

# Completing a Supplemental Disability Statement

## As a Former Employee, you must meet the following requirements to file for disability leave benefits once they leave active state service:

- You were eligible for disability leave benefits when you were an active employee.
- The date you became disabled was prior to your separation from state service.
- You still have remaining disability leave hours in your leave accrual balance.
- You were voluntarily or involuntarily disability separated or terminated with benefits.
- You were not terminated without benefits or resigned your position.

For addition support, contact your former agency's Human Resources department.

#### Step 1 - Navigate to the Ohio Former Employee Portal at <u>https://FormerEmployee.Ohio.gov</u>.





### Step 2 – Select the myBenefits tile.

An official State of Ohio site: Here's ho Department of Administrativ Forme Endogee you may have aft log in and view o and update your	a would have ~ f e Services ter leaving state employment ar Id pay statements, download ta information with the State of O	nd allows you to x documents, hio.	Ц			Translation
\$ my	Pay		mvinfo		myBenefits	
Common Quest	iold pay statements or download Form W-2	0	Update your personal information	~	Download your Form 1095-C	

Step 3 – Enter your OHID User ID and password, then click Sign in.

<u>NOTE</u>: If this is your first time logging in to the Ohio Former Employee Portal, please refer to the **First Time Login** Job Aid.

Sign in with Stoud Difector	-V
0	1
User name	Forgot username
101XXXXX	
Password	Forgot password
	0
Sign in with IBMid	
Sign in with IBMid This system contains State of Ohio and United States governme	ent information and is restricted to authorized users
Sign in with IBMid This system contains State of Ohio and United States governme ONLY. Unauthorized access, use, misuse, or modification of this in transit to and from this system is strictly prohibited, may be i subject to administrative action, civil and criminal penalties. Us and policies.	ent information and is restricted to authorized users s computer system or of the data contained herein or in violation of state and federal law, and may be se of the system is governed by U.S. law and Ohio law



**Step 4 –** The **OAKS Benefits** navigation collection displays on the left. Click the **Disability Claim** list item.



✓ OAKS Self Service		OAKS Benefits	<u>ଜେ ୧ : ଡ</u>
E Benefits Summary	Disability Claim	]	New Window   Help   Personalize Page
🛞 Benefits Enrollment	Disubility cluim		
Senefit Statements			
👸 Life Events		New Disabi	ity Claim
👃 Disability Claim			
8 HSA Deduction	Employee's exist	ing claim details	1-2 of 2 View All
1095-C Consent	Claim Number	Claim Sequence Number	Create New Supplemental Statement
View Form 1095-C	50012265	Employee Initial Statement	Create New Supplemental Statement
	50012264	Employee Initial Statement	Create New Supplemental Statement



**Step 5 –** The **Disability Claim** page displays. Click the **Create New Supplemental Statement** button for the desired claim.

E L	q						1-2 of 2 ⊻	P P	I View All
Claim	Number	Clai	m Sequence Nur	mber		Create Nev	v Supplemental S	tatement	
500	12265	Employee In	itial Slatement			Create Ne	w Supplemental S	latement	]
OAKS Benefits				Employee	Sup Landing	]			습 Q :
mployee Supplem	ental Statem	nt						Help	Personalize Page
ie SUSAN S	HUSTER		Empl ID	10203384	Empl Red	cord 0			
of Birth 11/	12/1977		Agency	сом	Job Title	Program	n Administrator 2		
ability Claim - Su	pplemental	Employee Rep	port						
laim Effective Sec	uence	1	Claim Number	5001226	5				
mployee Contac	t Informatio	n							
*	🗹 Check to	use Mailing Add	ress on file. If addr	ress is incorrect, upd	ate My Info.				
*Address Line 1	100 Main St	2							
Address Line 2									
Address Line 3									
*City	ORIENT			*State OH	*Postal	43146			
Email Address	10203384@	BUS.STATE.OH.	US.DV		Cout				
*Telephone	614/867-530	19							
)ieahility / Illnoss	Dotails								
*Have there beer	any changes	in your condition	since your original cl	laim?		🗆 Yes	🗆 No		
If Yes, Please E	plain								
*Any conditions t	hat have beco	ome disabling tha	t were caused by or r	esulting from your jo	b?	□ Yes	□ No		
If Yes, please de	scribe								





#### Step 6 - The Employee Supplemental Statement page displays.

The **Employee Contact Information** section populates with information on file in OAKS. If during your recovery you will have a temporary address you wish disability information to be sent to, clear the checkbox to remove the information and enter the temporary address in the following fields.

**NOTE:** Only make **temporary Employee Contact Information** changes here. For permanent changes visit the **myInfo** section in the Ohio Former Employee Portal.

Click the Check to use Mailing Address on file option.

*	Check to use Mailing Addre	ss on file. If address is i	ncorrect, up	odate My Info.	
Address Line 1	100 Main St.				
Address Line 2					
Address Line 3					
*City	ORIENT	*State	OH	*Postal Code	43146
Email Address	10203384@BUS.STATE.OH.US	3.DV			
*Telephone	614/867-5309				

**Step 7** – Indicate if there have been any changes in your condition since your original claim by selecting the **Yes** checkbox, **No** if there were not.

Notice that the field, If Yes, Please Explain is grayed out. This will be available when Yes is selected.

If **Yes**, Provide an explanation as to how your condition has changed since you originally filed your claim.

E	
	-



**Step 8** – Indicate if there were any conditions that have been disabling that were caused by or resulting from your job by selecting the **Yes** checkbox, **No** if they were not.

Notice that the field, **If Yes, please describe** is grayed out. This field will be available if **Yes** is selected.

Have there been any changes in your condition since your original claim?	✓ Yes	
Yes, Please Explain Complications with my surgery. The incision site has become infected.		
Any conditions that have become disabling that were caused by or resulting from your job?	□ Yes	
f Yes, please describe		

**Step 9 –** Indicate if you were hospitalized since your original claim by selecting the **Yes** checkbox, **No** if you were not.

Notice that the field, **If Yes, Name of Hospital and City** and the **Dates of Confinement/Other hospital visits** fields are grayed out. These fields will be available when **Yes** is selected. Complete the fields and date fields if **Yes** is selected.

ve you been hospitalized sin	ce your original claim?			□ Yes		L] No
If Yes, Name of Hospital and City						
Reason for						
confinement						
confinement	Dates of Confinement/Other hos	pital visits	*			
confinement	Dates of Confinement/Other hos	pital visits	s * 1-1 of 1 ☑	) )	H T	View All
confinement	Dates of Confinement/Other hos	pital visits	s * 1-1 of 1⊻ To Date	¥ 1	H T	View All



**Step 10 –** Have you yet returned to work? Select **Yes** or **No** as appropriate. Depending on your response additional fields may activate for completion.

Depending on your answer to the previous question, either the If Yes or If No field will be available for data entry.

*Have you returned to work?		🗆 Yes	🗆 No
If yes, Give Date	If no, what date do you expect to return		
*Are you returning to work part-time an	d applying for disability benefits on a part-time basis?	□ Yes	🗆 No

**Step 11** – Please answer the following question with a **Yes** or **No**:

Have you engaged in any occupation for wage or profit since the onset of your disability?

**If Yes**... fields become available if the **Yes** checkbox was selected. If the **No** checkbox was selected, you would skip over these fields.

Employer Name Employer Address		Employer Phone		Your Po	sition	
If Yes, provide Employ	ver information		R A	1-1 of 1	री ।≽ । । । ।	View All
Provide Dates Worked:		From		То		
If Yes, did you receive con	npensation?				Yes	No No
*Have you engaged in any	occupation for wage or profit since the	onset of your a	lisability?		□ Yes	L No

**Step 12** – If there are additional employers you have worked for since your disability, add an additional row by clicking the **[+]** icon.

lf Yes, provide Emplo	yer information				
<b>₽</b>		14	< 1-1 of 1 🗸 🕨	Þ.	View All
Employer Name	Employer Address	Employer Phone	Your Position		
Jones Top Soil	123 Buckeye Lane	614/555-1212	Receptionist ×	+	-



**Step 13** – If you are not on worker's compensation, indicate if any other conditions resulting from your job have become disabling.

If Yes is selected the If yes, Please Describe field becomes active.

JAKS Benefits		Employee Sup Landing	J		ଜ	Q	$\oslash$
'If your claim was not as an that were caused by or resu If Yes, Please Describe	advancement of workers' comper ting from your job?	isation, have any conditions become disabling	□ Yes	□ No			
★□ I agree to the following to the f	g Employee Certification						
EMPLOYEE CERTIFICAT	ION/AUTHORIZATION FOR REI	EASE OF INFORMATION practitioner, including my health plan, the stat	e's mental	^			
health vendor, Optum, the system which I participate provide the Department of to work or claim for disabi	Employee Assistance Program ( in or any other person, office or p Administrative Services (DAS) of ity benefits with complete inform	EAP), the Bureau of Workers' Compensation, provider with knowledge of my illness, injury or r its representative and state agencies involve gling as to my heatth and medical bistory, aligi	the retirement condition to 1 with my returr bility for	1			
Disability Retirement Ben privileged character of sur representative to release	efits and any information required th information. I also hereby authors any such information it receives to	in connection with this claim, hereby waiving a prize the Department of Administrative Service on my health plan, the state's mental health ven	iny and all s or its dor, Optum, the	6			
Employee Assistance Pro and state agencies involve mental health vendor, Opt	gram (EAP), the Bureau of Worke ad with my return to work or claim um, state agencies or other party	rs' Compensation the retirement system which for disability benefits. I understand my health acting as a representative for the state may c	I participate in plan, the state's ontact me	1			
understand that it is my re	assisting me to return to work. A sponsibility under ADA to contact	my employer if I wish to apply for reasonable.	is the original. I	Ť			
Last Update Date/Time	9	Last updated by					

Step 14 – Read the Employee Certification statement.

Check the I agree to the following Employee Certification box.

I agree to the following Employee Certification	
EMPLOYEE CERTIFICATION/AUTHORIZATION FOR RELEASE OF INFORMATION	~
I hereby authorize any hospital or clinic, physician, nurse or practitioner, including my health plan, the state's mental health vendor, Optum, the Employee Assistance Program (EAP), the Bureau of Workers' Compensation, the retirement system which I participate in or any other person, office or provider with knowledge of my illness, injury or condition to provide the Department of Administrative Services (DAS) or its representative and state agencies involved with my ret to work or claim for disability benefits with complete information as to my health and medical history, eligibility for Disability Retirement Benefits and any information required in connection with this claim, hereby waiving any and all privileged character of such information. I also hereby authorize the Department of Administrative Services or its representative to release any such information it receives to my health plan, the state's mental health vendor, Optum, Employee Assistance Program (EAP), the Bureau of Workers' Compensation the retirement system which I participate and state agencies involved with my return to work or claim for disability benefits. I understand my health plan, the state may contact me regarding their services in assisting me to return to work. A photocopy of this authorization shall be valid as the original understand that it is my responsibility under ADA to contact my employeer if Lwish to apply for reasonable.	t Jrn he in e's L.1 V

**Step 15** – There are five (5) buttons available to perform actions on the initial application.

Add Attachment: Attach pertinent medical documents from the doctor (e.g., the Attending Physician Statement).

View Attachment: View Claim Attachments.

Revised: 10/31/2023



**Save for Later:** If the medical documents are unavailable or if there are fields which are not completed because further information from the employee is required. The date and time and your OAKS ID number are recorded, also, the application is assigned a Claim Number.

**Submit:** All fields have been completed and pertinent medical documents have been attached. The date and time and your OAKS ID number are recorded, also, the application is assigned a Claim Number.

**Cancel:** This button cancels the entire transaction, all data entered will be lost.

		Employee S	up Landing			ធ	Q	1	Ø
'If your claim was not as an a hat were caused by or resultii If Yes, Please Describe	Ivancement of workers' compe 1g from your job?	nsation, have any conditions be	ecome disabling 🛛	Yes 🗹 N	No				
* 🗹 🛛 agree to the following	Employee Certification								
EMPLOYEE CERTIFICATION	ital or clinic, physician, nurse o	LEASE OF INFORMATION r practitioner, including my heal	Ith plan, the state's men	tal					
EMPLOYEE CERTIFICATION I hereby authorize any hosp health vendor, Optum, the I system which I participate in provide the Department of to work or claim for disabilit Disability Retirement Benef privileged character of such representative to release an Employee Assistance Progr	IN/AUTHORIZATION FOR RE- ital or clinic, physician, nurse o imployee Assistance Program or any other person, office or doministrative Services (DAS) of benefits with complete inform ts and any information required information. I also hereby auth y such information it receives t am (EAP), the Bureau of Work (EAP), the Bureau of Work	LEASE OF INFORMATION r practitioner, including my heal (EAP), the Bureau of Workers' provider with knowledge of my ir its representative and state a vation as to my health and medi in connection with this claim, the orize the Department of Admini o my health plan, the state's me ers' Compensation the retireme	Ith plan, the state's men Compensation, the retir illness, injury or conditio gencies involved with m ical history, eligibility for ereby waiving any and istrative Services or its ental health vendor, Op ental system which I partic	tal ement in to y return all um, the ipate in					
EMPLOYEE CERTIFICATION I hereby authorize any hosp health vendor, Optum, the I system which I participate in provide the Department of / to work or claim for disabilit Disability Retirement Benef privileged character of such representative to release an Employee Assistance Prog and state agencies involved mental health vendor, Optu regarding their services in a understand that it is my rese	NNAU HORIZATION FOR RE- ital or clinic, physician, nurse o imployee Assistance Program or any other person, office or dministrative Services (DAS) o benefits with complete inform ts and any information requiree information. I also hereby auth y such information it receives I am (EAP), the Bureau of Work with my return to work or clain n, state agencies or other party usisting me to return to work. A ponsibility, under ADA to contact	LEASE OF INFORMATION r practitioner, including my heal (EAP), the Bureau of Workers' provider with knowledge of my in ts representative and state and halton as to my health and medi in connection with this claim, the orize the Department of Adminion o my health plan, the state's me ers' Compensation the retirement for disability benefits. I unders a cuting as a representative for a photocopy of this authorization t mw.emplower. If Liwish to apply	Ith plan, the state's men Compensation, the retir illness, injury or conditi gencies involved with m ical history, eligibility for nereby waiving any and istrative Services or its ental health vendor, Opt ental health vendor, Opt ental system which I partic tand my health plan, the the state may contact m n shall be valid as the or for reasonable.	tal ement in to y return all um, the ipate in e state's ie iginal. I					
EMPLOYEE CERTIFICATION I hereby authorize any hosp health vendor, Optum, the E system which I participate in provide the Department of I to work or claim for disabilit Disability Retirement Benef privileged character of such representative to release ar Employee Assistance Prog and state agencies involved mental health vendor, Optu regarding their services in a understand that it is my resu- Last Update Date/Time	INAUTHORIZATION FOR RE- ital or clinic, physician, nurse o imployee Assistance Program or any other person, office or dministrative Services (DAS) o benefits with complete inform ts and any information required information. I also hereby auth y such information it receives t am (EAP), the Bureau of Work y such antormation or there party with my return to work or claim n, state agencies or other party ssisting me to return to work. A nonsibility under ADA to contact	LEASE OF INFORMATION r practitioner, including my heal (EAP), the Bureau of Workers' provider with knowledge of my ir its representative and state a ation as to my health and medi in connection with this claim, forize the Department of Adminin o my health plan, the state's me ers' Compensation the retireme nof disability benefits. Lunders r of disability benefits. Lunders r ophotocopy of this authorization t my employer if Livish to apply Last update	Ith plan, the state's men Compensation, the retir illness, injury or conditio gencies involved with m ical history, eligibility for hereby waiving any and istrative Services or its ental health vendor, Opt nt system which I partic tand my health plan, the the state may contact m n shall be valid as the or for reasonable	tal ement in to y return all um, the ipate in e state's ie iginal. I					

**Step 16** – Upon submission, the **Supplemental Employee Report** will display in either a new browser tab or window depending on your computer's setup.

Returning to the **Employee Supplemental Statement** electronic submission form, the page now reflects the Last Update Date/Time field and Last Updated by field containing your OAKS ID.

derstand that it is my res	nonsibility under ADA to contact	my employer if I wish to apply for re-	asonable	•	
.ast Update Date/Time	09/26/22 10:30:20AM	Last updated by	10203384		
Add Attachment	View Attachment	Save for Later	Submit	Cancel	



**Step 17** - When finished, and you no longer need to be in the system, select Sign Out from the left sidebar.

	OAKS Benefits	ଲ
Elenefits Summary		Contact Information
D Benefits Enrollment	Benefits Summary	Phone 8004091205 x OPT 2
• Benefit Statements	To view your benefits as of another date, enter the date and select Refresh.	Email
28 Life Events	My Benefits on 10/27/2023 EE Refresh	myBenefits@das.ohio.gov Address
🛃 Disability Claim	No Benefit Summary information is available for this date.	Ohio Dept of Admin Services 30 E. Broad St., 40th Floor Columbus, OH 43215
8 HSA Deduction		
⊨ 1095-C Consent		
View Form 1095-C		
📲 Sign Out		

Important Note: Closing the browser tab does not sign you out of the current session.

For addition support, contact your former agency's Human Resources department.