AIR CANADA COMPONENT OF CUPE WAGE INDEMNITY PLAN

Maternity Leave Top-Up - Statement of Claim

SECTION 1 - TO BE COMPLETED BY THE CLAIMANT ***(please print)***

NAME (Last)	(First)	
ADDRESS (Number, Street, City, Province)		POSTAL CODE
E-MAIL: _____ CELL #: _____ HOME PHONE #:	YOUR DATE OF BIRTH Day / Month / Year	AIR CANADA EMPLOYEE NUMBER
LAST DATE WORKED: _____ *Year/Month/Day*		BASE: _____
DATE MATERNITY LEAVE BEGAN: _____ *Year/Month/Day*		DATE OF HIRE: _____ *Year/Month/Day*

SECTION 2 - EARNINGS INFORMATION TO BE OBTAINED BY MANION WILKINS & ASSOCIATES

Previous 3 months gross earnings available at the beginning of the Maternity Leave of Absence:

1. _____ *Year/Month* 2. _____ *Year/Month* 3. _____ *Year/Month*

SECTION 3 - ATTENDING PHYSICIAN'S STATEMENT ***(please print)***

1. Diagnosis of present condition

2. a) Date of delivery: *(year/month/day)*
   [ ] Vaginal birth [ ] Caesarean birth

3. a) To the best of your knowledge, indicate period patient has been unable to work at own occupation as a result of present condition.
   From: *(Year/month/day)* | To: *(Year/Month/Day)*

4. Remarks - Please provide comments and further details which you feel would be helpful.

Name of attending physician (please print)	Specialty	Telephone no. ( )
Address (number, street, city, province, postal code)		
Signature	Date (day, month, year)	

SECTION 4 - PATIENT AUTHORIZATION

I hereby certify that the above statements are true, accurate and complete to the best of my knowledge and belief. I understand that Manion, Wilkins & Associates Ltd. will use the information provided by me on this claim form strictly to process my claim. I hereby authorize my employer, any licensed physicians or other health professionals, any medical facility, any insurance company or government body, and any other person or institution to release relevant information to Manion, Wilkins & Associates Ltd. solely for the purpose of processing this claim. A photocopy of this release shall be as valid as the original.

_____ Signature _____ Date *(Year/Month/Day)*

ONCE COMPLETED, PLEASE FORWARD TO THE OFFICE OF THE ADMINISTRATOR :

IN ORDER TO PROCESS YOUR CLAIM WE ALSO REQUIRE COPIES OF YOUR EI STUBS FOR THE PERIOD BEING CLAIMED. PLEASE SUBMIT WITH THIS CLAIM FORM.

MANION, WILKINS & ASSOCIATES
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