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 E. Town St. Suite 457 OR Via Fax: 614-222-9457
Columbus, OH 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 which (***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)