



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) are available to assist you with credit counseling.

Once you have completed your Wings Application, you must then check the Wings Website, www.wingsfoundation.com, and review your Base information and look for a "Case Work Manager". Make contact with that individual and inquire as to where you may FAX or Mail your application. Should your base not have an assigned "Case Work Manager", you may then go to the list of "Case Workers" for your base, contacting one of them and they will instruct you as to where your Wings Application may be submitted. Not following this procedure will severely delay the processing of your application.

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.

Revised 08/2009

Wings Foundation Inc.

APPLICATION FOR ASSISTANCE

Please Print Clearly:

Today's Date: _____

Employee # _____
 Current Base _____
 Previous Base(s) _____
 Date Of Hire _____
 Social Security # _____
Last 4 digits ONLY

Current Work Status (*check one*)

Unpaid SK
 Family Leave
 Social Security
 Other

Last Day Worked: _____
 Est. Return Date: _____
 SK hours Avail? _____
 Unpaid SK Start Date _____

Wings Use ONLY:

Name of Person Verifying: _____ Form/Document Used for Verification: _____

NAME: _____
 ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____

Mailing Address: (if different from above)

ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____

PHONE: HOME: _____
 CELL: _____
 PAGER: _____
 FAX: _____

EMAIL ADDRESS: _____

DEPENDANTS: (*use back side if necessary*)

NAME	AGE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT STATUS: (CHECK ONE)

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> SINGLE | <input type="checkbox"/> MARRIED |
| <input type="checkbox"/> DIVORCED | <input type="checkbox"/> SEPARATED |
| <input type="checkbox"/> LIVE-IN | <input type="checkbox"/> DOMESTIC PARTNER |

If you are in a domestic partnership, do you have an affidavit on file with AMR? YES NO

If yes, Name & Contact: _____

EMERGENCY CONTACT:

NAME: _____
 ADDRESS: _____
 PHONE: () _____
 RELATIONSHIP: _____

HAVE YOU APPLIED FOR: (check one)

- | | |
|--|---------------------|
| <input type="checkbox"/> Short Term Disability | Date applied: _____ |
| <input type="checkbox"/> Long Term Disability | Date applied: _____ |
| <input type="checkbox"/> State Disability | Date applied: _____ |
| <input type="checkbox"/> Social Security | Date applied: _____ |

Brief Description of illness / injury / disability:

Use backside if necessary:

If IOD, date of injury: _____
 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 \$ _____
 Other Assets
 _____ \$ _____
 _____ \$ _____
 _____ \$ _____

Monthly Expenses

Mortgage / Rent \$ _____
 Auto Payments \$ _____
 Auto Insurance \$ _____
 Other Insurance \$ _____
 Utilities \$ _____
 Food \$ _____
 Medicine \$ _____
 Phone Expense \$ _____
 Credit Card Payment \$ _____
 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
- Evaluation date Return to Work without restriction
- Date Disabled from Working any job?
- Physician signature

Physician Letterhead and Date (sample)

(your name) broke his/her leg and is disabled from working from

June 15, 2009 to August 31, 2009 and may return to work September. 1st, 2009, 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.

Applicant's Signature

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 Representatives.

Applicant's Signature

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.

Applicant's Signature

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, 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.

Applicant's Signature

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. _____ Proof of Social Security Number:
 - a. Copy of Social Security Card
 - b. W2
 - c. Recent Income Tax Return
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 of 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
9. _____ On the Wings Website (www.wingsfoundation.com), locate "my base" **Case Work Manager** or **Case Worker** for best way to forward my application. Mailing or Faxing to insure processing ASAP. **see page 1*

In addition, the items 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 Representative at any time.

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Page intentionally left blank for additional information pertaining to Assistance Application