HOW TO FILE A WAGE INDEMNITY CLAIM

The Application for Wage Indemnity Plan Benefits, including the Claimant's Statement, Employer's Statement and Physician's Statement, should be completed as soon as you know you will off work for more than 7 days. Your 7-day elimination period commences from the date of your **first flight missed** or first reserve day missed, if on reserve.

YOUR COMPLETED APPLICATION MUST BE RECEIVED WITHIN 30 DAYS OF YOUR FIRST FLIGHT MISSED OR FIRST RESERVE DAY MISSED, IF ON RESERVE.

EMPLOYER'S STATEMENT

Air Canada will send the Employer's Statement directly to Manion after the expiry of the elimination period.

CLAIMANT'S STATEMENT

Mail/fax/email the completed claimant's statement directly to **MANION.** Do not use crew boxes or leave at the Airport Office.

In case of an accident, be sure to explain the circumstances on a separate sheet. (WCB, Motor Vehicle, Home)

Ensure you sign and date the Authorization at the bottom of the page.

PHYSICIAN'S STATEMENT

You must see a physician (MD) within 14 days of your first flight missed or first reserve flight missed, if on reserve, in order to qualify for benefits commencing on the 8th day of your disability.

Have your treating physician FULLY complete the Physician's Statement. Most claim delays are due to incomplete medical evidence. Please make sure that the physician's name is legible and that the address and telephone number are complete.

Have your physician clearly indicate the diagnosis, complications (if any), treatment, medication, all dates of visits and provide copies of the clinical notes and test results.

If your physician does not know when you can return to work, an approximate date should be given. Indicating "indefinite" will delay your claim.

If you are receiving treatment from any other medical practitioner who is not a licensed physician (MD), you must **ALSO** be under the regular and ongoing care of a licensed physician (MD).

Please sign the Authorization Request. If you do not sign this authorization statement your claim will be returned to you, resulting in a delay.

DO NOT ALTER OR ADD ANY INFORMATION TO THE PHYSICIAN'S STATEMENT.

TO ENSURE CONFIDENTIALITY PLEASE SEND THE PHYSICIAN'S STATEMENT DIRECTLY TO MANION.

THE EMPLOYER DOES NOT REQUIRE A COPY OF THE PHYSICIAN'S STATEMENT.

If your disability arose out of, or in the course of your employment, you MUST apply for Workers' Compensation (CNESST in Quebec). However, you must also apply for Weekly Indemnity benefits in the interim. All Weekly Indemnity claims must be submitted within 30 days of your first flight missed or first reserve flight missed, if on reserve, regardless of whether you have also filed a Worker's Compensation claim. Failure to file a Weekly Indemnity claim will jeopardize your entitlement to these benefits in the event that your Workers' Compensation claim is refused or terminated. Weekly Indemnity benefits will be payable only for a maximum of 120 days from the date of disability while a decision is pending from Workers' Compensation. Please contact your Regional Office for more information if you are applying for Workers' Compensation benefits.

When you have returned to work, notify MANION immediately, so that your Weekly Indemnity claim can be finalized.

Your benefits will be deposited directly into your bank account, therefore please submit the Direct Deposit application along with a void cheque when you submit your application.

While you are receiving Weekly Indemnity benefits, supplementary medical forms will be forwarded to you periodically. Upon receipt, have these completed and returned to MANION, as soon as possible so that payments will not be delayed. It is your responsibility to provide proof of disability.

The claimant is responsible for having all forms completed and any charges incurred for completion of same.

You may submit your claim to MANION by sending your documents in:
by mail; Manion
500-21 Four Seasons Place
Toronto, ON M9B 0A5
by FAX; 416-234-0127/1-855-665-7764, or
by email to: acclaims@manionwilkins.com.

IF YOU HAVE ANY QUESTIONS OR PROBLEMS REGARDING YOUR CLAIM, OR CLAIM SUBMISSION, PLEASE DO NOT HESITATE TO CONTACT MANION.

Please note: You must advise MANION before you travel at any time during your Weekly Indemnity claim. Out-of-country travel requires written medical clearance from your physician and approval by MANION.

APPLYING FOR BENEFITS – TIME LIMITS

Your claim will be processed within 5 business days when the claimant's statement, the employer's statement and the physician's statement have all been received. You should therefore follow up with your employer and your physician to ensure the forms are completed in a timely manner and avoid delay of benefits due to late submission.

It is your responsibility to submit proof of disability within:

- 30 days of your first flight missed or first reserve flight missed, if on reserve;
- 30 days of the termination of your disability benefits under the Employment Insurance Act of Canada in order to reinstate your claim under this Wage Indemnity Plan; and
- 30 days of the recurrence of a disability.

If you fail to meet these deadlines, you will not be entitled to receive benefits for any period prior to the date MANION receives all required documentation unless you can show sufficient reason in writing as to why you could not meet the deadline.

In all cases and under all circumstances, for a WIP claim to be approved, all required documents must be submitted to Manion no later than 12 months following the end of the elimination period.

MANION

APPLICATION FOR WAGE INDEMNITY PLAN BENEFITS

Ensure all sections are completed before submitting application.

CLAIMANT'S STATEMENT

The information requested in items 1 to 4 should also be entered on the upper section of the "Attending Physician's Statement".

1 Last Name: _____ 2 First Name: _____

3 Contract No.: 29 880 (Group No.) _____ (Employee No.) 4 Social Insurance No.: _____

5 Complete address: _____

_____ Postal Code: _____

6 Home telephone: (_____) _____ - _____ Other: (_____) _____ - _____ Extension: _____

7 Gender: F ☐ M ☐ 8 Date of birth: Y M D

9 Since you stopped working, have you had any other employment? no ☐ yes ☐ → Date of beginning: Y M D

If yes, specify the nature of the employment: _____

10 Is the disability the result of an accident? no ☐ yes ☐ → Describe the circumstances, including date and location.

_____

_____

11 Have you already undergone a medical assessment related to your disability? no ☐ yes ☐

12 Have you applied for benefits under any of the following programs?

	NO	IF YES			IF DENIED	
		Pending	Accepted	Declined	Do you intend to appeal this decision? yes	no
PROGRAM Employment Insurance (HRDC) — If yes, date on which payment of benefits began: Y M D	☐	☐	☐	☐	☐	☐
Worker's Compensation as per your province	☐	☐	☐	☐	☐	☐
Any provincial or Federal Agency	☐	☐	☐	☐	☐	☐
Automobile Insurance Law or any other compensation program	☐	☐	☐	☐	☐	☐
PLAN Retirement or Pension Plan	☐	☐	☐	☐	☐	☐
Salary Continuance Plan	☐	☐	☐	☐	☐	☐
Health or Welfare Plan	☐	☐	☐	☐	☐	☐
Any other group insurance plan:	☐	☐	☐	☐	☐	☐

NOTE: PLEASE INCLUDE COPIES OF ANY DOCUMENTS RECEIVED FROM THESE SOURCES, INCLUDING ANY BENEFIT PAYMENT STATEMENTS.

I hereby authorize any physician, any other professional and participating party in the health care and rehabilitation sectors as well as any public or private health or social services institution, any insurance company, as well as any insurer, any public or private institution, any information officer, any market intermediary, any employer or ex-employer, the policyholder as well as any other person who has files or personal information, especially medical information to provide to SSQ Life Insurance Company Inc. (hereinafter SSQ) or to its subsidiaries, affiliates, third party administrators and reinsurers, all information that he, she or it has, for the following purposes: to investigate and confirm the accuracy of my claim, determine my eligibility for benefits, administer my claim, assess and facilitate my ability to return to work and administer the group benefits plan and coverage.

I also authorize SSQ to disclose this information to the persons indicated above whenever necessary, within the framework of their activities and the processing of my file.

I also authorize SSQ and my group policyholder's medical consultants to collect, use and disclose between them information about me including details relating to diagnosis, treatment, or medication, that is relevant to my claim, for the purpose of planning and managing my rehabilitation and return to work.

In the event of death, I formally authorize the policyholder, employer, beneficiary, successors or assigns, to provide to SSQ or to its subsidiaries, affiliates, third party administrators and reinsurers, when required, all information or authorizations that make possible the processing of my file.

This authorization is valid for the purposes of this contract, its amendment, extension or renewal. A photocopy or electronic copy of this authorization shall be as valid as the original.

Important

The following sections must be completed and signed:

By the insured
- Claimant's Statement (1 to 14)
- Upper section of Attending Physician's Statement

By the plan administrator
- Employer's Statement

By the attending physician
- Attending Physician's Statement

13 _____ Signature

14 Y M D Date

Underwritten by:

SSQ insurance

MANION WILKINS & ASSOCIATES LTD • 500 - 21 FOUR SEASONS PLACE • ETOBICOKE ONTARIO • M9B 0A5
TEL.: 1-800-663-7849 (Toll-free) • 416-234-3513 • Fax: 416-234-0127 • acclaims@manionwilkins.com

MANION

PSYCHOLOGICAL ILLNESSES

NOTE: For physical illnesses, complete the form on the reverse.

Section to be completed by the patient

1 Last Name: _____ 2 First Name: _____

3 Contract No.: 29 880 (Group No.) _____ (Employee No.) 4 Social Insurance Number: _____

ATTENDING PHYSICIAN'S STATEMENT (To be completed in block letters and returned to patient)

1. DIAGNOSIS

1.1 Primary: _____

1.2 Secondary: _____

1.3 Current symptoms: _____

1.4 Degree of severity: mild ☐ moderate ☐ severe ☐ with psychotic manifestations ☐

1.5 Instigating or complicating factors: _____

1.6 Date symptoms first appeared: Y M D

1.7 Is this an initial occurrence? no ☐ yes ☐

If no, specify the date of previous occurrence(s): Y M D Y M D Y M D

2. TREATMENT

2.1 Medication (name, dosage, date of prescription): _____

2.2 Is the patient seeing a psychotherapist or other practitioner? no ☐ yes ☐

If yes, name of practitioner: _____ Specialization: _____

2.3 a) Hospitalization: from _____ to _____ Name of hospital: _____

b) Clinical observation: number of hours: _____

3. FOLLOW-UP

3.1 Please indicate all dates of visits for the current condition:

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

3.2 Frequency of follow-up for this disability: _____

3.3 Has the patient been referred for psychiatric examination or treatment? no ☐ yes ☐ Name of physician: _____

Please attach a copy of your clinical notes and any test results or consultant reports available.

4. PROGNOSIS

4.1 In your opinion, is this patient totally incapable of performing his/her normal work duties? no ☐

yes ☐ → from _____ to _____ inclusive.

4.2 Anticipated date of return to work: Y M D

5. PHYSICIAN IDENTIFICATION

5.1 Last Name: _____ First Name: _____

5.2 Address: _____

5.3 Licence No.: _____ Telephone: (_____) _____ - _____

General practitioner ☐ Specialist ☐ → Specify: _____

_____ *Signature*

Y M D *Date*

NOTE: ANY COSTS FOR COMPLETING THIS FORM ARE THE RESPONSABILITY OF THE PATIENT

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MANION

PHYSICAL ILLNESSES

NOTE: For psychological illnesses, complete the form on the reverse.

Section to be completed by the patient

1 Last Name: _____ 2 First Name: _____

3 Contract No.: 29 880 (Group No.) _____ (Employee No.) 4 Social Insurance Number: _____

ATTENDING PHYSICIAN'S STATEMENT (To be completed in block letters and returned to patient)

1. DIAGNOSIS

1.1 Primary: _____

1.2 Secondary: _____

1.3 Complications: _____

1.4 Is the illness related to:

a) an accident? no ☐ yes ☐ → Specify: _____ Date: Y M D

b) a work-related accident? no ☐ yes ☐ → relapse ☐ recurrent ☐ Date: Y M D

c) an automobile accident? no ☐ yes ☐ → relapse ☐ recurrent ☐ Date: Y M D

d) pregnancy? no ☐ yes ☐ Anticipated delivery date: Y M D

2. TREATMENT

2.1 Medication (name, dosage, date of prescription): _____

2.2 Do you anticipate:

a) examinations? no ☐ yes ☐ → Specify: _____ Date: Y M D

b) surgery? no ☐ yes ☐ → Specify: _____ Date: Y M D

c) other treatments? no ☐ yes ☐ → Specify: _____ Date: Y M D

2.3 Type of treatment: _____

a) day-surgery: Y M D other surgery: Y M D

b) hospitalization: from _____ to _____ Name of hospital: _____

c) clinical observation: number of hours: _____

3. FOLLOW-UP

3.1 Please indicate all dates of visits for the current condition:

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

3.2 Frequency of follow-up: _____

3.3 Referral to another physician? no ☐ yes ☐ Name of physician: _____ Specialty: _____

Please attach a copy of your clinical notes and any test results or consultant reports available.

4. PROGNOSIS

4.1 In your opinion, is this patient totally incapable of performing his/her normal work duties? no ☐

yes ☐ → from _____ to _____ inclusive.

4.2 Anticipated date of return to work: Y M D

5. PHYSICIAN IDENTIFICATION

5.1 Last Name: _____ First Name: _____

5.2 Address: _____

5.3 Licence No.: _____ Telephone: ( ) - _____

General practitioner ☐ Specialist ☐ → Specify: _____

_____ *Signature*

Y M D *Date*

NOTE: ANY COSTS FOR COMPLETING THIS FORM ARE THE RESPONSABILITY OF THE PATIENT

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FAI623A (2022-05)

MANION

DIRECT DEPOSIT APPLICATION FORM

Plan Member Identification

Surname	First Name	AC Employee Number

Telephone Number	Plan Name or Group Number
	Air Canada Component of CUPE WIP, Policy 29880

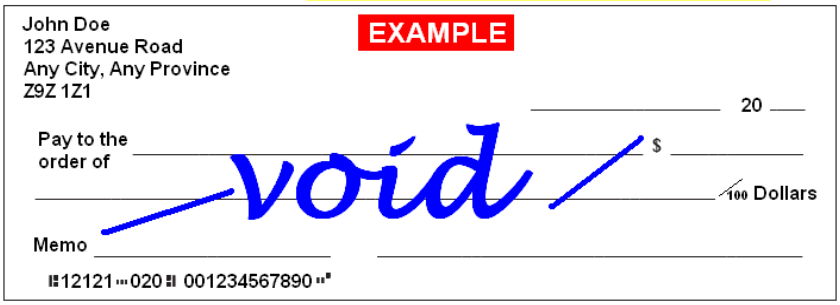
Address	City, Town, or Village	Province	Postal Code

Email Notification: Complete to receive email notification of payments being issued.

Email Address

Bank Account Information

For CHEQUING ACCOUNTS, please securely attach a voided cheque to form.



For SAVINGS ACCOUNTS, please have your banking institution attach a statement of banking information.

Acknowledgement

Confidentiality of plan member information is of utmost importance to Manion Wilkins and we are committed to the highest standard of information privacy. Visit our Privacy Policy at http://www.manionwilkins.com for more information.

Manion Wilkins & Associates Ltd. is not liable for misdirected, intercepted or altered e-mail communications arising from no fault of Manion Wilkins staff, but from the inherent risks associated with e-mail.

I authorize Manion Wilkins & Associates Ltd. to credit the bank account noted above. I understand that it is my responsibility to keep my bank account and contact information up-to-date. I will advise Manion Wilkins of any change to this information to avoid pre-authorized payment and notification errors.

Signature of Plan Participant	Date

Questions? Call: 416- 234-3513 or 1-800-663-7849; Email: acclaims@manionwilkins.com

PERSONAL INFORMATION DISCLOSURE FORM

AUTHORIZATION AND DIRECTION

TO: Manion, Wilkins & Associates Ltd. ("MWA")
626 – 21 Four Seasons Place
Etobicoke, ON M9B 0A6

I, _____ (print name), identified by my Employee number: _____, my birth date: ___/___/____ (DD/MM/YY) and my home address: _____ (Street Address), _____ (City), _____ (Postal Code), I am a Member of the Air Canada Component of CUPE WIP (Plan Name).

For the purposes of this form, a third party is limited to:

- The WIP Plan Administrator, Patricia Eberley.

Upon my request I hereby authorize and direct MWA to release a copy of my file regarding my WIP claim of ___/___/____ (DD/MM/YY) to the third party.

I agree to notify MWA in writing if I wish to authorize and direct MWA to release only specific information to specific individuals.

Information will be disclosed in accordance with governing legislation and Plan documents.

THIS SHALL BE YOUR GOOD AND SUFFICIENT AUTHORITY FOR SO DOING.
By signing below, I release the Trustees, the Trust Fund(s), and Manion, Wilkins & Associates Ltd. from any resultant liability that may occur from the disclosure of personal information.

I understand that this authorization and direction to disclose information remains in effect until I otherwise inform Manion, Wilkins & Associates Ltd in writing or in person. It is my responsibility to ensure that this authorization and direction is up-to-date and reflects my current wishes.

Dated at _____ this _____ day of _____, 20____

_____ _____
Name of Employee (Please Print) Signature of Employee

PERSONAL INFORMATION DISCLOSURE FORM

INSTRUCTIONS FOR COMPLETION

In order to protect your privacy, your personal information used for the administration of your benefits cannot be released or discussed with anyone other than yourself – not even your Spouse - unless you specifically request and authorize it. The Personal Information Disclosure Form allows you to authorize the Plan Administrator to release or discuss your personal information relating to the benefits administered on your behalf with certain Third Parties (defined as follows).

Third Parties include:

- Your spouse or a member of your immediate family (parents, siblings or adult children)
- Your WIP Union Representative

If you wish the Plan Administrator to release or discuss your personal information with any Third Party (as defined above) please complete the form, sign it and return it to the Plan Administrator.

If you wish to specifically designate someone who is not identified as a Third Party, to make inquiries on your behalf, or if you don't want your information released to a particular party, please notify us in writing of your wishes.

This form goes into effect on the date the Administrator receives the information and is valid until you wish to change your designation. Your designation may be changed at any time by notifying the Plan Administrator in writing.

If you have any questions or wish to make a specific inquiry please contact the Plan Administrator directly at (416) 798-3399 x 258 or toll free at 1 877-411-3552 x 258.