Plan member confirmation of illness form

Please complete this form only if your absence is due to COVID-19 symptoms and you are waiting for test results or you have a clinical diagnosis of COVID-19. Since there is increasing pressure on medical clinics and hospitals due to the COVID-19 pandemic, we will not initially require an attending physician's statement as part of your short-term disability claim if your absence is due to COVID-19 symptoms or a clinical diagnosis of the virus. This time-limited exception will apply during the current situation.

In the absence of an attending physician's statement, we require confirmation of your symptoms, your test results and any medical treatment you may have received. Please complete and sign this form and return it with your plan member statement.

1. **Please confirm:**

Policy number:	Plan sponsor's name:
Certificate number:	Date symptoms first appeared:
Plan member's name:	First day of absence from work:

2. **Please indicate the symptoms associated with your illness:**

☐ Fever	☐ Loss of appetite	☐ Diarrhea
☐ Cough	☐ Runny nose	☐ Loss of sense of taste or smell
☐ Fatigue	☐ Nausea	☐ Shortness of breath
☐ Muscle pain	☐ Vomiting	☐ Other _____
☐ Sore throat	☐ Headache	_____

3. **Do you have any other health problems that might affect your recovery** (diabetes, heart disease, respiratory illness, or other)?

4. A) Date of medical consultation related to COVID-19:

   B) Whom did you consult (physician/clinic/hospital/public health authority)?

5. A) Date of COVID-19 test:

B) Name, address and phone number of facility where the test was conducted:

C) Test results: ☐ Positive ☐ Negative ☐ Not yet received – Date expected to receive results:
Please attach results, if available.

6. Have you been instructed to self-isolate?

☐ Yes, as of the following date:

☐ No

When do you expect your isolation period to end?

When is your next medical appointment?

When do you expect to return to work?

Can you work from home? ☐ Yes ☐ No

7. Are there any other details about your health condition you would like us to know:

I certify that the statements in this form are true and complete and understand that further information may be required to process my claim.

Full name: Phone number:

Cell number: Email:

Signature: _____ Date:

For more information about COVID-19, see the Public Health Agency of Canada website at **https://www.canada.ca/en/public-health.html**.

For any questions about your claim, please contact your employer or group insurance plan administrator. If necessary, call our customer service at 1 888 651-2307(for Quebec clients) or at 1 866 885-6772 (for clients of other provinces).