

Attached you will find the English Wage Indemnity Application Form:

- 1) How to File a Wage Indemnity Claim,
- 2) Direct Deposit Application form – to be completed for benefits to be deposited into your bank account
- 3) The English Claimant's Statement to be filled out by the member
- 4) The Physician's Statement (Physical and or Psychological) to be filled out by a licensed practitioner (MD) within the 14-day elimination period in order to qualify for benefits commencing on the 15th day of your disability
- 5) The Employer's Statement **Note** – Employee services will send the full application form to your home address with the completed earnings information after day 15 of your first flight missed has been reached. You may send in your Claimant's and Physician's forms once completed, minus the Air Canada Employers' statement of earnings to Manion, Wilkins and Associates once completed. Your completed application minus the earnings information will be held in a pending file until Manion receives earnings statement from Eservice. Once they have received everything, your application will be processed in 5 business days. Air Canada (Employee Services) will send you the Employers portion by mail once completed and at the same time Eservice will fax a copy of your earnings information directly to Manion, Wilkins and Associates.

Should you require further clarification please do not hesitate to contact me,

Thank you,

Stephen

1-877-411-3552 X258

s.morash@acomponent.ca

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 14 days. Your 14-day qualifying period commences from the date of your **first flight missed** or reserve day, if on reserve.

YOUR COMPLETED APPLICATION MUST BE RECEIVED WITHIN 30 DAYS OF THE END OF YOUR QUALIFYING PERIOD.

EMPLOYER'S STATEMENT

- * If not already completed when received, have your Employer complete the Employer's Statement as soon as possible.

CLAIMANT'S STATEMENT

- * Mail the completed claimant's statement directly to, **MANION, WILKINS & ASSOCIATES LTD.** 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 (M.D.) within the 14-day qualifying period in order to qualify for benefits commencing on the 15th 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 his/her name is legible and that the address and telephone number is complete.
- * Have your Physician clearly indicate the diagnosis, complications (if any), treatment, medication and all dates of visits.
- * If your Physician does not know when you can return to work, an approximate date should be given. To indicate "indefinite", will delay your claim.
- * If you are receiving treatment from any other medical practitioner who is not a licenced Physician (M.D.), you must **ALSO** be under the regular and ongoing care of a licenced Physician (M.D.).
- * Please sign the Authorization Request. If you do not to 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
SEND PHYSICIAN'S STATEMENT DIRECTLY TO
MANION, WILKINS & ASSOCIATES LTD.**

THE EMPLOYER DOES NOT REQUIRE THE PHYSICIAN'S STATEMENT!

If your disability arose out of, or in the course of your employment, you **MUST** apply for Workers' Compensation (C.S.S.T. in Quebec). However, you must also apply for Weekly Indemnity benefits in the interim. All WI claims must be submitted within 30 days of the end of your qualifying period, regardless of whether you have also filed a Workers' Compensation claim. Failure to file a WI claim will jeopardize your entitlement to these benefits in the event that your Workers' Compensation claim is refused or terminated. Weekly Indemnity benefits will only be payable 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, WILKINS & ASSOCIATES immediately, so that your WIP claim can be finalized.

If you would like your benefits directly deposited to your bank account, please submit a void cheque with your application.

While you are receiving WIP benefits, supplementary reports will be forwarded to you periodically. Upon receipt, have this report completed and returned to the Administrator, as soon as possible so that payments will not be delayed. It is your responsibility to provide proof of disability. You must submit proof of disability **WITHIN 45 DAYS** of the commencement of disability. If you submit after 45 days, it will not be processed unless you can show sufficient reasons in writing for not applying earlier.

The claimant is responsible for having all forms completed and any charges incurred for completion of same. Although you may fax your documents in as notification of a claim, **originals are required before your claim will be processed.**

Please note: You must advise Manion, Wilkins & Associates before you travel at any time during your WIP claim. Out of country travel requires written medical clearance from your physician.

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

ADMINISTRATOR:

MANION, WILKINS & ASSOCIATES LTD.
626-21 FOUR SEASONS PLACE
ETOBICOKE, ON
M9B 0A6

Local: 416- 234-3513
Toll Free: 1-800-663-7849
Fax: 416-234-0127



MAIL COMPLETED FORM TO:
 Manion Wilkins & Associates Ltd.
 500-21 Four Seasons Place
 Toronto, ON M9B 0A5
 c/o Administration

DIRECT DEPOSIT APPLICATION FORM

Plan Member Identification

<input type="text"/>		<input type="text"/>	
Surname		First Name	
<input type="text"/>		<input type="text"/>	
Telephone Number		Certificate/Identification Number	
<input type="text"/>		<input type="text"/>	
Address		Plan Name or Group Number	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
City, Town, or Village	Province	Postal Code	

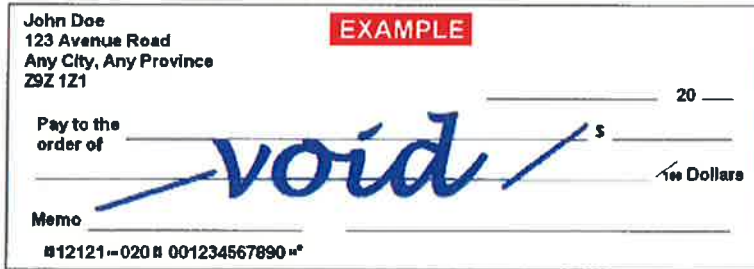
Email Notification: Complete to receive email notification of payment of health and dental claims.
 If no email is provided, notifications will be available to view and print using MWAOnline.

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- 234-3511 or 1 866-532-8999; Email info@manionwilkins.com

Administration Department Use Only

APPLICATION FOR WAGE INDEMNITY PLAN BENEFITS

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

CLAIMANT'S STATEMENT

1 Last Name: _____ 2 First Name: _____

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

5 Complete address: _____ Postal Code: _____

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

7 Gender: F M 8 Date of birth: _____

9 Since you stopped working, have you had any other employment? no yes → Date of beginning: _____

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?

PROGRAM	If yes, date on which payment of benefits began: _____	NO	IF YES			IF DENIED	
			Pending	Accepted	Declined	Do you intend to appeal this decision?	
			yes	no			
Employment Insurance (HRDC)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worker's Compensation		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any provincial or Federal Agency		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Automobile Insurance Law or any other compensation program		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PLAN							
Retirement or Pension Plan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salary Continuance Plan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health or Welfare Plan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other group insurance plan:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

I hereby certify that the above information is true, accurate and complete.

Solely for purposes of processing this benefit claim, I authorize the following:

- physicians or other health professionals;
- medical or paramedical establishments or clinics;
- the policyholder, the employer;
- any other insurance or reinsurance companies;
- any public or parapublic body, such as EI, Worker's compensation, Provincial automobile insurance;
- any other person or institution.

who may have information regarding my claim, particularly any medical information, to communicate such to SSQ, Life Insurance Company inc. (hereinafter SSQ) or its agent. In so doing, I discharge them of their obligations of confidentiality and authorize them to provide SSQ or its agent with any information requested.

Moreover, I hereby authorize SSQ or its agent to submit my file to one or more physicians chosen by SSQ or its agent for the purpose of evaluation.

Photocopies of this document shall have the same effect 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 _____ 14 _____
Signature Date

1 Last Name: _____ 2 First Name: _____
 3 Contract No.: **29 880** Employee No. _____ 4 Social Insurance Number: _____
Group No.

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: _____
 b) a work-related accident? no yes → relapse recurrent Date: _____
 c) an automobile accident? no yes → relapse recurrent Date: _____
 d) pregnancy? no yes Anticipated delivery date: _____

2. TREATMENT

2.1 Medication (name, dosage, date of prescription):
 2.2 Do you anticipate:
 a) examinations? no yes → Specify: _____ Date: _____
 b) surgery? no yes → Specify: _____ Date: _____
 c) other treatments? no yes → Specify: _____ Date: _____
 2.3 Type of treatment:
 a) day-surgery: _____ other surgery: _____
 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: _____

5. PHYSICIAN IDENTIFICATION

5.1 Last Name: _____ First Name: _____
 5.2 Address: _____
 5.3 Licence No.: _____ Telephone: (_____) _____
 General practitioner Specialist → Specify: _____
 Signature _____ Date: _____

NOTE: ANY COSTS FOR COMPLETING THIS FORM ARE THE RESPONSABILITY OF THE PATIENT
 MANION WILKINS & ASSOCIATES LTD • 626-21 FOUR SEASONS PLACE • ETOBICOKE ONTARIO • M9B 0A6
 TEL.: 1 800 663-7849 (Toll-Free) • (416) 234-3513 • FAX: (416) 234-2071

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:
 1.7 Is this an initial occurrence? no yes
 If no, specify the date of previous occurrence(s):

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:

5. PHYSICIAN IDENTIFICATION

5.1 Last Name: _____ First Name: _____
 5.2 Address: _____
 5.3 Licence No.: _____ Telephone: (_____) _____
 General practitioner Specialist → Specify: _____

Signature

Date:

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

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EMPLOYER'S STATEMENT

1 Contract No.: **29 880**
Group No. Employee No

2 Last Name of employee:

3 First Name of employee:

4 Base:

5 Date of hire:

6 Previous 3 months gross earnings available at time of book off:

1) \$

2) \$

3) \$

If Minimum Monthly Guarantee (MMG) is provided, please indicate actual earnings and why actual earnings are below MMG.

Hourly rate of pay \$ /hr.

7 Personal exemptions: Federal TD1 \$ Provincial TP1015.3 \$

8 Last day worked:

9 First flight missed:

10 Has the employee returned to work? no yes → Date:

11 Does the disability result from a work-related accident? an occupational illness?

12 Does the disability coincide with, or is the employee returning from:

a dismissal? no yes → Date:

a lay-off? no yes → from to Date of notification:

an elimination of a position? no yes → Date:

an unpaid leave? no yes → from to

13 other: specify from to

I hereby certify that the above information is true, accurate and complete.

14 Signature of authorized person

Title:

15 Date: