HOW TO FILE A WAGE INDEMNITY CLAIM

The Application for Wage Indemnity Plan Benefits, including the Claimant's Statement, Employer's Statement and Medical Practitioner's Questionnaire, 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.

MEDICAL PRACTITIONER'S QUESTIONNAIRE

Note that the following medical professionals you are seeking treatment from may sign the Medical Practitioner's Questionnaire:

- MD (traditional medical doctor / family physician)
- Psychiatrist
- Nurse Practitioner
- Ophthalmologist

The following medical professionals used as first point of contact for Medical Treatment from may sign the Medical Practitioner's Questionnaire, for disabilities of duration 14 days or less. You must see a Doctor after 14 days for continuation of coverage.

- Dentist
- Midwives
- Chiropractor

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

Have your treating medical professional FULLY complete the Medical Practitioner's Questionnaire. 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 medical professional 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 medical professional 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) if the disability lasts more than 14 days.

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 MEDICAL PRACTITIONER'S QUESTIONNAIRE.

TO ENSURE CONFIDENTIALITY PLEASE SEND THE MEDICAL PRACTITIONER'S QUESTIONNAIRE DIRECTLY TO MANION.

THE EMPLOYER DOES NOT REQUIRE A COPY OF THE MEDICAL PRACTITIONER'S QUESTIONNAIRE.

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 day 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 Local Office for more information if you are applying for Workers' Compensation benefits. Note: The Physician's Statement from your Workers' Compensation claim may be used in lieu of the Medical Practitioner's Questionnaire Manion sent to you with your WIP claim.

When you have returned to work, notify MANION immediately, so 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 10 business days when the claimant's statement, the employer's statement and the Medical Practitioner's Questionnaire have all been received. You should therefore follow up with your employer and your medical professional 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 day 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

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 (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	☐	☐	☐	☐	☐	☐
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

APPLICATION FOR WAGE INDEMNITY PLAN BENEFITS

Please ensure that form is fully completed before submission

The patient is responsible for any fees related to the completion of this form.

Plan Member/Employee Information and Consent — To Be Completed By Patient

☐ Male ☐ Female Plan Member/Employee Name : ______________________
Last Name First Name

Date of Birth Y Y Y Y | M M | D D | Height | Weight | Home Phone # (+ Area Code) | Cell Phone # (+ Area Code)

Address ______________________
Street City Province Postal Code

Employer's Name | Plan Contract # | Member Certificate #

Last Date Worked Y Y Y Y | M M | D D | **Date Returned to Work or Expected Return to Work Date** Y Y Y Y | M M | D D | **Date of Next Medical Follow Up**

Questions — To Be Completed By Medical Practitioner

- **If your patient has returned to work or is expected to return to work within 4 weeks of the Last Date Worked, complete sections 1 to 4 only and sign the end of the form.**
- **For absences expected to be greater than 4 weeks, please complete Pages 1 and 2 in full.**

1) Diagnosis

Primary Diagnosis: ______________________

Secondary and/or Complications: ______________________

If Childbirth - Expected or Actual Delivery Date Y Y Y Y | M M | D D Vaginal ☐ C-Section ☐

Occupational Illness/injury? ☐ Yes ☐ No
If yes, date of event: Y Y Y Y | M M | D D

Auto accident? ☐ Yes ☐ No
If yes, date of event: Y Y Y Y | M M | D D

Date of first visit to you pertaining to this condition: Y Y Y Y | M M | D D

First date of work absence due to condition: Y Y Y Y | M M | D D

2) Hospitalization

Is/was patient hospitalized? ☐ **or** had day surgery? ☐

Y Y Y Y | M M | D D Date of admittance — Y Y Y Y | M M | D D Date of discharge — Institution Name

If surgery was performed please provide date and description of surgery:

Y Y Y Y | M M | D D Date — Description

3) Treatment (drug, dosage, physiotherapy, other):

____

4) Prognosis Please provide the prognosis for recovery:

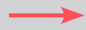
Has the patient been treated for this same or similar condition in the past? ☐ Yes ☐ No

If yes, date: Y Y Y Y M M D D Treatment Provider:

Please describe the patient's symptoms including history, severity and frequency:

Frequency of Visits: Weekly ☐ Monthly ☐ Other ☐

5) Continuation of Medical Practitioner Statement for Absences that may be Greater than 4 Weeks



Please attach copies of all relevant:

- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed)**
- **consultation reports**

If consultation report is not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist | Specialty | Date of Visit Y Y Y Y M M D D

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations:

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period:

Is the patient following the recommended treatment program? ☐ Yes ☐ No

Do you have concerns about the patient's ability to manage his/her own affairs? ☐ Yes ☐ No

Notice to Medical Practioner

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law.

Name (please print) Date Signed: Y Y Y Y M M D D

Specialty License Number:

Address: Street City Province Postal Code

Telephone # (+ area code): Fax # (+ area code):

Signature:

MEDICAL PRACTITIONER'S QUESTIONNAIRE
MENTAL HEALTH CONDITIONS

The patient is responsible for any charge made for the completion of this form.

Section A – Plan Member/Employee Information and Consent — TO BE COMPLETED BY PATIENT

☐ Male ☐ Female Plan Member/Employee Name: ____________________
Last Name First Name

Phone # (+ Area Code) | Date of Birth Y Y Y Y M M D D | E-mail address

Address ____________________
Street City Province Postal Code

Employer's Name | Plan Contract # | Member Certificate #

Date Last Worked Y Y Y Y M M D D | **Date Returned to Work or Expected Return to Work Date, if known** Y Y Y Y M M D D

Section B – Attending Physician's Questionnaire — TO BE COMPLETED BY MEDICAL PRACTIONER

I am the: Attending Physician ☐ Consulting Specialist ☐ Other ☐ (please specify): ____________________

1) Diagnosis

Primary: ____________________

Secondary: ____________________

Is this condition related to: Occupational Illness/injury ☐ Auto accident ☐

If so, date of event: Y Y Y Y M M D D

Details: ____________________

Date of first visit to you pertaining to this condition Y Y Y Y M M D D | First date of work absence due to this condition Y Y Y Y M M D D

Has the patient been treated for this same or similar condition in the past? ☐ Yes ☐ No

If yes, date: Y Y Y Y M M D D By whom: ____________________

Have you completed any other disability claim forms recently for this patient? ☐ Yes ☐ No

If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) ____________________

2) Patient's Description of Symptoms

Please describe the patient's current symptoms including frequency and severity: ______

______

______

______

3) Your Clinical Findings and Observations

Please describe how the condition has impacted the following and to what degree:

	No impact	Mild	Moderate	Severe
Appearance	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Energy / Vigour	☐	☐	☐	☐
Behaviour	☐	☐	☐	☐
Decision making	☐	☐	☐	☐
Socialization	☐	☐	☐	☐
Concentration / Focus	☐	☐	☐	☐
Speech	☐	☐	☐	☐
Affect/Mood	☐	☐	☐	☐
Insight/Judgement	☐	☐	☐	☐
Self-Criticism	☐	☐	☐	☐

Observations or comments supporting the above: ______

______

______

______

4) Complicating Factors

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate the patient's recovery period:

☐ Workplace Issues
☐ Social / Family Issues
☐ Financial / Legal Problems
☐ Physical Condition
☐ Alcohol / Drug Abuse
☐ Medication Side Effects
☐ Pain Perception
☐ Coping Skills
☐ Personality / Motivation
☐ Other

Please describe:

______

______

______

______

Please describe the supports in place, or planned, to assist with these issues:

______

______

______

______

______

______

5) Investigations

Please attach copies of all relevant:

- test results/investigations (If test results are not attached, we will interpret this as tests were not performed)
- consultation reports

Are tests / investigations / consultations pending? ☐ Yes ☐ No Date report expected: Y Y Y Y M M D D

Does the patient have an appointment booked with any specialist(s) in the near future? ☐ Yes ☐ No

Name of Specialist	Specialty	Date of Appt
1.		Y Y Y Y M M D D
2.		Y Y Y Y M M D D

Reason for requesting the consultation: ____________________

Has any license held by the patient been restricted or revoked as a result of this condition? ☐ Yes ☐ No ☐ Don't Know

If yes, as of when? Y Y Y Y M M D D Type of license: ____________________

6) Medications (please attach separate list if insufficient space)

Medication Name	Initial dosage and date started		Current dosage and date changed if applicable	Response
		Y Y Y Y M M D D	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Y Y Y Y M M D D	

7) Hospitalization

Is/was the patient hospitalized? ☐ Yes ☐ No

Is future hospitalization anticipated? ☐ Yes ☐ No

	Date admitted	Date discharged	Institution Name
1.	Y Y Y Y M M D D	Y Y Y Y M M D D	
2.	Y Y Y Y M M D D	Y Y Y Y M M D D	

8) Treatment Details - Psychological (e.g.: cognitive behavioural, drug/alcohol, group, family, marital, Day Hospital program)

Type of therapy	Name of provider or facility	Date treatment began	Frequency of visits	Date of last visit	Response
		Y Y Y Y M M D D	Weekly ☐ Monthly ☐ Other ☐	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Weekly ☐ Monthly ☐ Other ☐	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Weekly ☐ Monthly ☐ Other ☐	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Weekly ☐ Monthly ☐ Other ☐	Y Y Y Y M M D D	

9) Treatment Details - Concurrent Physiological Disorders, if known (e.g.: physiotherapy, chiropractic, other rehabilitation therapy)

Type of therapy	Name of provider or facility	Date treatment began	Frequency of visits	Date of last visit	Response
		Y Y Y Y M M D D	Weekly ☐ Monthly ☐ Other ☐	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Weekly ☐ Monthly ☐ Other ☐	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Weekly ☐ Monthly ☐ Other ☐	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Weekly ☐ Monthly ☐ Other ☐	Y Y Y Y M M D D	

10) Overall Response to Treatment

Please describe the response to treatment to date: ☐ Complete ☐ Partial ☐ None ☐ Too soon to tell

Is the patient following the recommended treatment program? ☐ Yes ☐ No

Please explain: ______________________________

____

____

Are there any plans to change or augment the current treatment program? ☐ Yes ☐ No

If so, please explain: ______________________________

____

11) Prognosis and Recovery

What return-to-work goals have been discussed with the patient? Please explain: ______________________________

____

____

Please provide the patient's prognosis for improvement: ______________________________

Please provide any other information that will help us understand the patient's current condition, recovery goals and prognosis:

____

____

____

____

Notice to Medical Practitioner

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law.

Name of Practitioner ______________________________ Date Signed: Y Y Y Y M M D D

(please print)

Specialty ______________________________ License Number: ______________________________

Address: ______________________________ ______________________________ ______________________________ ______________________________

Street City Province Postal Code

Telephone # (+area code): ______________________________ Fax # (+ area code): ______________________________

Signature: ______________________________

DIRECT DEPOSIT APPLICATION FORM

Plan Member Identification

Surname

First Name

AC Employee Number

Telephone Number

Air Canada Component of CUPE WIP, Policy 29880

Plan Name or Group Number

Address

City, Town, or Village

Province

Postal Code

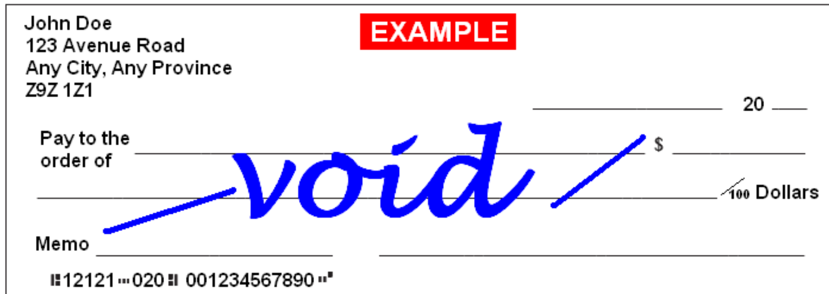
Email Notification:

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.
- Your spouse or a member of your immediate family (parents, siblings, or adult children). If you wish to authorize any such individual, please clearly print their name and relationship to you in the space below.

Name: __________________________ Relationship: ___________________________

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.