EMPLOYEE'S APPLICATION FOR TEMPORARY OR LONG TERM DISABILITY

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

This application is for ◯ Temporary Disability ◯ Long Term Disability

CLAIMANT:

Full Name: _____Employee Number_____

Street Address: _____

City:_____ State: _____ Zip Code: _____

Telephone Number: _____ Secondary Telephone Number: _____

Date of Birth: _____ _____

Email Address: _____ Base: _____

Date of Hire: _____/_____/_____ Last Date Flown: _____/_____/_____ Date you became unable to fly: _____/_____/_____

Date you first called in sick for this Disability: _____/_____/_____ Approximate date Sick Leave exhausts: _____/_____/_____

Normal Occupation and Position: _____

Are you working now? ◯ Yes ◯ No Date you either resumed work or plan to resume work: _____/_____/_____

Date of Planned Retirement: _____/_____/_____ Furlough Date (if applicable): _____/_____/_____

Current status of your FAA Medical Certificate. (Check only one and fill in date certificate is current through or date that action was taken by the FAA. Attach a copy of FAA Revocation or Denial letter)

Current ◯ Date _____/_____/_____ Lapsed ◯ Date _____/_____/_____

Revoked ◯ Date _____/_____/_____ Denied ◯ Date _____/_____/_____

Complete this section **ONLY** if your disability is due to **ILLNESS, including pregnancy** (Please attach additional pages if more space is needed.):

Nature of Illness: _____

Cause of Illness: _____

Date Illness was first noticed: _____/_____/_____ Date first treated for Illness: _____/_____/_____

List of ALL symptoms and history of illness: _____
_____
_____
_____
_____

Have you ever had this condition or been treated for this condition previously? ◯ Yes ◯ No

If Yes, list date(s) of previous treatment(s): _____/_____/_____, _____/_____/_____, _____/_____/_____, _____/_____/_____

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Complete this section **ONLY** if your disability is due to **INJURY** (Please attach additional pages if more space is needed.):

Was this an on the job injury (OJI)? ◯ yes ◯ no

Complete description of Injury: _____

Cause of Injury: _____

Date of Accident: _____/_____/_____ Time of Accident: _____

Location of Accident: _____

Attending Physician Information:

Name of Physician: _____

Mailing Address: _____

City:_____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Telephone Number: _____

List any other physicians consulted for this illness or injury (Please attach additional pages if more space is needed):

Name: _____ Address: _____

Telephone Number: _____

Name: _____ Address: _____

Telephone Number: _____

List all periods of hospital admission for the past five years (Please attach additional pages if more space is needed.):

Name of Hospital: _____ Address: _____

Telephone Number: _____

Date(s) of Admission: From: _____/_____/_____ Thru: _____/_____/_____

Reason for Admission: _____

Name of Hospital: _____ Address: _____

Telephone Number: _____

Date(s) of Admission: From: _____/_____/_____ Thru: _____/_____/_____

Reason for Admission: _____

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Name of Hospital: _____ Address: _____

_____

Telephone Number: _____ _____

Date(s) of Admission: From: _____/_____/_____ Thru: _____/_____/_____

Reason for Admission: _____

_____

Are you receiving, eligible to receive or have you applied to receive benefits from:

	Eligibility	Applied for Benefits	Application Date	Receiving	Date First Received
Worker's Compensation	◯ Yes ◯ No	◯ Yes ◯ No	_____	◯ Yes ◯ No	_____
State Disability	◯ Yes ◯ No	◯ Yes ◯ No	_____	◯ Yes ◯ No	_____
Retirement	◯ Yes ◯ No	◯ Yes ◯ No	_____	◯ Yes ◯ No	_____

If yes, please specify the source(s):_____

_____

_____

If you become eligible to receive or receive these benefits at a later date, Harvey Watt must be notified immediately. We require copies of all letters either denying or awarding any benefits for which you have applied.

Reimbursement Agreement: If I receive a disability benefit payment(s) greater than that which should have been paid, I understand that the Plan has the right to recover such overpayment in accordance with the provisions of the D&S Plan, , including the right to reduce future payments from the Plan and I hereby authorize the deduction of any such overpayment from my payroll check, in the event that I return to active service prior to completing repayment .

Certification: I certify that the information provided by me in support of this claim is true and correct. I understand that I am required to make every effort to regain my FAA medical certificate, including pursuing the most appropriate means of treatment for my disabling condition.

I understand that I am required to furnish evidence of my continued disability as required by the Delta Pilots Disability and Survivorship Plan and the Pilots Working Agreement; such proof may include furnishing medical records from any or all providers of medical treatment.

I understand that any intentional misrepresentation or falsification of information will be reported to the Delta Pilots Disability and Survivorship Plan and Delta Air Lines, Inc. could result in disciplinary action, up to and including termination of employment.

Notification: If applying for Long Term Disability benefits, these benefits will not start until your Temporary Disability benefits have been exhausted.

Printed Name: _____

Signature: _____

Date: _____/_____/_____

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