Confirmation of Illness/Absence Form

Please only complete this form if your absence is due to symptoms or diagnosis of COVID-19, or if your absence is directly related to the COVID-19 pandemic.

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 symptoms of or a clinical diagnosis of COVID-19, 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, or other information to support your absence. Accordingly, please complete and sign this form and return it to covid19dm@homewoodhealth.com.

Section 1 - Employee Information and Consent To Be Completed by the Employee (Please print)			
Member Name: (Last, First, Middle Initial)	SIN #	ID #	
Home Phone Number: (+ Area Code)	Cell Phone Number: (+ Area Code)	☐ Male ☐ Female	Date of Birth: (mm/dd/yyyy)
Address: (Street, City, Province, Postal Code)			
Job Title:	Email Address:	Preferred Language: ☐ English ☐ French	

Member's Authorization for Release of Information

I hereby authorize Homewood Health Inc. (HHI) to collect, use and disclose all information and documents pertaining to my Short Term Disability (STD) case with any physicians, therapists and other health care providers for the purpose of determining my eligibility for benefits and managing my medically supported absence.

I also authorize HHI to collect, use and disclose information about me within the HHI organization and with any physicians, treatment providers, service providers or medical and para-medical professionals for the purpose of facilitating optimal care and for planning and managing my return to work.

I agree that HHI and my Trustees/Union may also share financial information related to my case with Canada Life and J&D Benefits for the purposes relevant to the management of the service agreement. I understand that information about me pertaining to the financial information about my case may be reviewed in the event this service agreement is audited.

I further authorize HHI to collect, use or disclose with J&D Benefits and Canada Life information for the purposes of payment of all benefits that I may be entitled to under the MPWHBT.

I further authorize HHI to use all related medical information from my STD file should I need to apply for Long Term Disability Benefits. I understand that only the information relating to my ability to work will be shared with my Union and J&D Benefits. All information will be handled in accordance with applicable Privacy legislation.

I agree that my consent is valid for the duration of my case or during any appeal process, but for the purposes of audit, for the duration of the plan. I understand that I can revoke this consent at any time but that without it my case may not be assessed and HHI's ability to assist with my recovery and return to work may be impeded. I agree that a photocopy of this authorization or an electronic version is as valid as the original. Any reference to HHI or the Trustees includes their respective agents and service providers.

Member Signature: _____ **Date**: _____

Section 2 – Please complete the following:	
If you have symptoms, date symptoms first appeared (mm/dd/yyyy) :	First day absent from work (mm/dd/yyyy) :
Please indicate the symptoms associated with your illness: ☐Cough ☐Runny Nose ☐ Nausea ☐Vomiting ☐Headache ☐Fever ☐Decreased Appetite ☐Fatigue ☐Muscle Aches ☐Sore throat ☐Shortness of breath ☐ Other: _____	
Do you have any other health problems that might affect your recovery (e.g. diabetes, heart disease, respiratory illness)?	
What event(s) led to the potential exposure (e.g., travelled to the affected region, exposed to someone who is infected)?	
Please select one of the following: ☐ I'm following public health recommendations to self-quarantine **(or)** ☐ I was directed to self-quarantine.	
Please provide the following information:	
Name and phone number of person or agency who directed you to self-quarantine:	Date you were advised to self-quarantine (mm/dd/yyyy):
When did the self-quarantine period start? (mm/dd/yyyy):	When do you expect the self-quarantine period to end? (mm/dd/yyyy):
When do you expect to return to work? (mm/dd/yyyy):	When are you next seeing your physician? (mm/dd/yyyy) :
Did you undergo a test for COVID-19? ☐ Yes ☐ No	Date COVID-19 testing completed (mm/dd/yyyy):
If testing was completed, what were the test results (please attached results)? ☐ Positive ☐ Negative	If test results not received, when are they expected? (mm/dd/yyyy):
If not tested, why not?:	
Can you work from home? ☐ Yes ☐ No	

Please complete and sign this form and return it to covid19dm@homewoodhealth.com

For more information on COVID-19, go to the Public Health Agency of Canada's website at
https://www.canada.ca/en/public-health.html

BENEFITS OF FILM

IATSE 891 | ACTIVE HEALTH PLAN

DIRECT DEPOSIT AUTHORIZATION

Please complete this direct deposit authorization which allows your benefit payments to be automatically deposited to your bank account. **All benefit payments covered under one plan number will be deposited into the same bank account.**

Enter the name of your financial institution, your transit number, institution number, and your account number in the spaces below. These numbers can be found on your passbook, bank statement, personal deposit slip or cheque or by consulting your financial institution.

OR

Attach a blank cheque with the banking information coded on it and marked "VOID" to this form and fax or mail it to your disability management services office.

Your bank account number appears at the bottom of your cheque. This sample has been provided to assist you in locating your bank account information.

TRANSIT NO. (5 digits)	INSTITUTION NO. (3 digits)	ACCOUNT NO. (12 digits)

NAME OF BANK, TRUST CO, CREDIT UNION, ETC

DATE

SIGNATURE OF EMPLOYEE