Plan Member Confirmation of Illness Form

Please only complete this form if your absence is due to symptoms of COVID-19 and you're 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, which you also need to complete.

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1. Please confirm:

Policy number: 335645

Certificate Number:

Plan Member Name:

Plan Sponsor Name: CISVA

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
- ☐ Cough
- ☐ Fatigue
- ☐ Muscle aches
- ☐ Sore throat
- ☐ Shortness of breath
- ☐ Other
- ☐ Decreased appetite
- ☐ Runny nose
- ☐ Nausea
- ☐ Vomiting
- ☐ Headache

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

4. A) Date of medical consultation relating to COVID-19:
(dd/mm/yy)

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

5. A) Date of COVID-19 test:
(dd/mm/yyyy)

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

C) Test result:

- ☐ Positive
- ☐ Negative
- ☐ Pending - if pending, date expected:

Attach test results if available. (dd/mm/yyyy)

6. Have you been instructed to quarantine?

- ☐ Yes, as of this date:
- ☐ No (dd/mm/yyyy)

- When do you expect the quarantine to end? (dd/mm/yyyy)
- When are you next seeing your physician? (dd/mm/yyyy)
- When do you expect to return to work? (dd/mm/yyyy)
- Can you work from home? ☐ Yes ☐ No

7. Any other details relating to your illness you'd 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 validate my claim.

Name: _____ Phone #: _____ Cell #: _____

Signature: _____ Date: _____

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

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