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 elimination 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 ELIMINATION PERIOD.

EMPLOYER'S STATEMENT
If not already completed when received, the Employer's Statement should be completed 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 (MD) within the 14-day elimination period in order to qualify for benefits commencing on the 15th day of your disability.

Have your treating physician complete the Physician's Statement FULLY. 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 and all dates of visits.

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 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 elimination period, regardless of whether you have also filed a Worker's 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 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 WILKINS & ASSOCIATES LTD immediately, so that your WI claim can be finalized.

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

While you are receiving WI 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 proof 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 Ltd before you travel at any time during your WI 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
416-234-3513 (Local) / 1-800-663-7849 (Long Distance)
FAX: 416-234-2071

SSQ Financial Group

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 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 _____ Signature

14 Y M D Date

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

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: Y M D

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

1) Y M $ _____

2) Y M $ _____

3) Y M $ _____

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: Y M D

9 First flight missed: Y M D

10 Has the employee returned to work? no ❑ yes ❑ → Date: Y M D

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: Y M D

a lay-off? no ❑ yes ❑ → from Y M D to Y M D Date of notification: Y M D

an elimination of a position? no ❑ yes ❑ → Date: Y M D

an unpaid leave? no ❑ yes ❑ → from Y M D to Y M D

13 other: specify _____ from Y M D to Y M D

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

14 _____ (Signature of authorized person) Title: _____ 15 Date: Y M D

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: 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) Date: Y M D

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

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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: 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) Date: Y M D

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