Teamsters Local 213 Members Benefit Plans

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March 13, 2020

SHORT TERM DISABILITY CLAIMS AND CORONAVIRUS - INFORMATION

FOR PLAN MEMBERS OF:
- **TEAMSTERS LOCAL 213 HEALTH & WELFARE PLAN (POLICY #G1018)**
- **TEAMSTERS LOCAL 213 MISCELLANEOUS DIVISION HEALTH & WELFARE PLAN (POLICY #G787)**

Please note: As the Coronavirus ("COVID-19") situation continues to evolve, these requirements may be changed based on government declarations.

There are two (2) scenarios for eligible plan members:

1) **Plan Member has been medically directed to quarantine by a Doctor or Public Health Agency:**

The plan member qualifies for Short Term Disability benefits provided that they have been:

- tested for COVID-19,
- medically directed to quarantine (14 day period is the current standard)
- unable to work from home.

Waiting Period: the 3 day waiting period will be waived.

Confirmation of Illness form: must be completed. This form replaces the Attending Physician Statement, and must be included with the claim application package. This form can be obtained from The Co-operators (www.cooperators.ca), or by contacting Teamsters Local 213 Members Benefit Plans, or via the Teamsters Local 213 website: teamsters213.org.

Email or fax the completed form to the Co-operators:

Email: Disability_Claims_Admin@cooperators.ca, **Fax**: 1.866.889.9926

If the illness extends beyond 14 days: The Attending Physician Statement form is required.

2) **Plan Member chooses to self-quarantine, or is asked to self-quarantine by their employer (14 day period is the current standard):**

Waiting Period: the 3 day waiting period will be waived.

Confirmation of Illness form: must be completed. This form replaces the Attending Physician Statement, and must be included with the claim application package. This form can be obtained from The Co-operators (www.cooperators.ca), or by contacting Teamsters Local 213 Members Benefit Plans, or via the Teamsters Local 213 website: teamsters213.org.

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Email: Disability_Claims_Admin@cooperators.ca, **Fax**: 1.866.889.9926

If the illness extends beyond 14 days: The Attending Physician Statement form is required.

Note: The Co-operators will consider accepting a telephone diagnosis from a physician if a plan member is unable to send the Confirmation of Illness form.

Ingrid Ochodek, CEBS, Administrator

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
- ☐ 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. 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.

_____

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5. Did you undergo a test for Coronavirus? Yes / No (circle one)
   If yes, what were the results: positive or negative (circle one)
   If test results not received, when are they expected? _____ (dd/mm/yyyy)

   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 ☐

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