# Plan Member Confirmation of Illness Form

**Please only complete this form if your absence is due to the novel coronavirus (2019-nCov)] symptoms or if you have a clinical diagnosis of the novel coronavirus.**

In recognition of the increasing pressure on our medical clinics and hospitals due to the global health emergency, we will not, at the outset, require an Attending Physician's Statement as part of your Short Term Disability claim submission if your absence is due to novel coronavirus symptoms, a clinical diagnosis of the virus, or a quarantine order. This is a time limited exception as we move through the current situation.

In the absence of an Attending Physician's Statement, we require confirmation of your symptoms and any medical treatment you may have received for your condition. Accordingly, please complete and sign this form and return it with your Plan Member Statement to the appropriate Claims Office.

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1. Please confirm:

   Date symptoms first appeared: _____ (dd/mm/yyyy)

   First day absent from work: _____ (dd/mm/yyyy)

2. Please indicate the symptoms associated with your illness:

   - ☐ Fever above 38° Celsius
   - ☐ Cough
   - ☐ New onset Fatigue
   - ☐ New onset Muscle pain
   - ☐ Sore throat
   - ☐ Shortness of breath
   - ☐ Other _____
   - ☐ Decreased appetite
   - ☐ Runny nose
   - ☐ Nausea
   - ☐ Vomiting
   - ☐ Headache
   - ☐ Diarrhea
   - ☐ Loss of sense of taste or smell
   - ☐ Pneumonia
   - ☐ Purple markings of the fingers or toes of children

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

4. What event(s) led to the potential exposure (e.g., travelled to the affected region, exposed to someone who is infected)?

☐ I'm following Public Health recommendations to stay at home.

☐ Who directed you to self-quarantine (Public Health, Physician, Other – indicate who)?

☐ Date(s) of medical consultation or date directed by Public Health to self-quarantine? _____ (dd/mm/yyyy)

☐ Name and phone number of medical authority/clinic/physician who instructed you to self-quarantine.

5. Did you undergo a test for novel coronavirus? If so, what were the results (positive, negative)? If test results not received, when are they expected? If not tested, why not?

- When did the self-quarantine period start? (dd/mm/yyyy)
- When do you expect the self-quarantine period to end? (dd/mm/yyyy)
- When do you expect to return to work? (dd/mm/yyyy)
- When are you next seeing your physician? (dd/mm/yyyy)

6. Can you work from home? ☐ Yes ☐ No

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

Name: Phone #: Cell #:

Signature: Date:

Contract Number: Member ID:

For more information on the novel coronavirus, go to the Public Health Agency of Canada's website at https://www.canada.ca/en/public-health.html