**Plan Member Confirmation of Illness Form**

**Please only complete this form if your absence is due to symptoms of COVID-19 and you are pending test results, or if you have a clinical diagnosis of COVID-19.**

In recognition of the increasing pressure on our medical clinics and hospitals due to the COVID-19 pandemic, we will not, at the outset, require an Attending Physician’s Statement as part of your disability claim submission if your absence is due to COVID-19 symptoms, or a clinical diagnosis of the virus. 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, your test results, 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.

1. Please confirm:

|  |  |  |  |
| --- | --- | --- | --- |
| Policy Number: | Click or tap here to enter text. | Certificate Number: | Click or tap here to enter text. |
| Plan Member Name: | Click or tap here to enter text. | Plan Sponsor Name: | Click or tap here to enter text. |

|  |  |
| --- | --- |
| Date symptoms first appeared: | Click or tap to enter a date. |
| First day absent from work: | Click or tap to enter a date. |

1. Please indicate the symptoms associated with your illness:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Fever |  | Decreased appetite |  | Diarrhea |
|  | Cough |  | Runny nose |  | Loss of sense of taste or smell |
|  | Fatigue |  | Nausea |  | Pneumonia |
|  | Muscle aches |  | Vomiting |  | Purple markings of the fingers or toes |
|  | Sore throat |  | Headache |  | Shortness of breath |
|  | Other Click or tap here to enter text. |  |  |  |  |

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

|  |
| --- |
| Click or tap here to enter text. |

4. A) Date of medical consultation relation to COVID-19: Click or tap to enter a date.

B) Who was the medical consultation with (e.g.: physician/clinic/hospital/Public Health authority)?

|  |
| --- |
| Click or tap here to enter text. |

5. A) Date of COVID-19 test: Click or tap to enter a date.

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

|  |
| --- |
| Click or tap here to enter text. |

C) Test result:

|  |  |
| --- | --- |
|  | Positive |
|  | Negative |
|  | Pending – if pending, date expected: Click or tap to enter a date. |

Attached test resulted if available.

6. Have you been instructed to quarantine?

|  |  |
| --- | --- |
|  | Yes, as of this date: Click or tap to enter a date. |
|  | No |

* When do you expect the quarantine to end? Click or tap to enter a date.
* When are you next seeing your physician? Click or tap to enter a date.
* When do you expect to return to work? Click or tap to enter a date.
* Can you work from home? Yes No

7. Any other details relating to your illness you would like us to know:

|  |
| --- |
| Click or tap here to enter text. |

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: Click or tap here to enter text. | Phone Number: | Click or tap here to enter text. |
| Email: Click or tap here to enter text. | Cell Phone Number: | Click or tap here to enter text. |
| Signature: | Date: | Click or tap to enter a date. |

Have questions about your claim? Contact the Customer Contact Center at 1-xxx-xxx-xxxx.

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>