SSQ Financial Group

APPLICATION FOR WAGE INDEMNITY PLAN BENEFITS

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:

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?

	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:	❑	❑	❑	❑	❑	❑
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 Date

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

SSQ Financial Group

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:

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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acclaims@manionwilkins.com

SSQ Financial Group

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:

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

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HOW TO FILE A WAGE INDEMNITY CLAIM

The Application for Wage Indemnity Plan Benefits, including the Claimant's Statement, and Physician's Statement, should be completed as soon as you know you will be 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.

CLAIMANT STATEMENT

Mail, fax or email (acclaims@manionwilkins.com) 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 (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 licensed Physician (M.D.), you must **ALSO** be under the regular and ongoing care of a licensed 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!
If you need additional information, please contact the HR Connex Centre toll-free at 1-855-855-0785, Monday to Friday, from 8 a.m. to 6 p.m. (ET).

Pour des renseignements supplémentaires, veuillez communiquer avec le Centre Connex RH au numéro sans frais 1 855 855-0785, du lundi au vendredi, entre 8 h et 18h (HE).

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

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 immediately, so that your WIP claim can be finalized.

Your benefits will be deposited to your bank account, therefore please complete the Direct Deposit Application or 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 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. Please fax, mail or email (acclaims@manionwilkins.com) your claim forms directly to Manion.

Please note. You must advise Manion 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.

ADMINISTRATOR:
MANION
626-21 FOUR SEASONS PLACE
ETOBICOKE, ON
M9B 0A6
Local: 416- 234-3513
Toll Free: 1-800-663-7849
Fax: 416-234-4127

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

Surname | First Name | AC EMP #

Telephone Number | Plan Name or Group Number: Air Canada Component of CUPE Wage Indemnity Plan 29880

Address | City, Town, or Village | Province | Postal Code

Email

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

INITIAL CALCULATION OF BENEFIT RATE

Benefits are calculated at a weekly rate of 60% of the last three months earnings available at the time of book off as provided by the employer.

Example :

Three months earnings added together :

January 2001 -	**$ 2500.00**
February 2001 -	**$ 2750.00**
March 2001 -	**$ 2250.00**
Total A:	**$ 7500.00**

Total A is then divided by 13 weeks (average number of weeks in three month period)

	$ 7500
	÷ 13
Total B	**576.92**

Total B is then multipied by 60% in order to arrive at a weekly benefit rate.

	$576.92
	x 0.60
Total C :	**$346.15**

Total C is then rounded up to the nearest dollar.

∴ the weekly benefit rate for this claim is $ 347.00.