



# 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  
Columbus, OH 43215-4626

OR Via Fax: 614-222-9457

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)**