OTIP RAEO®

OTIP LTD Appeals
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Long Term Disability Benefits Claim: Appeal Process

Overview

If your claim for disability benefits has been denied or terminated, you can appeal the decision one time — and we can help. You need to complete the appeal process before you start arbitration or litigation. An OTIP Disability Service Representative (DSR) can help you navigate the appeals process, or you can appeal on your own.

Your DSR can:

- Assist you with completing the **Appeal Member's Statement form**
- Provide you with details related to the claim decision
- Conduct in person, virtual, or telephone meetings with you and your federation or association representative to review your individual situation, options and correspondence.
- Provide information regarding other disability benefit plans, such as the Canada Pension Plan (CPP) and Employment Insurance Sickness Benefits

You have **six months from the date of the claim denial or termination** to send in a completed Appeal Member's Statement form and **new** medical information in support of your appeal. This date is in your claim decision letter. You can also find this time-frame information outlined in your group plan provisions.

How the appeal process works

A Disability Specialist will review your appeal and conduct an assessment. The Disability Specialist may approve your appeal or send it to the Appeals Committee for review. The Appeals Committee conducts an independent review of your claim and appeal. They may:

- Approve your appeal
- Request additional information, including an Independent Medical Examination (IME) or a Functional Capacities Evaluation (FCE)
- Maintain the initial decision (deny or terminate your claim)

The Appeals Committee comprises two or three senior representatives from OTIP and a medical consultant all of whom have never reviewed the file previously. Members of the Appeals Committee review the claim file independently then meet to discuss the claim, rendering a final appeal decision.

If the Appeals Committee maintains the denial or termination of your claim, and you still wish to pursue your claim, you can discuss your options for arbitration or litigation with your federation or association representative or legal counsel. There is a **two-year time limit** from the date of the original denial or termination decision letter to initiate any legal action, arbitration or litigation if the appeal is not successful.

Start your appeal

You can send the completed **Appeal Member's Statement and new medical information** to OTIP by **one** of the following ways:

- **Email**: appeals@otip.com
  Please note: To submit via email, please complete the Authorization and Consent to Communicate by Email form included in your forms package.
- **Fax**: 1-877-205-6847
- **Mail to**: OTIP LTD Appeals, 125 Northfield Drive West, Waterloo ON N2L 6K4

Frequently Asked Questions

When does my appeal review start?

Once we have received your completed Appeal Member's Statement and new medical information, your file will be assigned to a Disability Specialist for handling and an appeal review will begin.

Important notes:

- The appeal process may not change the original decision.
- We need to receive all information for your appeal as soon as possible. Both the completed form and new medical information are required. Delays may affect our ability to make a timely decision on your appeal.
- OTIP is not responsible for any cost that you may incur to obtain new medical information.

How will my appeal be assessed?

Your information will be reviewed by a Disability Specialist. The Disability Specialist will review all information submitted with a fresh set of eyes. Our appeal process is thorough with the goal to make a fair and objective decision based on the information available to us.

How will my medical information be reviewed?

During the appeal review, the Disability Specialist will review the new medical information in conjunction with your entire file. The Disability Specialist may contact your treating physician(s) for additional information. They may also request an Independent Medical Evaluation, paid for by OTIP.

If additional clarification is required from your physician, OTIP will make every effort to obtain medical information as quickly as possible. If we need assistance in obtaining additional information, we will contact you.

You are responsible for providing proof to OTIP that you are entitled to benefits, and this includes providing new medical information that has not been previously submitted.

You are responsible for all expenses related to the submission of any new medical information.

How is my appeal evaluated?

Your appeal will be evaluated based on the contractual definition of disability and contractual provisions, for the time period being appealed, as defined in your Group Long Term Disability contract.

What if my appeal is approved?

If your appeal is approved, you will be paid benefits from the date benefits would have been paid or from the date your benefits were terminated. Your file will then be referred to the Disability Analyst for ongoing case management.

If your appeal is approved on a time limited basis, you will be paid benefits up to the date of denial or termination as indicated in your appeal approval letter. Once payment is made, your claim will be closed.