Waterfront Employers
British Columbia
400 – 349 Railway Street, Vancouver, BC V6A 1A4
t (604) 689 7184 | f (604) 681 7447

COVID-19 QUARANTINE BENEFIT
ILWU – Employer Association Health & Benefit Plan

- This benefit is provided to eligible Longshore Plan Members who are directed by a **Public Health Official** or a **Medical Doctor** to render a **14-day Quarantine/Self-isolation** due to possible exposure to **COVID-19**
- Benefit Amount: **$573/week** (taxable)
- Maximum Benefit Period: **14 days**
- No waiting period will be applied to the claim; **Commencement of Benefit is the first day of Quarantine/Self-Isolation as advised by a Public Health Official, Medical Doctor and/or CBSA or other Border advisory**
- Claims received after **Tuesday, 12 noon** of the current week will be processed the following week

PLEASE ANSWER THE QUESTIONNAIRE COMPLETELY AND AVOID LEAVING BLANK AREAS

1. Information about you the member – be sure to fully complete this section:

Name:	Employee #:	Birthdate (yyyy-mm-dd):

Address (Street number and name):	City:	Province:

Postal Code:	Home Phone #:	Cell Phone #:	Email:

Date Symptoms Started: _____/_____/_____
Day Month Year

1. **ARE YOU CURRENTLY EXPERIENCING OR HAVE EXPERIENCED COVID-19 SYMPTOMS SINCE MARCH 1, 2020?**

YES ☐ NO ☐

If yes, please check the symptoms you are experiencing:

☐ **Fever**
☐ **Cough**
☐ **Colds**
☐ **Body Pain**
☐ **Shortness of Breath**
☐ **Ongoing Chest Pain**
☐ **Dizziness & Headaches**
☐ **Vomiting**
☐ **Diarrhea**

2. **HAVE YOU RETURNED FROM TRAVEL OUTSIDE CANADA ON OR AFTER MARCH, 1, 2020?**

YES ☐ NO ☐

If **yes**: Date of Return:_____Country of Travel:_____

Please provide travel details and attach flight or other travel confirmation as applicable:

If **yes**: Have you been directed, upon return to Canada to self-isolate/quarantine?

YES ☐ NO ☐

3. **HAVE YOU BEEN EXPOSED TO A PERSON AND/OR PLACE THAT IS A POTENTIAL COVID-19 CARRIER?**

YES ☐ NO ☐ UNKNOWN ☐

If **yes**, if possible, please specify person and/or place: _____

4. **HAVE YOU BEEN TESTED FOR COVID-19?**

YES ☐ NO ☐

If **yes**, please attach results.

5. **HAVE YOU CONSULTED A DOCTOR FOR COVID-19 SYMPTOMS?**

YES ☐ NO ☐

If yes, please attach doctor's note and complete the information below:

DATE OF DOCTOR'S VISIT:
NAME OF DOCTOR:
CONTACT NUMBER:

6. **HAVE YOU ADVISED BEEN ADVISED TO QUARANTINE OR SELF-ISOLATE BY APUBLIC HEALTH OFFICIAL?**

YES ☐ NO ☐

If **yes**, Please attach Quarantine/Isolation Notice.

7. **HAVE YOU BEEN UNDER QUARANTINE OR SELF-ISOLATION?**

YES ☐ NO ☐

If **yes**, please indicate first day of self- isolation/quarantine: _____

8. **DO YOU HAVE ANY PRE-EXISTING MEDICAL CONDITIONS?**

YES ☐ NO ☐

If **yes**, please specify:_____

9. **ARE YOU CURRENTLY AIDING SOMEONE SHOWING SYMPTOMS OF COVID-19?**

YES ☐ NO ☐

If **yes**, please specify relationship:_____Start date: _____

In all cases, it is our intent to process your application as quickly as possible. Any documentation you are able provide will assist in processing your application in a timely manner.

BENEFITS ARE PAID VIA DIRECT DEPOSIT ONLY. PLEASE ATTACH A VOID CHEQUE OR A PRINT OUT OF YOUR BANKING STATEMENT.

EMPLOYEE CERTIFICATION & CONSENT

- I hereby certify that the information provided on this form is complete and true to the best of my knowledge and belief.
- In the event that an overpayment is made or should I fail to make full reimbursement to the Plan, I irrevocably authorize the Waterfront Employers of BC (WEBC) to deduct up to $500 from my weekly pay until full re-payment is made, and apply applicable interest to the outstanding balance. Any outstanding balance owed may also be deducted from my vacation pay.
- Where applicable, I hereby authorize each and every physician, health care professional, hospital, health care institution or provider to provide to or exchange with WEBC all information and documents requested concerning my medical or behavioral health condition relative to this claim for the purpose of facilitating the delivery of best practice medical care and the assessment of my ability to work. This authorization is valid from the date hereof through the date of return to work to full duty. All information will be treated in a highly confidential manner.

Employee Signature: _____ Date: _____