

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 Public Employees Deferred Compensation Program
6085 Emerald Parkway
Dublin, OH 43016

Dear Administrator:

This letter is to certify that, through the date of this letter, our employee, **Employee Name**, **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.

Employee Name (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)