Equitable Life of Canada®

Head Office
Group Disability Claims Department
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SHORT TERM DISABILITY PLAN MEMBER COVID–19 CLAIM FORM

Please complete this form if your absence is due to symptoms of COVID-19. If you are quarantining but have no symptoms, please submit an application to Employment Insurance (EI).

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.

To submit your application for STD Benefits related to COVID-19, please:

- **Complete, date and sign the form and upload, mail, or fax using the instructions below.**
- **Have your employer complete the Short Term Disability Employer COVID-19 Claim Form (#421B)**

1. Please confirm:

Policy Number: _____ Certificate No.: _____

Plan Member Namer: _____

Plan Sponsor Name: _____

Date symptoms first appeared:_____ First day absent from work:_____

2. Please indicate the symptoms associated with your illness:

☐ Fever ☐ Cough ☐ Fatigue ☐ Muscle aches ☐ Sore throat ☐ Shortness of breath

☐ Decreased appetite ☐ Runny nose ☐ Nausea ☐ Vomiting ☐ Headache

☐ Other _____

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

4. Please confirm:

A) Date of medical consultation relation to COVID-19: _____

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

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5. Please confirm:

A) Date of COVID-19 test: _____

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

_____

C) Test result (**Attach test results**): ☐ Positive ☐ Negative ☐ Pending – if pending, date expected: _____

- When are you next seeing your physician? _____
- When do you expect to return to work? _____
- Can you work from home? ☐ Yes ☐ No

6. Any other details relating to your illness you would 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 Number:_____Cell Phone Number: _____Email: _____

Signature:_____Date:_____

Have questions about your claim?

Contact the Customer Contact Center at 1.800.265.4556.

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

Upload the signed and completed form via www.equitablehealth.ca using our secure Document Submission Tool located under the My Resources tab. You can also fax them to 1.888.505.4373 or mail them to:

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