



Teamsters Local 213 Members Benefit Plans

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MARCH 19, 2020 UPDATE: SHORT TERM DISABILITY CLAIMS AND CORONAVIRUS

FOR PLAN MEMBERS OF:

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

This is an update to clarify the handling of Short Term Disability "STD" claims.

Note: As the Coronavirus ("COVID-19") situation continues to evolve, these requirements may be changed based on government declarations, regulatory & plan sponsor requirements/guidelines.

Note: The Co-operators will accept a telephone diagnosis from a physician if a plan member is unable to send the Confirmation of Illness form or the Attending Physician Statement. Phone: 1-866-442-3098.

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: **tested positive** (have symptoms, or not displaying symptoms)

- have been medically directed to quarantine (14 day period is the current standard)
- are 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 by contacting Teamsters Local 213 Members Benefit Plans (email: inquiries@teamsters213benefits.com), or via the Teamsters Local 213 website: teamsters213.org.

For a copy of the STD claim application package: email: inquiries@teamsters213benefits.com or The Co-operators at the email address below (state you plan's policy number – see above).

Completed forms - email or fax the completed forms 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) Self-Quarantine: Plan Member chooses to self-quarantine or is asked to self-quarantine by their employer, and is symptomatic:

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

- are symptomatic, and unable to be tested for COVID-19 due to testing availability
- have chosen to self-quarantine, or been directed to self-quarantine by employer (14 day period is the current standard)
- are 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 by contacting Teamsters Local 213 Members Benefit Plans (email: inquiries@teamsters213benefits.com), or via the Teamsters Local 213 website: teamsters213.org.

For a copy of the STD claim application package: email: inquiries@teamsters213benefits.com or The Co-operators at the email address below (state you plan's policy number – see above):

Completed forms - email or fax the completed forms 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.

Note: If you are in self-quarantine due to travel outside of the country, and are not symptomatic, you do not qualify for Short Term Disability benefits.

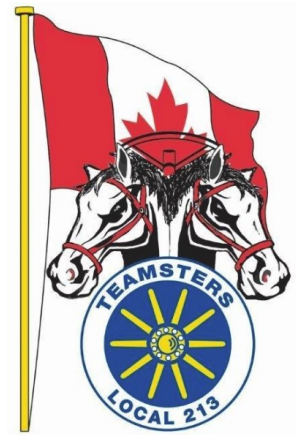
3) Short Term Disability claims not related to COVID-19

If you cannot get the Attending Physician Statement completed due to the COVID-19 pandemic, The Co-operators will accept a telephone diagnosis from your physician (phone #: [1-866-442-3098](tel:1-866-442-3098)).

Get from your physician whatever medical reports and notes that you can and provide to The Co-operators.

Teamsters Local 213 Members Benefit Plans has a Business Continuity Plan in place to make sure that critical administration services can be provided remotely, including verifying member eligibility for short term disability claims with The Co-operators.

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 Co-operators at **Email:** Disability_Claims_Admin@cooperators.ca, or **Fax:** 1.866.889.9926.

1. Please confirm: Date symptoms first appeared: _____ First day absent from work: _____
(dd/mm/yyyy) (dd/mm/yyyy)

2. Please indicate the symptoms associated with your illness:

- | | |
|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Decreased appetite |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Runny nose |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Muscle aches | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Shortness of breath | |
| <input type="checkbox"/> Other _____ | |

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 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>