AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

Delta Pilots
Disability and
Survivorship Plan

Return Completed form to:

Harvey W. Watt & Co.
P. O. Box 20787
Atlanta, GA 30320
FAX (404)761-8326

Your signature on this form enables Harvey Watt & Co. to obtain necessary information to determine your eligibility for TD or LTD benefits. This authorization also allows Harvey Watt & Co. to release claim and other information to other parties or organization(s) for specific purposes.

Authorization to Obtain Information

I authorize the following persons having any records or knowledge of my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically-related facility or association.
- Any insurance company.
- Any employer or plan sponsor.
- Any organization or entity administering a benefit program.
- Any educational, vocational or rehabilitation organization or program.
- Any government agency (*for example, but not limited to, the Pension Benefit Guaranty Corporation, Worker's Compensation Board, etc.*)

To give the following information:

- Charts, notes, x-ray reports, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of any physical or mental condition, including:
  - Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
  - Any communicable disease or disorder.
  - Any psychiatric or psychological condition, including test results, but *excluding* psychotherapy notes. Psychotherapy notes include: notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the content of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms prognosis and progress to date.
  - Any condition, treatment or therapy related to substance abuse, including alcohol and drugs.

  And:
- Any non-medical information requested about me, including such things as earnings or finances, or eligibility for other benefits (*for example, but not limited to, Workers Compensation Board, claim status, benefit amounts and effective dates, etc.*)

To Harvey W. Watt & Co., Inc. and/or Delta Air Lines and any of its subsidiaries:

- In additional, I authorize the Pension Benefit Guaranty Corporation to provide information to Delta regarding retirement benefits being paid to me by them on behalf of the terminated Delta Pilots Retirement Plan.
- I understand that Harvey W. Watt & Co., Inc. (Harvey Watt), the Delta Pilots Disability and Survivorship Plan, Delta Air Lines and any of its subsidiaries, will use the information only to evaluate my eligibility for temporary or long-term disability benefits and to provide Federal Aviation Administration (FAA) license re-certification assistance for me.
- I understand and agree that this authorization shall remain in force throughout the duration of my claim for temporary and/or long-term disability benefits. I understand that I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to Harvey Watt, except to the extent that it has been relied upon to disclose requested records. A revocation of the authorization or the failure to sign the authorization:
  - May be a basis for denying benefits under the Plan
  - May impair Harvey Watt's ability to evaluate or process my claim for benefits and result in a denial of my claim for benefits.
  - May also impair Harvey Watt's ability to evaluate my eligibility for FAA license re-certification assistance and may be a basis for Harvey Watt being unable to provide such assistance.

_____ Initial

_____ Date

Authorization to Release Information

- I understand that Harvey Watt and the Disability and Survivorship Plan may disclose medical, financial and other information contained in my disability file to Delta, its employees or non-affiliated parties, such as a plan administrator, ALPA or persons performing business or legal services for Harvey Watt, Delta or the Disability and Survivorship Plan strictly as it pertains to the processing of my claim for disability benefits.
- I understand that the information disclosed to Harvey Watt and/or Delta pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law.
- I acknowledge that I have read this authorization and understand that a photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.
- I understand that this authorization supersedes any authorization that was submitted prior to the date of this form.

Printed Name of Claimant

Employee Number

Signature of Claimant /Guardian/Representative

Date

Printed Name of Guardian/Representative (*if applicable*)