

According to your region, please submit form to:

**Quebec**  
PO Box 800, Station Maison de la Poste  
Montreal, Quebec H3B 3K5  
Fax: 514-499-6691

**Ontario, Atlantic and Western Provinces**  
522 University Avenue, Suite 400  
Toronto, Ontario M5G 1Y7  
Fax: 1 877-781-1583

## Plan Member Confirmation of Illness Form

**Please only complete this form if your absence is due to flu like illness or if you have a clinical diagnosis of H1N1.**

In recognition of the increasing pressure on our medical clinics and hospitals due to the H1N1 pandemic situation, 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 flu like symptoms or a clinical diagnosis of H1N1. This is a time limited exception as we move through the 2009-2010 flu season.

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 Industrial Alliance Disability Claims department at the above address.

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"/> Other _____  |   |

3. Do you have any other health problems that might affect your recovery?

\_\_\_\_\_

4. What medical attention have you sought for your symptoms?

- None at this time – I'm following public health recommendations to stay at home.
- I've called my provincial public health line, flu clinic or doctor's office for a telephone consultation.

Date(s) of consultation \_\_\_\_\_

Name and phone number of service/clinic/physician \_\_\_\_\_

What advice were you given regarding managing your illness? \_\_\_\_\_

\_\_\_\_\_

- I have seen my physician, or have gone to a clinic/hospital for assessment.

Date(s) of visit \_\_\_\_\_

Physician's name or name of clinic/hospital \_\_\_\_\_

What advice were you given regarding managing your illness and/or treatment received?

\_\_\_\_\_

\_\_\_\_\_

5. When did you return to work? \_\_\_\_\_ Or expect to return? \_\_\_\_\_  
(dd/mm/yyyy) (dd/mm/yyyy)

I certify that the statements in this form are true and complete and understand that further information may be required to validate my claim. I hereby authorize any healthcare provider or professional, medical organization, the policyholder, my employer as well as any other person, private or public organization to disclose and exchange any personal or health information, records (including physicians' notes) or knowledge concerning myself with Industrial Alliance, its employees or agency acting on behalf of Industrial Alliance which is necessary for the purpose of assessing my illness claim.

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Contract Number: \_\_\_\_\_ Member ID: \_\_\_\_\_

For more information on flu and the H1N1 flu virus, go to [www.fightflu.ca](http://www.fightflu.ca) or the Public Health Agency of Canada's website at <http://www.phac-aspc.gc.ca/index-eng.php>.