OHIO DEFERRED COMPENSATION

The following information is needed to document lost wages of a participant requesting an unforeseeable emergency withdrawal of deferred compensation funds.

PLEASE PROVIDE THE FOLLOWING INFORMATION ON EMPLOYER LETTERHEAD.

(Date)

Ohio Deferred Compensation
257 East Town Street, Suite 457 OR Fax: 614-222-9457
Columbus, Ohio 43215-4626

Dear Administrator:

This letter is to certify that, through the date of this letter, our employee, ***Employee Name***, ***xxx-xx-#### (last 4 of Social Security)***, has lost income for unpaid time off for medical reasons that (***is***/***is not***) due to a work-related injury.

(If applicable) ***Employee Name*** exhausted all vacation, sick, and personal leave balances on **date**.

We (***do*** or ***do not***) offer employer-sponsored disability insurance and the waiting period is ***calendar/working*** days.

Choose all that apply:

	Applied for	Awarded	Denied
Employer Disability	_____	_____	_____
Retirement Disability	_____	_____	_____
Workers' Compensation	_____	_____	_____
Other leave benefits	_____	_____	_____

Dates of absence: _____ through ***(not later than date of letter)***

Hourly rate: $ _____

Regular hours absent: X _____

Total absent wages: $ _____

Less benefits used:

Vacation $ _____

Sick Leave $ _____

Disability $ _____

Workers' Compensation $ _____

Other _____ $ _____

Total benefits used: $ _____

Total wages lost (total absent wages less benefits used): $ _____

Sincerely,

(Signature)
(Name)
(Title)
(Phone Number)