



Enclosed is your application for a CAUSE Foundation® grant. These funds are intended to be a *short-term* bridge to help United Airlines Flight Attendants and their dependents in times of illness, injury, disability or death. Our objective is to help with the basic necessities through an unexpected difficulty, or to provide breathing room while more permanent arrangements are made in a long-term situation. We can assist with excess medical bills, but cannot pay credit card debt or other personal financial obligations.

We realize this may be a difficult process for you and want to make it as easy as possible. It is preferable that you fill out your application with your CAUSE representative, but if you are unable to do so, please help us help you by doing the following: Read the entire packet before filling out the application. Print clearly, as these pages may be faxed and/or copied several times. A *complete* application is required before any grant can be considered. We have enclosed a checklist to help you, and we ask that you initial each item as you complete it, and return a copy of it with your completed application. If your medical documentation cannot be enclosed with the application, please fax or mail it to your representative.

Once all the information has been received, our policy requires that two CAUSE committee members review your application to determine the amount granted. The amounts are decided on a case-by-case basis according to need and the availability of funds. The number of applicants requesting assistance can impact that figure and ongoing assistance may vary monthly due to the volume of requests.

The funds received from the CAUSE Foundation are grants. They are not taxable, nor do we ask that they be paid back. This is money our flying partners have donated to help us help each other. We have an obligation to spend it as wisely and carefully as possible.

We want to assure you that this process is confidential. The Health Insurance Portability and Privacy Act requires written permission for any information about your situation to be discussed outside the Foundation. The only person who will know you have applied will be the supervisor who signs your Status Release Form. Be assured that they receive no other information about your application.

We are here to help, and we promise to assist you as quickly as possible. Please understand, though, that this process can take several weeks to complete. Every CAUSE volunteer representative is a full time flight attendant, and our schedules may prohibit us from getting back to you as quickly as we would like. Feel free to contact us at any time, and we will return your call as soon as we can.

NAME OF REPRESENTATIVE

PHONE NUMBER/DATE



CERTIFICATION OF DISCLOSURE

I, _____, do hereby certify that I have truthfully disclosed all information requested by The CAUSE Foundation in regard to my pending application. If any part of the information submitted is found to be fraudulent it will result in my application being denied and I will return any monies already paid to me by The CAUSE Foundation. I will then be denied any future requests of The CAUSE Foundation.

I also understand that if I transfer to another domicile, I must submit a new application to that domicile. Further, I will inform The CAUSE Foundation of any change in my United Airlines employment status such as retirement, furlough or other separation from the company at the onset of that status change. I will immediately inform The CAUSE Foundation when I return to active status. If my Unimatic records are secured so that my CAUSE representative does not have full access to my LOF information, grant payments will cease.

This certificate informs me that checks may be made out, at the discretion of the CAUSE committee either to the Flight Attendant, institution or provider of services. The CAUSE Foundation may provide financial assistance for up to nine months. If the illness or injury exists past that nine months, a new application may be submitted no sooner than six months following the previous termination of grants.

The CAUSE Foundation is not in a position to grant emergency funds. Grant approval can take two to six weeks. Timely processing of grants is dependent on how quickly my completed application is submitted.

Checks will be mailed by the 15th of each month barring unforeseen circumstances.

SIGNATURE OF APPLICANT

DATE

No application will be processed without this signed certificate.
Please mail original signed document to The CAUSE Foundation after making a copy for your records.



STATUS INFORMATION RELEASE

I hereby grant United Airlines permission to release any sick bank data to The CAUSE Foundation for documentation to attach to my application.

TO BE COMPLETED BY APPLICANT

Applicant's Signature

File # / Domicile

Date

TO BE COMPLETED BY SUPERVISOR

Sick Bank Hours Available _____

Status of Applicant _____
(Sick Leave, MLOA, FMLA, Occupational Leave, Unused Vacation Days, etc.)

Information provided by _____

Date _____



THE CAUSE FOUNDATION
GENERAL RELEASE FORM

I, _____ AUTHORIZE

THE FOLLOWING PERSON(S) TO RELEASE INFORMATION TO
REPRESENTATIVE(S) OF THE CAUSE FOUNDATION.

- NAME/PHONE/FAX _____
- ORGANIZATION/TITLE _____

(THIS CAN BE PHYSICIAN, BANKING INSTITUTION AND ACCOUNT #, EAP,
ETC.)

THE INFORMATION RELEASED SHALL BE FOR THE PURPOSE OF OBTAINING A
CAUSE FOUNDATION GRANT.

COMMENTS: _____

THIS RELEASE SHALL BE IN EFFECT FROM _____ TO _____

I UNDERSTAND THAT I CAN REVOKE THIS RELEASE AT ANY TIME.

SIGNATURE

DATE



***IF YOU ARE SUBMITTING MEDICAL BILLS,
PLEASE HELP US HELP YOU!***

IN ORDER TO EXPEDITE OUR ASSISTANCE TO YOU, PLEASE MAKE SURE THAT EACH OF YOUR MEDICAL BILLS IS ATTACHED TO THE CORRESPONDING “EXPLANATION OF BENEFITS” (EOB) THAT YOU RECEIVE FROM YOUR INSURANCE COMPANY. PLEASE DO NOT SUBMIT A GROUP OF MEDICAL BILLS AND A SEPARATE GROUP OF EOB STATEMENTS—YOU ARE THE PERSON WHO BEST UNDERSTANDS YOUR MEDICAL HISTORY AND WE NEED YOUR HELP TO MATCH UP THIS INFORMATION CORRECTLY.

ALL PAGES OF THE EOB STATEMENT MUST BE INCLUDED, EVEN IF YOU BELIEVE SOME OF THE PAGES CONTAIN NO PERTINENT INFORMATION. IF THE FIRST PAGE OF THE EOB STATES “PAGE 1 OF 3”, PLEASE INCLUDE ALL THREE PAGES. THE ADDITIONAL PAGES OFTEN CONTAIN AN EXPLANATION AS TO WHY A BILL, OR PORTION OF A BILL, WAS NOT PAID, AND YOUR CAUSE REPRESENTATIVE NEEDS THIS INFORMATION TO ACCURATELY PROCESS YOUR REQUEST.

IF YOUR CAUSE GRANT IS ONGOING, PLEASE SUBMIT YOUR MEDICAL BILLS AND THE CORRESPONDING EOB’S AS SOON AS YOU RECEIVE THEM. THIS WILL ASSIST US IN HELPING YOU TO MEET YOUR FINANCIAL OBLIGATIONS IN A TIMELY MANNER.

IF YOU HAVE ANY QUESTIONS, CONTACT YOUR CAUSE REPRESENTATIVE.

(FOR THOSE OF YOU SUBMITTING BILLS FROM FOREIGN COUNTRIES, PLEASE INCLUDE AN EXPLANATION IN ENGLISH AS TO WHAT THE BILL IS FOR, I. E. “DOCTOR’S BILL” “ HOSPITAL BILL” OR “PHARMACY BILL”)



CHECK LIST

Thank you for requesting information from The CAUSE Foundation. This checklist is provided to assist you in filling out your application. Please initial as each applicable item is completed, sign it below and return it with your completed application. If an item is not applicable, indicate "n/a". **All** items should be checked off.

Failure to return this checklist will delay the processing of your grant application.

- ___ An application form must be filled out completely and signed by the applicant and CAUSE Representative. The "Amount Requested" space ***must*** be filled in. Monetary amounts must be stated in US currency
- ___ Medical documentation signed by your doctor ***must*** accompany the application or be sent to the CAUSE Representative. It is your responsibility to provide updated documentation every three months. The following FAX number can be used: _____.
- ___ A copy of all the pages of the "Explanation of Benefits" from the insurance company ***must*** accompany any request for medical bill payments. The bills ***must*** be attached to the corresponding EOB's. (Explanation of Benefits)
- ___ Copies of paycheck stubs for the previous two months prior to your last day worked ***must*** accompany your application.
- ___ Copies of spouse's/ domestic partner's (if applicable) paycheck stubs for the previous two months ***must*** accompany your application.
- ___ Copies of W-2's and income tax returns for the previous two years ***must*** accompany your application. The CAUSE Foundation reserves the right to request further financial documentation.
- ___ If you are single/divorced with dependent children, a copy of the divorce decree and custody agreement with child support agreement ***must*** accompany your application.
- ___ If this application is related to a Worker's Compensation claim, a copy of the First Report of Injury/Illness (accident report) ***must*** accompany the application.
- ___ ***Once your application is approved, it is your responsibility to contact your domicile CAUSE Representative by the 5th of each month regarding your grant continuation. Failure to do so will result in no funds issued for that month. In addition, a review of an ongoing application will occur every three months. Updated documentation is required at least every three months.***
- ___ If you are in litigation in conjunction with the illness or injury listed on this application and receive a settlement, it would be appreciated if you would consider making a donation to The CAUSE Foundation so that we may continue to help other flying partners in need.
- ___ Status Release and General Release forms are to be returned only when requested by your domicile representative. Please keep them with your files.
- ___ All applications must have the appropriate documentation in place before checks can be issued. ***No exceptions!*** Please make copies of all paperwork for your personal file.

SIGNATURE OF APPLICANT



THE CAUSE FOUNDATION
APPLICATION FOR GRANT

Date _____

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

E-Mail _____ Domicile _____ Date of Birth _____

File# _____ FAX# _____ SW Seniority Date _____

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Domestic Partnership _____ Roommate _____

If you are involved in a domestic partnership, do you have an affidavit on file with UAL? Yes _____ No _____

Number of Dependents _____ Names and Ages of Dependents _____

Brief description of disability and/or illness and date of onset _____

_____ Work Related? Yes _____ No _____

Health Insurance: BC/BS _____ (name) _____ Other (name) _____

Last day worked _____ If known, an approximate return date _____

Have you or are you applying for other assistance/grants? (i. e. United Airlines Employee Relief Fund, Pegasus, Churches, etc.)

If yes, Name and Results _____

Have you applied for Disability Benefits? _____ If so, Results _____

Have you or a household member previously applied for a CAUSE grant? _____ Date/Domicile _____

Have you declared bankruptcy in the past 24 months? _____ Amount Requested _____

I, the undersigned, certify that all of the statements and representation of this application constitute a true and accurate account of my illness/disability and financial condition as of the date below. I have attached, in support of this application, requested documentation. Fraudulent use of The CAUSE Foundation will cause forfeiture of all future benefits and may result in criminal and/or civil litigation and prosecution. Additionally, CAUSE will investigate all possible avenues of recouping monies obtained under false pretenses.

I, the undersigned, on my behalf or as guardian of another, authorize THE CAUSE Foundation to release information to its Board of Directors, employees and volunteers as necessary with regard to my grant application. I give the above authorization with the recognition of my privacy rights under the Health Insurance Portability and Accountability Act and the Final Rule promulgated under HIPAA, 45 CFR Parts 160 and 164.

Applicant's Signature _____

Date _____

MONTHLY INCOME (US \$\$)

ASSETS (US \$\$)

Current UAL \$ _____
 Spouse/Partner \$ _____
 Soc. Security Disability \$ _____
 State/Foreign Disability \$ _____
 Long Term Disability \$ _____
 Alimony/Child Support* \$ _____
 Additional Job Income \$ _____
 Other Income:
 _____ \$ _____
 _____ \$ _____
 _____ \$ _____
 _____ \$ _____

Savings Balance \$ _____
 Checking Balance \$ _____
 Value of 401K/IRA \$ _____
 Credit Union Balance \$ _____
 Investments \$ _____
 Other Assets:
 _____ \$ _____
 _____ \$ _____
 _____ \$ _____
 _____ \$ _____
 Do you have an Alliant Credit Union Account?
 Yes _____ No _____

*If you are **not** receiving your court awarded child support, please attach documentation explaining what steps you are taking to pursue collection.

MONTHLY EXPENSES:

Mortgage/Rent (your share) \$ _____
 Car Payment(s) \$ _____
 Auto Insurance \$ _____
 Other Insurance \$ _____
 Utilities \$ _____
 Food \$ _____
 Medicines \$ _____
 Telephone Expense \$ _____
 Cell Phone Expense \$ _____
 Cable/Satellite/Internet \$ _____

Alimony/Child Support \$ _____
 Credit Card Payments \$ _____
 Total Owed on Credit Cards \$ _____
 401K Loan Payments \$ _____
 Other Loan Payments \$ _____
 Child Care \$ _____
 Other Expenses:
 _____ \$ _____
 _____ \$ _____
 _____ \$ _____

Use additional sheet if needed.

The CAUSE Foundation certifies that any and all information obtained to support this application will be kept confidential by the persons signing this application and their officers.

It is the policy of The CAUSE Foundation to review each grant application without regard to an individual's race, creed, color, religion, sex, age, national origin, nature of disability or sexual orientation.

*****For CAUSE Representative USE only*****

Amount Granted \$ _____ To Whom Payable _____
 1) Month _____ Amount \$ _____ 4) Month _____ Amount \$ _____
 2) Month _____ Amount \$ _____ 5) Month _____ Amount \$ _____
 3) Month _____ Amount \$ _____ (Update Needed) 6) Month _____ Amount \$ _____

Name(s) of Domicile Committee Member(s) who assisted in this application process

Domicile Representative Signature

Date

Officer Signature

Date

Attach Documentation/Send Copy to CAUSE Office