Wings Foundation, Inc.

Dear Flight Attendant:

Thank you for contacting the Wings Foundation. We realize that this is a difficult time for you and we would like to make applying for assistance as easy as possible. The following application has a check-list to assist you.

"The stated mission of Wings shall be to form a grassroots volunteer organization that collects and administers funds from and for Flight Attendants on the American Airlines Inc. System Seniority list who are in critical need of financial assistance as a result of illness, injury, or disability; or who are out of sick time; or who are without disability benefits; or those who have had a catastrophe or disaster which causes major hardship that would justify financial support."

Wings endeavors to assist AA flight attendants on the system seniority list who are out of sick time or almost out of sick time or who is a caregiver for a registered ill dependent with basic living expenses. WINGS Assistance is designed to be a bridge. Please keep in mind that Wings is not an insurance or disability policy.

Wings, exists through the generosity of your fellow flight attendants and volunteer committee members.

All information is confidential.

Please complete the application in its entirety. The information provided must be legible. Once the application is completed and signed and all required documentation is complied, please FAX to:

(817)527-2727 (Wings Foundation FAX Number)

Sincerely,

Wings Foundation, Inc.

www.wingsfoundation.com "click on your Base" OR Call (817) 571-7083 to Leave a message.

Wings Foundation Inc.
APPLICATION FOR ASSISTANCE

Please Print Clearly: **Today's Date**: _____

NAME: _____ **PHONE:** HOME: _____

ADDRESS: _____ CELL: _____

CITY: _____ STATE: ZIP: _____ FAX: _____

Mailing Address: (if different from above)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL ADDRESS:

_____

AA Six (6) digit Employee # _____

Current Base _____

Previous Base(s) _____

Date Of Hire _____

Current Work Status (check one)

- ☐ Unpaid Sick
- ☐ Family Leave
- ☐ Injury On Duty
- ☐ Other

Last Day Worked: _____

Est. Return Date: _____

Sick hours Available _____

Unpaid Sick Start Date _____

DEPENDENTS: (use back side if necessary)

NAME	AGE	RELATIONSHIP

EMERGENCY CONTACT:

NAME: _____

ADDRESS: _____

_____

PHONE: ( ) _____

RELATIONSHIP: _____

Brief Description of illness / injury / disability:

CURRENT LIVING SITUATION/STATUS: (CHECK ONE)

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Roommate
- ☐ Divorced
- ☐ Living Alone

HAVE YOU APPLIED FOR: (CHECK ALL THAT APPLY)

- ☐ Short Term Disability Date applied: _____
- ☐ Long Term Disability Date applied: _____
- ☐ State Disability Date applied: _____
- ☐ Social Security Date applied: _____

If Injury On Duty:

Date of injury: _____

Claim Pending? ☐ YES ☐ NO

Use backside if necessary: _____

_____

_____

_____

Wings Use ONLY:

Application Received by: _____ Date: _____

Wings Volunteer

Assigned to Case Worker: _____ Date: _____

Wings Volunteer

Applicants Name:_____Employee No: _____
Please Print Clearly

Monthly Household Income

Average Monthly Salary $ _____
Spouse / Partner Salary $_____
Roommate(s) Contribution $_____
Social Security Disability $ _____
State Disability $ _____
Short/Long Term Disability $ _____
Workman's Compensation $ _____
Alimony $ _____
Unemployment $ _____
Child Support Income $ _____
Long Term Care Income $ _____
Supplemental Insurance $ _____
Rental Income $ _____
Pensions $ _____
Fund Me Accounts (ANY TYPE) $ _____
_____ $ _____
_____ $_____
Total: $ _____

Assets

Savings Balance $ _____
Checking Balance $ _____
Credit Union $ _____
Certificate of Deposit (C.D.'s) $ _____
Stock_____ $ _____
_____ $ _____
_____ $ _____
Other Assets_____ $ _____
_____ $ _____
_____ $ _____

Monthly Household Expenses

Primary Mortgage / Rent $ _____
HOA $ _____

Home Utilities

- Heat/AC (Electric) $ _____
- Water / Sewer $ _____
- Gas / Oil $ _____
- Phone (Land *OR* Cell) $ _____

Auto Payment $ _____
Automobile Gas/Public Trans $ _____
Food $ _____

Other Expenses

- Child Support $ _____
- Child Care $ _____
- Medical Expenses $ _____
- Medical Out of Pocket Prescriptions $ _____

Medical Insurance

- Health – Primary $ _____
- Health – Secondary $ _____
- COBRA $ _____
- Vision $ _____
- Dental $ _____
- Short Term Disability $ _____
- Long Term Disability $ _____
- Critical Illness $ _____
- Life Insurance $ _____

Other Insurance

- Home Insurance $ _____
- Rental Insurance $ _____
- Car Insurance $ _____

Have you applied for other assistance? (Ex: American Family Fund, American Cancer Society, Red Cross, SNAP/Food Stamp Program)

▪▪ Yes ▪▪ No If yes, name and results: _____

Have you previously applied to the Wings Foundation for assistance?

▪▪ Yes ▪▪ No If yes, date(s) and base(s): _____

SAMPLE PHYSICIAN LETTER

This letter is to include the following on Physician Letterhead

- ***Your name***
- ***Diagnosis***
- ***Start date you were unable to work in the capacity of a Flight Attendant***
- ***Date when you may return to work as a Flight Attendant or date of re-evaluation***
- ***Physician Signature (MD, DO, EAP). WINGS will also accept the Sick Verification Letter supplied to American Airlines.***

> ***Wings Foundation, Inc. reserves the right to contact the medical provider for verification of your letter. No other personal information will not be requested from medical provider during the verification.***

(SAMPLE)

PHYSICIAN OFFICE LETTERHEAD

(From the Office of Dr. _____)

To Whom This May Concern:

_____ is a patient of mine at _____ Clinic/Office.
(Flight Attendant Name) *(name of clinic/office)*

_____ has the diagnosis of _____ This condition has caused
(Flight Attendant Name) *(Specify)*

_____ to be unable to work in the capacity of a Flight Attendant since _____
(Flight Attendant Name) *(Date)*

_____ will be re-evaluated *(or will return to work in the capacity of a Flight Attendant*
(Flight Attendant Name)

with no restrictions.) On _____
(Date)

Please call our office with any further questions

Sincerely,

Printed Name of Physician

Signature of Physician

Applicants Name:_____Employee No: _____
Please Print Clearly

Collection and use of Personal Information

Your privacy is important. Furnishing us this information is voluntary. The information you provide will be used to determine if you qualify for assistance. Failing to provide us with all or part of the requested information may prevent us from making a timely decision on your assistance. Personal information will be kept confidential. However, your information may be disclosed as required by law or with your permission.

Conduct

Please be advised that any conduct of a threatening or harassing nature, whether verbal, written or physical, will not be tolerated. Such conduct directed towards the Wings Foundation or a representative of the Wings Foundation will result in immediate and permanent termination of assistance. Any such reported conduct may be referred to American Airlines Security Department or outside law enforcement for further action.

Gift

Financial assistance received from Wings Foundation, Inc. is a gift made possible by the generosity of your fellow flight attendants and does not have to be repaid. Wings Foundation, Inc., however, is grateful for any donation received from an applicant who has been awarded a settlement due to litigation.

Responsibility to update information

It is responsibility of the applicant to keep Wings informed of any changes to your health, work or financial situation. If approved, you will be asked to make contact with your assigned caseworker at least monthly.

"As a reminder, financial assistance received from Wings Foundation, Inc. is a gift made possible primarily by the generosity of your fellow American Airlines Flight Attendants and is intended to pay for medical insurance and allowable living expenses. Any misuse of these funds may result in the suspension or termination of assistance."

Certification

I, the undersigned, certify that I have read and understand all the information contained in this application and that all the statements and representations made by me in this application and any accompanying forms are true and correct.

_____ _____

Applicant's Signature Date

_____

Print Applicants Name

FLIGHT ATTENDANT REQUESTING ASSISTANCE CHECKLIST

This checklist is provided to assist you in filling out your application.

Applicant must supply documentation which covers mortgage, rent, auto and loan payments, insurance, payroll etc.. This may be through bank statements or actual billing.

1. _____ Completed, Signed Application
2. _____ Copies of the Last Three (3) Months of the following Payroll Documents:
   - Last three (3) Months of Payroll Statements (from **Applicant and Spouse**)
   - Checks Issued History (Full Page - All checks issued to Flight Attendant.)
3. _____ Medical documentation.
   (See sample of Physician's Letter for required information.)
4. _____ Copies of your last three (3) checking and savings statements.
5. _____ Medical Out of Pocket expenses (proof of payment) EOB
6. _____ Copies of your last three (3) months from the following:
   (i.e. Disability, Workman's Comp, Pensions, Employment Paychecks)
7. _____ A copy of your last monthly schedule/line block (HI-1).
8. _____ A copy of the most recent, Long Term/Short Term Disability and/or Social Security Disability Statement.
9. _____ Copies of loan statements (ie: Auto Loans, Credit Union Loans, Mortgage information/Rental Agreement.)

Additional information may be requested by Wings Foundation, Inc.

Wings Foundation, Inc., reserves the right to verify your documents by contacting the originator(s) of your documents. (ie: leases, rental agreements, etc.)

Wings Volunteer Contact Information:
Name:_____
Phone:_____Cell:_____
Email:_____
Fax: _____