Some of the protections include health care, loss of earnings payments and the obligation to re-employ the injured worker.

The WSIB is an independent agency who determines whether an accident/injury is work-related and if benefits can be paid to the worker. Decisions made by the WSIB to deny entitlement can be appealed. Please see WSIB Fact Sheet # 2 for more information on the appeal process.

Filing a Claim with the Workplace Safety and Insurance Board

Once you have reported the accident to the employer, the employer must report it to the WSIB if, due to the accident or injury you:

- require health care
- are absent from regular work
- earn less than regular pay for regular work (e.g. part-time hours)
- require modified work at less than regular pay
- require modified work at regular pay for more than seven calendar days following the day of the accident
- healthcare includes services requiring the professional skills of a health care practitioner (e.g. doctor, nurse, chiropractor or a physiotherapist, hospital and health facilities (walk in clinics) and prescriptions).

If the employer is required to report your accident to the WSIB, they must do so using a form 7 with the WSIB within 3 working days of the reporting

of the accident. The employer is required to give you a copy of the completed form 7.

The employer does not have to report the accident to the WSIB if only first aid was given and/or the worker requires modified work less than 7 calendar days. However, the employer must keep records of the accident.

If you lose time on the job on the day of the accident, the employer must pay your wages for that day. Also, the employer must permit you to seek medical attention from a health care professional and pay for the cost of the transportation to the treating health care professional.

This can include a walk-in clinic, the hospital, your doctor, or another type of health care professional.
The employer must file a Form 7 with the WSIB within 3 working days of the reporting of the accident. The employer is required to give you a copy of the completed Form 7.
When an injured worker seeks medical attention for an injury, the worker's treating physician is obligated to complete and submit a Form 8. This is the physician's reporting of the accident based upon an examination of the injured worker. If for some reason a Form 7 does not get filed, a Form 8 will also trigger the start of a WSIB claim. These forms are key to initiating a WSIB claim.

Worker's consent to release functional abilities
Every injured worker is obligated to consent to the release of functional abilities information. Functional abilities information is information regarding what the member can, and cannot physically do (e.g., no lifting, no standing longer than 15 minutes etc.). The information is provided to employers and is used to assess whether a member can return to his or her regular job, or if accommodations are needed. If the worker does not sign the consent, the WSIB may not approve your claim for benefits. The consent can be given by signing a section at the bottom of the Form 7 (Employer's Report of Accident), Form 6 (Worker's Report of Accident) or by signing the health professional completed Functional Abilities Form (FAF). The FAF is given to the injured worker by the employer for completion by the member's treating physician.

Your employer is only entitled to functional abilities information as it relates to your workplace accident. Employers should not have unlimited access to an injured member's medical history and injured members should not grant

an employer open-ended access to medical information. The information is then released to the employer. There is no limit on the number of times a request for functional abilities can be made.

Obligation to cooperate in an early and safe return to work
The Workplace Safety and Insurance Act sets out a duty of cooperation for both the injured worker and the employer. Both parties are required to contact one another as soon as possible after the accident or injury occurs and to maintain contact throughout the period of the worker's recovery or impairment.

Employers must attempt to provide suitable employment that is available and consistent with a member's functional abilities. Members must assist the employer as required or requested to identify suitable work that is available, consistent and within the member's functional abilities. Your OPSEU local can assist in this process if requested.

If you need help with reporting and filing your WSIB claim, contact your local union or your worker health and safety representatives.

If you wish to contact the Pensions and Benefits unit, please email us at pensionsandbenefits@opseu.org

Fact sheet number 2

Appealing a workplace safety and insurance decision

If the Workplace Safety and Insurance Board (WSIB) denies or terminates your claim and you do not agree with the decision, you have the right to appeal. As soon as you receive a decision from the WSIB Case Manager that you do not agree with, you should write a letter advising the WSIB that you are appealing the Case Manager's decision.

The letter should include:

- the claim number, the decision maker's name and the date of the decision
- an explanation of what you are appealing
- reasons why you feel that the decision is wrong
- new information such as medical reports, witness statements or anything else that supports your appeal
- a request to obtain a copy of your WSIB claim file as well as an Objection Form

The letter should be faxed to the Case Manager. You should keep a copy of the transmittal verification for your records. You may also wish to follow up with the Case Manager to ensure that they received your appeal letter. If you do not appeal in writing to the WSIB by the appeal deadline stated in the WSIB decision, your appeal will be refused by the WSIB. You should appeal the denial of any benefits or return to work disputes in writing to the WSIB as soon as you receive the WSIB decision. Keep a copy for your records.

Your WSIB Case Manager must first review all of the evidence submitted in the appeal letter that supports your claim and then render a decision regarding entitlement to WSIB benefits. If the decision to deny remains unaltered, you will be sent a copy of your WSIB claim file and the Objection Form and your file will be forwarded to the Appeals Branch of the WSIB for review by an Appeals Resolution Officer (ARO).

If after appealing, the ARO upholds the decision to deny or terminate the claim, you may request that your claim proceed to the final level of appeal at the Workplace Safety and Insurance Appeals Tribunal (WSIAT). You

must complete the WSIAT Notice of Appeal form and return it to the WSIAT within 6 months of the date of the final WSIB decision.

The Notice of the Appeal is available on the WSIAT site – www.wsiat.on.ca. You can mail or fax the Notice of Appeal and the ARO decision to WSIAT. You should keep a copy of the transmittal verification for your records. You may wish to follow up with the WSIAT to ensure that they received the WSIAT Notice of Appeal form.

Decisions made at the WSIAT level are final.

Representation is recommended at both levels of appeal (ARO and WSIAT). If you would like OPSEU to assist with your appeal at either level please contact the Benefits Unit of OPSEU at (416) 443-8888 or 1-800-268-7376 at extension 8662. For more information on obtaining assistance, please see WSIB Fact Sheet #3 – OPSEU Assistance with WSIB Issues.

If you wish to contact the Pensions and Benefits unit, please email us at

pensionsandbenefits@opseu.org

Fact sheet #3

Assistance with workplace safety and insurance appeals

General assistance

You should inform your caseworker at the Workplace Safety and Insurance Board (WSIB) of any changes concerning your claim such as medical, income and return to work status.

If the WSIB denies you a benefit or there is a return to work dispute, the WSIB caseworker will issue a written decision outlining the issue(s) under dispute and their reasoning for the denial.

You must appeal the WSIB decision as soon as possible and no later than the date stated in the decision letter.

Often, the reason for the denial of a benefit can be as a result of a lack of information or insufficient medical documentation. It is helpful if you contact the caseworker to determine what is needed. You should still appeal the decision but you can submit additional information in support of your claim.

Return to work

You should work with your union, employer and physician/specialist to return to work with proper accommodations, if possible. If you are having difficulties with return to work/accommodation issues, please contact your local's union representatives or an OPSEU staff representative for assistance.

If you are having difficulties with your working duties, you should ask for appropriate restrictions from your treating physician and ask your employer to accommodate them. If you feel your employer has discriminated against you on the basis of your disability (e.g., by not accommodating you), you may wish to file a grievance within the time limits prescribed in your collective agreement. Contact your steward, local president or OPSEU staff representative for assistance.

Workplace safety and insurance appeals

Benefit Counselors in the Membership Benefits Unit of OPSEU can provide assistance regarding the denial of WSIB claims. You may request that a Benefits Counselor review your claim file to determine what steps, if any, OPSEU may be able to undertake on your behalf. Please note that OPSEU's review of your file is not a guarantee that OPSEU will ultimately be able to assist in your appeal of your WSIB claim.

If you have been denied WSIB benefits, you should follow the directions for obtaining your WSIB file contained on Fact Sheet #2 – Appealing a Workplace Safety and Insurance Decision. Please take notice of the appeal time limits in the letter sent to you by your Case Manager at the WSIB. Failure to provide notice of appeal to the WSIB by the appeal deadline date on the WSIB decision letter constitutes a failure to meet the appeal deadline. This may well cause the WSIB to refuse to consider your appeal.

Once you receive the WSIB file and Objection Form it should be sent to the Membership Benefits Unit at OPSEU Head office. You can drop it off at the nearest OPSEU regional office and it will be sent to OPSEU Head Office via internal mail. You can locate the closest OPSEU office to you by visiting www.opseu.org and clicking on the Contact Us button or calling

416-443-8888 or toll free at 1-800-268-7376. Alternatively you can send your file directly to: Membership Benefits Unit, 100 Lesmill Road, Toronto, Ontario M3B 3P8.

Your file will be reviewed by a Benefits Counselor to determine whether your appeal has a reasonable chance of success based on the available evidence you send in. If there is not a reasonable likelihood of success based on the current information, the Counselor will let you know what kind of evidence might help your case.

Although not specifically addressed under WSIB policies, applying for WSIB benefits brings with it a duty on your part as the injured worker to mitigate your circumstances while awaiting benefit entitlement. This means you are expected to try and take whatever measures you can to help get yourself back to work at the earliest opportunity.

If you wish to contact the Pensions and Benefits unit, please email us at pensionsandbenefits@opseu.org

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Fact sheet number 4
Returning to work while on workplace safety and insurance

Rehabilitation and Return to Work (RTW) planning begins the day of the worker's absence from work or requires accommodation as a result of a workplace injury or illness.
The return to work process should:

- ensure a healthy recovery process for the injured worker;
- provide a safe return to work as soon as is medically possible;
- identify any limitations that should be placed on the worker if the worker comes back to a pre-injury job on a modified or part-time schedule (until capable of returning to normal job functions) and,
- restore pre-injury earnings where possible or a job that is comparable to pre-injury job in nature and earnings.

The worker, the employer and the union should provide effective, ongoing communication and documentation where requested. Based on this information a return to work or a written accommodation plan should be developed and implemented between the workplace parties.
As an injured worker returning to work, you should:

- get proper medical attention immediately upon experiencing a work related injury;
- report injury to employer as soon as you are reasonably aware of the injury;
- maintain effective communication between you, employer, the union representative and WSIB during recovery and RTW process
- help to identify suitable work with respect to your functional abilities and contribute to the development of your RTW plan
- report any significant change in your circumstances. This includes returning to work, additional income, or any change in your medical condition. These changes must be reported within ten days of the change occurring and comply with recommendations for treatment
- provide functional abilities information regarding your restrictions and limitations including your medical prognosis

You can expect ongoing evaluations of your work progress in relation to your injury from both your employer and WSIB to ensure that you are able to perform your pre-injury job functions or whether there is a need to modify your RTW plan.

Since December 2010, the WSIB will monitor all claims for worker opportunities to return to the workplace including part-time, modified and full-time work whether it is your home position or alternative employment. As soon as there is an opportunity, the WSIB will be arranging for a meeting at the worksite to discuss return to work with the worker, the employer and the union. The WSIB will arrange for a meeting no later than 12 weeks after the claim and must conduct the meeting within 6 months. However a meeting can be arranged much sooner based on the worker's ability to return to work.

An offer of work should include:

- what work is being offered
- the nature of the work
- hours of work
- associated remuneration
- location of work site

If you are not able to return to perform your job duties included in your RTW plan, you must:

- notify your employer that the job is not suitable and provide reasons
- communicate with your employer as to any alternate accommodations available
- where no resolution can be met, inform WSIB and provide all relevant information to the dispute.

In turn, the WSIB will consider all relevant functional abilities/health care information; all information regarding the job description including information pertaining to the physical and cognitive demands associated with the job offered; and any other relevant considerations, such as whether changes in the location of work or the hours expected to work will negatively impact your recovery.
You should work with your union, employer and physician or specialist to return to work.

You should contact and arrange for a union representative to act on your behalf throughout the RTW process. If you are having return to work issues (such as accommodation issues), please contact your local's union representative or an OPSEU staff representative for assistance.
If you wish to appeal a denial of a benefit or return to work dispute, please refer to Fact Sheet #1- Appealing a Decision.
If you wish to contact the Pensions and Benefits unit, please email us at pensionsandbenefits@opseu.org

Fact sheet number 4-2
Returning to work while on workplace safety and insurance

Rehabilitation and Return to Work (RTW) planning begins the day of the worker's absence from work or requires accommodation as a result of a workplace injury or illness.

The return to work process should:

- ensure a healthy recovery process for the injured worker;
- provide a safe return to work as soon as is medically possible;
- identify any limitations that should be placed on the worker if the worker comes back to a pre-injury job on a modified or part-time schedule (until capable of returning to normal job functions) and,
- restore pre-injury earnings where possible or a job that is comparable to pre-injury job in nature and earnings.

The worker, the employer and the union should provide effective, ongoing communication and documentation where requested. Based on this information a return to work or a written accommodation plan should be developed and implemented between the workplace parties.
As an injured worker returning to work, you should:

- get proper medical attention immediately upon experiencing a work related injury;
- report injury to employer as soon as you are reasonably aware of the injury;
- maintain effective communication between you, employer, the union representative and WSIB during recovery and RTW process
- help to identify suitable work with respect to your functional abilities and contribute to the development of your RTW plan
- report any significant change in your circumstances. This includes returning to work, additional income, or any change in your medical condition. These changes must be reported within ten days of the change occurring and comply with recommendations for treatment
- provide functional abilities information regarding your restrictions and limitations including your medical prognosis

You can expect ongoing evaluations of your work progress in relation to your injury from both your employer and WSIB to ensure that you are able to perform your pre-injury job functions or whether there is a need to modify your RTW plan.

Since December 2010, the WSIB will monitor all claims for worker opportunities to return to the workplace including part-time, modified and full-time work whether it is your home position or alternative employment. As soon as there is an opportunity, the WSIB will be arranging for a meeting at the worksite to discuss return to work with the worker, the employer and the union. The WSIB will arrange for a meeting no later than 12 weeks after the claim and must conduct the meeting within 6 months. However a meeting can be arranged much sooner based on the worker's ability to return to work.

An offer of work should include:

- what work is being offered
- the nature of the work
- hours of work
- associated remuneration
- location of work site

If you are not able to return to perform your job duties included in your RTW plan, you must:

- notify your employer that the job is not suitable and provide reasons
- communicate with your employer as to any alternate accommodations available
- where no resolution can be met, inform WSIB and provide all relevant information to the dispute.

In turn, the WSIB will consider all relevant functional abilities/health care information; all information regarding the job description including information pertaining to the physical and cognitive demands associated with the job offered; and any other relevant considerations, such as whether changes in the location of work or the hours expected to work will negatively impact your recovery.

You should work with your union, employer and physician or specialist to return to work.

You should contact and arrange for a union representative to act on your behalf throughout the RTW process. If you are having return to work issues (such as accommodation issues), please contact your local's union representative or an OPSEU staff representative for assistance.

If you wish to appeal a denial of a benefit or return to work dispute, please refer to Fact Sheet #1- Appealing a decision.

If you wish to contact the Pensions and Benefits unit, please email us at pensionsandbenefits@opseu.org

Fact Sheet - RTW

WORKPLACE SAFETY and INSURANCE BOARD (WSIB)

RETURN TO WORK POLICIES ARE CHANGING

The previous “Early and Safe Return to Work (ESRTW)” policies have now been replaced with the new “Work Re-integration (WR)” policies.

What does this mean?

- The purpose of the new WSIB Work Re-integration Policy is to get workers with active claims back to work as soon as possible after their accident
- The WSIB will be taking on a more pro-active role in the return to work process. Workers are now required to co-operate with the WSIB as well as their employer.
- To initiate early intervention the WSIB will arrange a return to work meeting (usually at the workplace) with the worker and the employer twelve (12) weeks into the claim regardless if you can attend or not
- The Board’s Return to Work Specialists will be actively involved in the planning and implementation of the return to work strategies at these RTW meetings
- The Work Re-integration process should ensure a healthy recovery for the injured worker, provide a safe return to work, identify any limitations or restrictions and restore pre-injury earnings where possible
- It will be the goal of the RTW Specialist to have a comprehensive return to work plan by the end of the meeting
- Both Employers and Workers will now face financial penalties for not co-operating in the work re-integration process

For complete information on these policy changes visit the WSIB website at www.wsib.on.ca; click on Workers → Resources → Operational Policy Manual (OPM)

Tips for the WSIB Work Re-integration Meeting:

- Be prepared!
- Involve your union representative in the process and have them attend the meeting with you

- Workers should co-operate in the process to avoid any possible loss of benefits
- Workers and their representatives should be aware of the worker's condition, limitations, restrictions and abilities and should also have the medical evidence / documentation to support it
- Provide updated functional abilities information from your treating physician that indicates your restrictions and limitations including your medical prognosis
- Help identify any suitable alternative work that may be available and within your capabilities
- Consider any modifications that could be done to your pre-injury position that would make it suitable for you to return to work
- Be willing to participate in the return to work plan; however should it appear unsuitable communicate at the meeting that you are not a Doctor and request that your doctor be given the opportunity to review the plan
- Keep in mind, it is the worker's medical professional (Doctor) who is qualified to determine what type of work is suitable or not according the medical condition.

Should you require assistance with your return to work meeting contact your OPSEU Staff Representative.
If you wish to contact the Pensions and Benefits unit, please email us at pensionsandbenefits@opseu.org

LIMITATIONS ACT, 2002

BASIC LIMITATION PERIOD

Basic limitation period

4. Unless this Act provides otherwise, a proceeding shall not be commenced in respect of a claim after the second anniversary of the day on which the claim was discovered. 2002, c. 24, Sched. B, s. 4.

Discovery

5. (1) A claim is discovered on the earlier of,

(a) the day on which the person with the claim first knew,

(i) that the injury, loss or damage had occurred,

(ii) that the injury, loss or damage was caused by or contributed to by an act or omission,

(iii) that the act or omission was that of the person against whom the claim is made, and

(iv) that, having regard to the nature of the injury, loss or damage, a proceeding would be an appropriate means to seek to remedy it; and

(b) the day on which a reasonable person with the abilities and in the circumstances of the person with the claim first ought to have known of the matters referred to in clause (a). 2002, c. 24, Sched. B, s. 5 (1).

Solidarity Reserve Fund Policy

Purpose and Criteria

The purpose of the Solidarity Reserve Fund is to assist OPSEU members with legal costs they incur in legal matters or proceedings that are in relation to their employment and not otherwise funded by OPSEU.

Members will be eligible for funding for legal matters or proceedings that: arise from their employment; threaten their employment or economic security; and are initiated by the actions of another person or agency. The possible impact of the legal matter or proceeding on the interests of the OPSEU membership is a guiding consideration.

How will the Fund be used?

Members may receive funding up to $5,000 per legal matter or proceeding that meets the purpose and criteria of the Solidarity Reserve Fund Policy, at the discretion of the Executive Committee. Examples of matters that are eligible for funding are:

Long Term Disability Lawsuits: Many members in the BPS and CAAT Divisions who are denied LTD cannot pursue their rights through a grievance and have no legal avenue other than a civil lawsuit against the insurance carrier.

Defense to Lawsuits Brought by "Clients": Members are sometimes sued by the "clients" with whom they deal. Employers do not always agree to provide representation. Limited funding for members' defense is available under the Criminal and Civil Lawyer Representation Policy. Members may apply for solidarity reserve funding if there are excess costs.

Criminal Charges: Members may face criminal charges that arise from the performance of their employment duties. There is limited funding available for criminal defense costs under the "Criminal and Civil Lawyer Representation Policy". Members may apply for solidarity reserve funding if there are excess costs.

Employment Insurance or Canada Pension Plan Appeals: Employees may be denied EI or CPP for various reasons that may be contested. In some cases, legal counsel may be required to effectively pursue an appeal.

Job Protection Lawsuits: Legal action may be required to protect members' jobs where an outside agency suspends qualifications that are necessary for continued employment. Examples are paramedics who are decertified by base hospitals, or special constables who are suspended by police services boards.

Criminal Injuries Compensation Board Claims: Members who are the victims of violent crimes perpetrated by clients can seek damages from the Criminal Injuries Compensation Board. Legal representation is not required but can be helpful.

Other: From time to time other matters or proceedings may arise that reflect the spirit and purpose of the Solidarity Reserve Fund. In such cases, the Executive Committee may choose to fund the issue in accordance with this Policy.

Approval Process

The Executive Committee has discretion to approve applications for funding in accordance with this Policy.

Inquiries and applications for funding should be referred to OPSEU General Counsel. Applications for funding must spell out the issue, the action/plan that is required to deal with the issue, and how much financial assistance is requested. Applications should be made prior to initiating any legal action, wherever possible.

Once an application is received, the General Counsel will provide a report to the Executive Committee, including recommendations on the merits of the application and the amount of funding. This report will be prepared after consultation with other staff or members as appropriate.

The Executive Committee has discretion to approve funding to retain counsel or reimburse members' legal costs, and may also direct that funding will be provided under conditions. Typical conditions are that: counsel and his or her rates are pre-approved by OPSEU General Counsel; counsel provides further information or reporting letters to OPSEU; or counsel or the member seek reimbursement of legal costs from the employer or in course of the proceeding.

The Executive Committee has discretion to discontinue funding that was approved under this Policy, with notice to the affected member.

When funding has been decided on, the administration of the issue will be passed to the General Counsel, who will release the funds only once satisfied that the funds will be spent consistent with this Policy and any directions of the Executive Committee, and that proper invoices are provided.

An annual report will be prepared and presented to OPSEU Convention on the use of the Solidarity Reserve Fund. The report will outline the issues that have been funded and the outcome, if known.

The Solidarity Reserve Fund Policy applies to members who are in good standing in accordance with the OPSEU Constitution. Former members, such as those who resign their employment through a grievance settlement, may be considered for funding at the discretion of the Executive Committee.

Independent Medical Examinations Fact Sheet

Independent medical examinations are consultations with a third party who is deemed to be "independent". The purpose is to provide expertise that the employer feels is necessary to determine the employee's health status.

Independent medical examinations are a controversial topic. Some unionists see them as a way to move the process forward, while others avoid them at all costs. What we all need to know is this:

- **They can be required** – an arbitrated decision (Telus vs. Telecommunications Workers Union 2006) upheld the employer's right to discontinue a worker's short-term benefits when the worker refused to attend an IME with a doctor of the employer's choosing.

- **Watch Collective Agreement Language** – Some STD language includes terms like "consult with a third party physician".

- **Employee's physician** – If the employer does not agree with, or feels they do not have enough, medical information, ask that they go back to the employee's family doctor for the information before IME.

- **Physician that is mutually agreeable** – Meet the employer halfway. The arbitrator said that the employer and employee should try to find an independent physician that is mutually agreed upon before picking a doctor of the employer's choice.

- **Reasonable grounds** – The employer must have reasonable grounds to distrust or challenge the employee's doctor.

- **Employee's rights** – In the end, the employee will always have the right to what is disclosed or to decide whether they attend an IME. They may not be disciplined for any choice they make, but the employer will have the right to deny sick benefits.

The necessity for an IME is assessed by arbitrators on a case-by-case basis. It is typically not upheld for an "initial/first instance" absence. Where an IME is warranted, other less intrusive ways of providing the medical information or clarification of medical information should be explored.