Wage Indemnity Plan Application Package

How to file a Wage Indemnity Claim	The Application for Wage Indemnity Plan Benefits, including the Claimant's Statement and Medical Practitioner's Questionnaire, should be completed as soon as you know you will off be off work for more than 7 days. 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 / 855-665-7764, or by email to: acclaims@manionwilkins.com. Your claim will be processed within 7-10 business days once your claim is received in full (Claimant's Statement, Medical Practitioner's Questionnaire and Employers Statement) and registered.
Medical Practitioner's Questionnaire	**You must see a medical professional within 14 days of the day you first miss work, to qualify for benefits commencing on the 8th day of your disability.** Your Medical Practitioner is only required to complete one of the applicable forms; physical health condition, or mental health condition in the WIP Application package unless you have both conditions. The following medical professionals you are seeking treatment from may sign the Medical Practitioner's Questionnaire: • MD (any traditional medical doctor / family physician / specialist) • Nurse Practitioner Note the following medical professionals: Dentists, Midwives, Chiropractors, used as first point of contact for Medical Treatment, may sign the Medical Practitioner's Questionnaire for disabilities of a duration of 14 days or less. You must be under the care of a medical doctor after 14 days for continuation of coverage. Have your medical professional clearly indicate the diagnosis, complications (if any), treatment, medication and all dates of visits. When utilising the Air Canada Maple app for an absence of 14 days or less, a Medical Practitioner's Questionnaire is not required. Please obtain and submit a copy of the Medical Notes and Clinical Comments, available for you to download from within the Maple app, and submit with your other claim forms.
Employer's Statement	Air Canada Will send the Employer's Statement directly to Manion after the expiry of the elimination period.
Payment of Benefits	Your benefits will be deposited directly into your bank account, therefore please submit the Direct Deposit application along with a void cheque (or statement of banking information) when you submit your application.

Your Completed Application must be received within 30 days of the day you first miss work.

To ensure confidentiality please send your application DIRECTLY to Manion.

Occupational Accidents, Illness or Injuries (Worker's Compensation/CNESST)

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 Plan benefits. All WIP claims must be submitted within 30 days of the day you first miss work. Failure to file a WIP claim will jeopardize your entitlement to these benefits in the event that your Workers' Compensation claim is refused or terminated. 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 enclosed in your WIP application package

PLEASE ALSO TAKE NOTE OF THE FOLLOWING:

- 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.
- Out-of-country travel requires written medical clearance from your physician and approval by **Manion**. You must advise **Manion** before you travel during your Weekly Indemnity claim.
- If you are submitting your claim late (after 30 days) please provide a written explanation regarding the delay. You may 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.
- When you return to work or terminate your employment, notify **Manion** immediately, so your WIP claim can be finalized.

Please review your application to ensure all the documents are completed, signed and dated before you submit your claim.

If you have any questions regarding your claim submission, please contact Manion.

By : 1-800-663-7849 or 416-234-3513

By : acclaims@manionwilkins.com

Important notice

On January 1, 2023, La Capitale Civil Service Insurer Inc. (La Capitale) and **SSQ, Life Insurance Company Inc. (SSQ Insurance)** combined operations to become Beneva Inc. (Beneva).

If you held a contract with La Capitale or **SSQ Insurance** before that date, Beneva is now your insurer and no action is required on your part.

Our documentation will be gradually updated with Beneva's name and logo. Accordingly, it is possible that you may receive contractual documents with La Capitale's or **SSQ Insurance's** name and logo for some time.

If you are a new customer, all documents establishing or related to your contract (including but not limited to consent and preauthorized debit agreements) must be read by replacing the name La Capitale or **SSQ Insurance** with Beneva, as applicable.

Please note that this notice constitutes a rider that modifies all previously mentioned documents.

This rider does not reduce the insurer's commitments and liabilities.

This rider constitutes an integral part of your contract. Please keep it in your records.

beneva

MANION

APPLICATION FOR WAGE INDEMNITY PLAN BENEFITS

Please ensure that form is fully completed before submission

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 Primary phone: (_____) _____ - _____ Email Address: _____

7 Gender at birth: F ☐ M ☐ Undeclared ☐ 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 If the claim is for 14 days or less (only):

Date first saw a doctor: Y M D Last day worked: Y M D Return to work date: Y M D

12 Have you already undergone a medical assessment related to your disability? no ☐ yes ☐

13 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 as per your province	☐	☐	☐	☐	☐	☐
Any provincial or Federal Agency	☐	☐	☐	☐	☐	☐
Automobile Insurance Law or any other compensation program (attach police report)	☐	☐	☐	☐	☐	☐
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 15)
- Upper section of Medical Practitioner's Questionnaire(s)

By the plan administrator
- Employer's Statement

By the Medical Practitioner
- Medical Practitioner's Questionnaire(s)

14 _____ Signature 15 Y M D Date

Underwritten by:

SSQ insurance

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

FAI623A (2024-07)

MANION

MEDICAL PRACTITIONER QUESTIONNAIRE
PHYSICAL HEALTH CONDITIONS

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 # **29880** | Employee No.

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) | **Please Provide your** Height: _____ Weight: _____

I hereby authorize the release of medical and health information in my file to SSQ, Life Insurance Company Inc. and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim may not be assessed. I understand that I am responsible for any fees related to the completion of this form. I agree that a copy or electronic version of this authorization shall be as valid as the original.

_____ (Y Y Y Y M M D D)
Plan member/Employee signature Date of Consent

Questions — **To Be Completed By Medical Practitioner**

STOP

- **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 sections 1 to 5 of Physical Health Conditions Questionnaire and complete Mental Health Conditions Questionnaire if applicable.**

1) Diagnosis

Primary Diagnosis: _____

Secondary and/or Complications: _____

If the interruption of work results from problems related to the following causes, please also complete the Questionnaire for Mental Health Conditions.:

☐ marital/family life ☐ personal or interpersonal problems ☐ professional problems ☐ alcohol or drug abuse and/or gambling problems

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

Manion Wilkins & Associates Ltd.
500-21 Four Seasons Place, Etobicoke, Ontario, M9B 0A5
Telephone: 416 234-3513 or 1-800-663-7849 | Fax: 416 234-0127
acclaims@manionwilkins.com

Underwritten by:
SSQ insurance

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 and frequency:

Degree of severity of all symptoms: ☐ Mild ☐ Moderate ☐ Severe

Frequency of Visits: Weekly ☐ Monthly ☐ Other ☐

Approximate duration of disability: No. of days _____ No. of weeks _____

☐ unspecified or date of return to work Y Y Y Y M M D D
☐ full-time
☐ gradual return

Specify:

Last Date Worked	Date Returned to Work or Expected Return to Work Date	
Y Y Y Y M M D D	Y Y Y Y M M D D	

5) Continuation of Medical Practitioner's Questionnaire 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:

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

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 Physician

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 Attending Physician _____ Date Signed : Y Y Y Y M M D D
(please print)

Physician's Specialty _____ License Number: _____

Address: _____
Street City Province Postal Code

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

Signature: _____

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

MANION

MEDICAL PRACTITIONER'S QUESTIONNAIRE
MENTAL HEALTH CONDITIONS

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 # **29880** | Employee No.

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)

Please provide your:
Height: _____ Weight: _____

I hereby authorize the release of medical and health information in my file to SSQ, Life Insurance Company Inc. and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim may not be assessed. I understand that I am responsible for any fees related to the completion of this form. I agree that a copy or electronic version of this authorization shall be as valid as the original.

_____ (Y Y Y Y M M D D)
Plan member/Employee signature — Date of Consent

Section B – Medical Practitioner's Questionnaire — TO BE COMPLETED BY MEDICAL PRACTITIONER

I am the: Medical Practitioner ☐ Consulting Specialist ☐ Other ☐ (please specify): _____

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) | **Date of the next follow-up appointment** (Y Y Y Y M M D D)

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.)

_____

_____

Manion Wilkins & Associates Ltd.
500-21 Four Seasons Place, Etobicoke, Ontario, M9B 0A5
Telephone: 416 234-3513 or 1-800-663-7849 | Fax: 416 234-0127
acclaims@manionwilkins.com

Underwritten by:
SSQ insurance

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)

Please attach a copy of your clinical notes and any test results or consultant reports available.

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 Medical Pratitioner _____ (please print) Date Signed: Y Y Y Y M M D D

Medical Practitioner's Specialty _____ License Number: _____

Address: _____ Street _____ City _____ Province _____ Postal Code

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

Signature: _____

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

DIRECT DEPOSIT APPLICATION FORM

MANION

Plan Member Identification

Surname	First Name	AC Employee Number

Telephone Number	Plan Name or Group Number
	Air Canada Component of CUPE WIP, Policy 29880

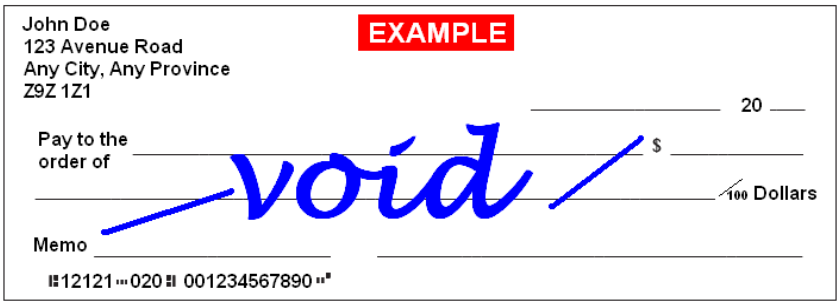
Address	City, Town, or Village	Province	Postal Code

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.