



## *Wings Foundation, Inc.*

Dear Flight Attendant:

Thank you for contacting the Wings Foundation. Enclosed is your application for assistance from the Wings Foundation, Inc. We realize that this is a difficult time for you and we want to make your request for assistance as easy as possible. Please read the entire package before completing the application. Print clearly, as your application may be copied/faxed several times. A completed application with documentation is required, for assistance to be considered. If your medical documentation cannot be enclosed with your application, please send/fax as soon as possible. **All information is confidential.**

“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’ intention is to assist with rent/mortgage, medical treatment/medicine, food and transportation expenses. Wings is designed to meet the essential needs of Flight Attendants, but is not an insurance policy and as such, cannot support lifestyles. The Employee Assistance Program (EAP) and Live and Work Well ([www.liveandworkwell.com](http://www.liveandworkwell.com)) are available to assist you with credit counseling.

Your application may be reviewed every three to six months or as circumstances change. It is the responsibility of the applicant to contact their Wings representative with any updates, changes or requests. Please make copies of all paperwork for your personal file. If you transfer to another base, you must submit a new and fully documented application.

Wings’ exists through the generosity of your fellow flight attendants and volunteer committee members. Your local base Wings representatives are available to receive your completed application and to address your questions and concerns.

Sincerely,  
Wings Foundation, Inc.

# *Wings Foundation*

## Application for Assistance

Please print clearly

Today's Date \_\_\_\_\_

Employee # \_\_\_\_\_

Current Work Status: (check one)

Last day worked \_\_\_\_\_

Current Base \_\_\_\_\_

Unpaid SK

Est. Return date \_\_\_\_\_

Previous Base(s) \_\_\_\_\_

Family Leave

SK hours avail? \_\_\_\_\_

Date of Hire \_\_\_\_\_

Social Security

Unpaid SK start date \_\_\_\_\_

Date of Birth \_\_\_\_\_

Other \_\_\_\_\_

Social Security # \_\_\_\_\_

(only last 4 digits)

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**Name:** \_\_\_\_\_

**Phone:** Home \_\_\_\_\_

**Address:** \_\_\_\_\_

Cell \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Pager \_\_\_\_\_

**Mailing Address:** (if different from above)

Fax \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Email Address** \_\_\_\_\_

**Dependants:** (use back side if necessary)

**Current Status:** (check one)

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Single

Married

Divorced

Separated

Live-in

Domestic Partner

If you are in a domestic partnership, do you have an affidavit on file with AMR?  NO  YES If yes, Name & Contact: \_\_\_\_\_

**Emergency Contact:**

**Have you applied for:** (check one)

Name: \_\_\_\_\_

Short Term Disability

Date applied \_\_\_\_\_

Address: \_\_\_\_\_

Long Term Disability

Date applied \_\_\_\_\_

Phone: \_\_\_\_\_

State Disability

Date applied \_\_\_\_\_

Relationship: \_\_\_\_\_

Social Security

Date applied \_\_\_\_\_

**Brief description of illness/injury/disability:**

If IOD, date of injury: \_\_\_\_\_

(use back side if necessary)

Claim Pending?  YES  NO

**Monthly Income**

Current Base Salary \$ \_\_\_\_\_  
Spouse / Partner Salary \$ \_\_\_\_\_  
Social Security Disability \$ \_\_\_\_\_  
State Disability \$ \_\_\_\_\_  
Short/Long Term Disability \$ \_\_\_\_\_  
Alimony/Child Support income \$ \_\_\_\_\_  
Long Term Care income \$ \_\_\_\_\_  
Other Income:  
\_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_

**Assets**

Savings Balance \$ \_\_\_\_\_  
Checking Balance \$ \_\_\_\_\_  
401 K \$ \_\_\_\_\_  
Credit Union Balance \$ \_\_\_\_\_  
Other Assets:  
\_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_

**Monthly Expenses**

Mortgage/ Rent \$ \_\_\_\_\_  
Auto Payments \$ \_\_\_\_\_  
Auto Insurance \$ \_\_\_\_\_  
Other Insurance \$ \_\_\_\_\_  
Utilities \$ \_\_\_\_\_  
Food \$ \_\_\_\_\_  
Medicine \$ \_\_\_\_\_  
Phone Expense \$ \_\_\_\_\_

Credit Card Payments \$ \_\_\_\_\_  
Total owed on Credit Cards \$ \_\_\_\_\_  
401 K Loan Payments \$ \_\_\_\_\_  
Other Loan Payments \$ \_\_\_\_\_  
Other Expenses: (cable, computer, etc)  
\_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_

Have you applied for other assistance? (AA/AE Family Fund, United Way, Red Cross, churches, etc)

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): \_\_\_\_\_

Please use the back side of this application for any other information you feel is pertinent.

**Thank you !**

# Sample Physician Letter

## ***Required Information:***

**Your Name**

**Diagnosis**

**Leave start date**

**Leave end date or re-evaluation date**

**Return to work without restriction date**

**Disabled from working any job?**

**Physician signature**

## **Physician Letterhead and Date**

**\_\_\_\_\_ (your name) \_\_\_\_\_ broke his/her leg and is disabled from working from  
June 15, 2007 to August 31, 2007 and may return to work Sept. 1, 2007 without restrictions.**

**Physician Signature**

# Signature Sheet

I, the undersigned, certify that all the statements and representations made by me in this application constitutes a true and correct account of my illness, injury or disability as well as my financial situation as of the date below. I also understand that should my illness, injury or disability and/or financial situation improve, I will immediately contact my Wings Representative and advise them of this fact. I have attached documentation in support of my application.

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Applicant's Signature

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Date

If the American Airlines/Wings PVD program is applicable in my case and I am accepted into the program, I understand and will accept the American Airlines/Wings guidelines and restrictions of the program as will be explained to me by my Wings Representative.

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Applicant's Signature

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Date

Please be advised that any verbal, written or physical conduct which does or is intended to threaten or harass Wings' volunteer caseworkers or representatives will result in immediate termination of all assistance from the Wings Foundation. Additionally, any and all conduct of a threatening or harassing nature will be referred to the American Airlines Security Department for investigation and further action. In applying for assistance from the Wings Foundation, Inc., I acknowledge and agree to be bound by this term and condition by my signature below.

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Applicant's Signature

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Date

I, the undersigned further agree that the Wings Foundation, Inc. as the entity and Wings volunteer caseworkers, representatives or agents my disclose Protected Health Information for the proper management and administration of my application and case provided that disclosures are Required By Law, or Wings Foundation, Inc., it's volunteers, representatives and/or agent obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Wings Foundation, Inc. of any instances of which it is aware in which the confidentiality of the information has been breached.

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Applicant's Signature

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Date

# Checklist

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

The following items must be submitted:

1. \_\_\_\_\_ Completed Application for Assistance
2. \_\_\_\_\_ Printed copy of your HI-9
3. \_\_\_\_\_ Copies of the following ePays Documents:  
Last Payroll Statement  
Checks Issued History (Full Page)
4. \_\_\_\_\_ Medical documentation must accompany the application or must be submitted in a timely manner.  
(See sample physician's letter for required information.)
5. \_\_\_\_\_ If applicable, a copy of all the pages of the Explanation of Benefits from the insurance company must accompany any request for medical payments.
6. \_\_\_\_\_ If available, a copy of your last HI-1.
7. \_\_\_\_\_ If applicable, a copy of the most recent Long Term/Short Term Disability and/or Social Security Disability Statement
8. \_\_\_\_\_ Signature sheet

In addition, the items below may be requested if necessary:

1. \_\_\_\_\_ Copy of bank statements, auto loans, Credit Union loans and/or 401K loans.
2. \_\_\_\_\_ Mortgage information/rental receipts

Keep in mind that additional information may be requested by Wings Representatives at any time.