



# Delta Pilot Disability Guide

## Application for Disability Benefits

Updated August 2018



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## PART 1 – BENEFIT SUMMARY

### Delta Pilot Disability Benefits

You may become eligible to receive disability benefits under the Delta Pilots Disability and Survivorship Plan (D&S Plan) if you sustain an injury, become sick or pregnant, and, as a result, are unable to perform your duties as a Delta Pilot. The disability benefits payments that you may be eligible to receive are based on a percentage of your wages and become payable after your disability has continued for seven days or, if later, when you exhaust accident leave or the Sick Leave credit hours that are available to you. Enclosed you will find the necessary forms needed to apply for temporary disability, long-term disability and top-up disability benefits and high level information on your eligibility for other Delta benefits while receiving these disability benefits.

This is just a summary. The plan document controls in the event of any conflict between this summary and the plan document.

### Maternity Leave Benefits

If you are pregnant, you have the option to fly as long as you continue to be fit to do so, and as long as you comply with the notification and update requirements under Section 13.G.1 and 13.G.2 of the PWA. You can be released from duty upon your request.

Once released from duty, you are eligible to use Sick Leave and unused earned vacation immediately. Once Sick Leave and any vacation you opt to use is exhausted, or once your baby is born, you will be eligible for Maternity Leave benefits. If you have not exhausted Sick Leave or vacation that you wish to use by the time your child is born, you can elect to use remaining Sick Leave and/or vacation prior to transitioning to Maternity Leave benefits. If you elect to use remaining Sick Leave and/or vacation once your baby is born, you must contact Pilot Leaves.

You receive Maternity Leave benefits for a period of six weeks for a normal birth or eight weeks for a cesarean birth, if you choose to fly within seven days of delivery. You can receive one additional week (7 days) if your absence begins at least 7 days before giving birth. If you are eligible for Maternity Leave benefits, the Plan provides you with a semi-monthly benefit equal to one-half of 100% of your monthly Final Average Earnings.

Your Maternity Leave and disability payments are provided to you in the same manner that you receive your active Delta pay: by check or through direct deposit. You can change your direct deposit account information for your disability payment online by logging on to Self Service on Deltanet. Once you exhaust your Maternity Leave benefits, you will transition to TD benefits provided you continue to meet the eligibility for disability.

For more information on Maternity Leave benefits, please refer to Deltanet at <https://deltaairlines.sharepoint.com/company/FlightOperations/Admin/Pages/Maternity-Leave.aspx>.

### Temporary Disability (TD) Benefits

You may qualify for TD benefits on the day you are prevented from performing the duties of a pilot solely as a result of injury, pregnancy, sickness or disease (including natural deterioration) provided that date occurs prior to or coincident with the cessation of your Earnings. This date becomes your Event Date for all purposes of that disability under the Plan. TD benefits are payable for a maximum of 26 weeks, starting on the Event Date. TD benefits are not payable during the first seven days of this period. Additionally, TD benefits are not paid

while you are exhausting accident leave or sick leave credit hours.

You also may be eligible for TD benefits if you meet all the D&S Plan requirements but elect not to undergo an invasive medical procedure required by the FAA in order to receive your First Class Medical Certificate.

If your application for TD is approved, the Plan provides you with a semi-monthly benefit equal to one-half of 50% of your monthly Final Average Earnings. Final Average Earnings is the monthly average of your highest 12 consecutive months of normal Earnings out of the last 36 months while you are on Active Payroll Status (including Accident and Sick Leave and vacation). However, if the last 36 months that you are on Active Payroll Status contains a month when you were on inactive status for more than 15 days, then the month immediately following will not be counted in the 36 months. Instead, an additional month in the consecutive period preceding the first day you were absent will be included as part of the 36 month period of normal Earnings. If you had less than 12 consecutive months of Earnings, then the average of Earnings in all consecutive months will be used.

#### Long Term Disability (LTD) Benefits

You are able to transition to monthly LTD benefits after exhausting your 26-week TD period. In order to qualify for LTD benefits, you must have met the requirements for TD benefits (whether or not you actually receive TD benefits) and not be eligible to exercise the privileges of your first class medical certificate, as determined by the Plan Administrator and subject to the medical review process. You also are deemed eligible for LTD benefits if the Company determines that you do not meet the standards established by the FAA for the issuance of a first-class medical certificate, including the FAA waiver and restriction policy. You also may be eligible for disability benefits for up to seven years if you meet all the D&S Plan requirements but elect not to undergo an invasive medical procedure required by the FAA in order to receive your First Class Medical Certificate.

If your application for LTD benefits is approved, your gross benefit will be 50% of your monthly Final Average Earnings. Final Average Earnings, as stated above, is the monthly average of your highest 12 consecutive months of normal Earnings out of the last 36 months while you are on Active Payroll Status (including Accident and Sick Leave and vacation). Payments are made on the last day of the month for that month.

#### Top-Up Disability Benefits

If you are a Pre-Merger NWA Pilot eligible under the Plan and are enrolled in the voluntary Delta Pilots Mutual Aid (DPMA) program, you may also be eligible for an additional Top-Up Disability benefit from the Plan, depending on your adjusted NWA Sick Bank hours.

The Top-Up Disability does just that – tops up the amount of your disability benefit by as much as an additional 50%. You must still meet all of the other criteria for disability benefits under the Plan in order to qualify for the Top-Up Disability benefit. This is an additional amount of disability benefit, but is only paid if you are Disabled under the Plan. It is not paid independently of the Plan disability benefits. Please refer to the Pilot Disability Benefit Handbook for additional details.

#### Disability Benefit Offsets

TD and LTD benefits are offset (reduced) by the other income benefits listed below.

- Workers' Compensation Benefits you receive on account of your employment with Delta (and also by Workers' Compensation benefits that you do not receive because you fail to apply for them)

To Report a Work Related Injury: Call Sedgwick at 877-67DELTA (877-673-3582)

- State Disability Benefits

For Pilots based in New York: Please contact MetLife at 1-866-729-9199 to initiate your state disability claim

For Pilots based in California: Please contact EDD at 1-800-480-3287 to initiate your state disability claim

- Retirement Benefits (including those paid from the PBGC)
- Earned Income (LTD only)

### Earned Income

If your income earned from other employment exceeds your LTD benefit amount, then your benefit will be reduced dollar for dollar based on the amount by which your income from employment exceeds your calculated disability benefit amount.

It is necessary that you report your income from other employment as specified on the attached Periodic and Annual forms. The Periodic Report of Disability Offset income form should be submitted if you are approved for LTD benefits and at any time thereafter when there is a change to your Earned Income. The Annual form must be submitted along with any applicable supporting documentation of your earnings by May 15<sup>th</sup> of the current calendar year. Both forms should be submitted, even if your earned income from other employment is zero.

Your total earned income amount generally includes all income subject to Federal employment taxes or self-employment income. It is reported on any W-2 statement issued by your employer or Schedule SE if you are self-employed.

Earned Income excludes any income, unless received in the course of your trade or business, reported on a Form 1099, such as annuities, pensions, Veterans benefits, and military retired pay, withdrawals from 401(k) plans, Social Security Disability Insurance payments, unemployment compensation, interest and dividends from savings accounts, stocks, personal loans, or home mortgages, insurance proceeds, gifts, inheritances, estates, trusts, endowments, prizes, awards, gambling or lottery winnings, alimony/child support, scholarships or fellowships, pay for jury duty, capital gains from the sale of personal property, amounts received in court actions, and rents or royalties.

### **Other Delta Benefits**

The following is an outline of Delta benefits that may be available to you while on disability status. For more details and additional information, refer to the applicable plan documents or contract language. For more information regarding benefit premiums, contact the ESC at 1-800 MY DELTA.

#### Delta Pilots Savings Plan (DPSP)

While receiving disability benefits from the D&S Plan, you are eligible to receive employer contributions to the pilot 401(k) plan at the same rate you would receive if you were on active pay status.

The DPSP will also accept employee contributions to the plan from disability pay for those pilots who meet certain eligibility requirements. Eligible pilots will be able to contribute to the 401(k) from their short- or long-term disability pay from the D&S Plan. To make 401(k) deferrals from disability payments, pilots must meet the following eligibility requirements:

- Pilots who are on the Pilot Seniority List on or after 6/1/06.
- Pilots who are considered eligible participants in the DPSP, and who receive disability pay from the D&S plan.
- Pilots that are removed from the Seniority List remain eligible to make employee contributions on their disability earnings as long as they continue to receive disability pay.

Ineligible pilots include those that have retired or terminated and pilots who are receiving disability pay from the NWA LTD plan.

Disability deferral limits are the same as those for active pay deferrals. Under the DPSP, you may contribute from 1% to 75 % of your short- or long-term disability pay each payroll period through Pre-tax, After-tax, Roth 401(k) and/or Catch-up Contributions to the plan. The maximum amount that you can contribute depends on your compensation, plan limits, and federal/IRS limits. **Please note that you must make a separate deferral election for contributions made to the DPSP while out on disability.** Deferral elections made as an active employee and DPSP plan participant *will only* apply for active earnings you may receive while on disability, such as Profit Sharing.

To elect to have deferrals made from your disability payments, simply go to NetBenefits at [www.netbenefits.com](http://www.netbenefits.com), click on *Contribution Amount* and scroll down to find the disability deferral options. Enter the percentage of your disability payment you'd like to contribute to your DPSP account, and Submit to make the change effective. You may also contact the Delta Service Center at Fidelity 1-800-554-0262 to make your disability elections.

#### 401(k) Loan Payments

If you have an outstanding 401(k) loan when you begin receiving disability benefits, your loan payments will not be deducted from your disability paycheck. You are responsible for ensuring your loan payments continue while you are on disability leave. Fidelity will mail information to you regarding the process to set up electronic ACH payments while you are on leave. You may also contact Fidelity at 800-554-0262 for this information. If you do not continue loan payments during your period of disability leave, you are at risk for defaulting on your loan(s).

#### Delta Group Medical, Dental, and Basic Life Insurance

While you are on an approved disability status, your healthcare and basic life insurance benefit coverage that was in place while on active status remains available for you and your covered eligible dependents. You must continue to timely pay any premiums that you were paying while on active status. They will be deducted from disability pay on a pre-tax basis while you are receiving disability benefits. In addition, your Delta Flexible Spending Account contributions and Optum Bank Health Savings Account contributions will continue to be deducted on a pre-tax basis from your disability pay.

#### Optional Insurances

Optional insurance includes optional life insurance, spouse life, child life, group accident insurance and private pilot coverage that you may have elected. While you are on an approved disability status, your benefit coverage will continue at the same level that was in effect for you and your dependents and the applicable premiums will be deducted from your disability check, unless you elect to cancel this benefit.

In the event of death within the first 30 days following removal from the active payroll, your Group Accident, Spouse/Child Life, Private Pilot, and Optional Life Insurance will be payable to your beneficiary.

#### Direct Deposit

If you use direct deposit to deposit your regular paycheck into your checking account (DCCU or outside institution), the entire disability check will be deposited to your checking account in most instances. If your check is issued outside of the regular disability payroll cycles, a paper check will be mailed to your address on file with the Company.

#### Delta Community Credit Union

Payroll deductions for loans *cannot* be made from disability benefit checks. You can make arrangements to meet your loan obligations during your absence by contacting the credit union directly.

#### Delta Employee ID

While on TD, Delta identification cards may be retained for identification purposes. Once you are absent from work for over 180 days, you must return your employee identification card to your Chief Pilot's office until you return to work.

#### Other Payroll Deductions

Deductions for Delta Pilots Savings Plan may be continued pre-tax and/or post tax while receiving disability benefits. If you have a 401(k) loan outstanding when you begin receiving disability benefits, you will be sent a coupon book to continue making those payments.

### Pass Travel

While on approved Temporary Disability, you continue to be eligible for active employee pass travel privileges on Delta; interline travel is not permitted. Once you transition to Long Term Disability, your travel privilege is determined by your age and years of service on your event date, as follows:

- If you are at least age 50 with 10 years of consecutive service at the time your approved disability leave began, you are eligible for the same pass privileges as a regular Delta retiree.
- Employees with at least 10 years of consecutive service at the time their approved LTD leave began are eligible for unlimited S3B pass travel privileges while they are receiving monthly benefits under the provisions of a Company-sponsored long-term disability (LTD) benefit program.
- Employees with less than 10 years of consecutive service at the time their approved LTD leave began will have unlimited S3B pass travel privileges for the length of their years of service only. All pass travel must be completed before eligibility ends. For example, if an employee had 7 years of consecutive service when their leave began, their pass eligibility will end 7 years from the date the leave began and they remain ineligible for pass travel privileges until they return to work.

All travel for you, your spouse, and eligible dependent children will be classified as SA-3B while on approved long-term disability status. You will be penalized a fee of \$150 for exceeding their boarding priority allotment, if you travel using an incorrect boarding classification.

### **Delta Pilots Mutual Aid**

Delta Pilots Mutual Aid (DPMA) is a voluntary organization with a Board of Trustees consisting of Delta pilots. It is not affiliated with Delta Air Lines, Inc. or ALPA. DPMA is “pilots helping pilots” and provides a monetary disability benefit (including Maternity) to qualifying members who exhaust their Delta provided sick pay and remain unable to work due to a disability. The DPMA benefit is paid in addition to TD and LTD benefits. All DPMA members are limited to a combined total of twenty-four months (730 days) of benefits in their lifetime. If you are a member and need to file for this benefit, please contact the DPMA directly by calling 404-559-9421 or accessing their website at [www.dpma.org](http://www.dpma.org).

## PART 2: IMPORTANT CONTACT INFORMATION

If you have any questions concerning the information in this Disability Guide, please contact the appropriate area listed below.

Benefit Type	Contact
<p><b>Disability Certification</b></p> <ul style="list-style-type: none"> <li>• Disability Plan guidelines</li> <li>• Application for TD or LTD</li> <li>• Disability Recertification</li> </ul>	<p><b>Harvey Watt &amp; Company</b>            P. O. Box 20787            Atlanta, GA 30320            FAX (404) 761-8326            PHONE (404) 767-7501 or (800) 241-6103</p>
<p><b>Disability Benefits</b></p> <ul style="list-style-type: none"> <li>• Disability Benefit Payments</li> <li>• Disability Overpayments</li> <li>• Coordination of offsets</li> </ul>	<p><b>Delta Employee Service Center</b>            P.O. Box 52049            Phoenix, AZ 85072            1-800 MY DELTA (1-800-693-3582)</p>
<p><b>Medical</b></p> <ul style="list-style-type: none"> <li>• Delta Account-Based Healthcare Plan (DABHP)               <ul style="list-style-type: none"> <li>◦ Gold HRA Medical Option, OOA Gold HRA Medical Option, Traditional Gold HRA Medical Option, OOA Traditional Gold HRA Medical Option, Gold HSA Medical Option, Silver HSA Medical Option, Bronze HSA Medical Option</li> </ul> </li> <li>• Delta Pilots Medical Plan (DPMP), Delta Pilots Medical Plan (DPMP) OOA</li> <li>• Health Plan Hawaii</li> </ul> <p><b>Humana Health Plan of Puerto Rico</b></p>	<p><b>UnitedHealthcare</b>            Claims Department            P.O. Box 740800            Atlanta, GA 30374-0800            877-912-1820  <a href="http://www.myHealthcareView.com">www.myHealthcareView.com</a></p> <p><b>Hawaii Medical Service Association</b>            818 Keeaumoku Street            Honolulu, HI 96814            808-948-6372  <a href="http://www.hmsa.com">www.hmsa.com</a></p> <p><b>Humana Health Plan of Puerto Rico</b>            Edificio El Mundo 3er. Piso            383 Ave F D Roosevelt            San Juan, Puerto Rico 00918-2131            787-282-7900 ext. 5500  <a href="http://www.humana.com">www.humana.com</a></p>



<p><b>Dental</b></p> <ul style="list-style-type: none"> <li>• Delta Account Based Healthcare Plan (DABHP) <ul style="list-style-type: none"> <li>○ Comprehensive Dental Option</li> <li>○ Basic Dental Option</li> </ul> </li> <li>• Delta Pilots Medical Plan (DPMP) Dental Option</li> </ul>	<p><b>MetLife Dental Claims</b>  P.O. Box 981282  El Paso, TX 79998-1282  855-700-7992  Fax: 859-389-6505  <a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a>  (company name "Delta Air Lines")</p>
<p><b>Vision</b></p>	<p><b>Davis Vision</b>  Vision Care Processing Unit  P.O. Box 1525  Latham, NY 12110  800-947-9955  <a href="http://www.davisvision.com">www.davisvision.com</a></p>
<p><b>Delta Pilots Savings Plan [401(k)]</b></p>	<p><b>Fidelity:</b> 800-554-0262</p>
<p><b>COBRA</b></p> <ul style="list-style-type: none"> <li>• Medical Options</li> <li>• Dental Options</li> <li>• Davis Vision Plan</li> <li>• Full Purpose Healthcare FSA</li> <li>• Limited Purpose Healthcare FSA</li> </ul>	<p><b>Employee Service Center (ESC)</b>  P.O. Box 52045  Phoenix, AZ 85072  1-800 MY DELTA (1-800-693-3582)</p>

Benefit Type	Contact
<p><b>Delta Community Credit Union (DCCU) Loan</b></p>	<p><b>Delta Community Credit Union</b>  P.O. Box 20541  Atlanta, GA 30320  Credit Union Loans – Dept. 930/ATG  404-715-4725 or 1-800-544-3328</p>
<p><b>Delta Employee Assistance Program (EAP)</b></p>	<p><b>OptumHealth Behavioral Solutions</b>  800-533-6939  <a href="http://www.liveandworkwell.com">www.liveandworkwell.com</a> (access code DAL)</p>
<p><b>Group Accident Insurance and Family Group Accident Insurance</b></p> <p><b>Private Pilots Accident Insurance</b></p> <p><b>Life Insurance</b></p> <ul style="list-style-type: none"> <li>• Basic</li> <li>• Optional Life</li> <li>• Dependent Life</li> </ul>	<p><b>Administrative Concepts, Inc. (ACI)</b>  994 Old Eagle School Road, Suite 1005  Wayne, PA 19087-1802  855-672-1273  <a href="http://info.visit-aci.com/delta">http://info.visit-aci.com/delta</a></p> <p><b>Metropolitan Life Insurance Company (MetLife)</b>  MetLife Recordkeeping Center  P.O. Box 14401  Lexington, KY 40512-4401  866-939-7409  <a href="http://www.metlife.com">www.metlife.com</a></p>
<p><b>Flexible Spending Accounts (FSAs)</b></p> <ul style="list-style-type: none"> <li>• Full Purpose Healthcare FSA</li> <li>• Limited Purpose Healthcare FSA</li> <li>• Dependent Care FSA</li> </ul>	<p><b>UnitedHealthcare Member Services</b>  P.O. Box 981506  El Paso, TX 79998-1506  Delta Health Direct: 877-912-1820  Fax: 915-231-1709  <a href="http://www.myHealthcareView.com">www.myHealthcareView.com</a></p>
<p><b>Eligibility and Enrollment Issues</b>  <b>Qualified Life Events</b></p>	<p><b>Delta Air Lines, Inc.</b>  Employee Service Center  P.O. Box 52045  Phoenix, AZ 85072  <b>1-800 MY DELTA (1-800-693-3582)</b></p>

Additional frequently called phone numbers can be accessed on Deltanet.

## PART 3: PILOT DISABILITY CHECKLIST

In preparation for your continued absence from work, please review this document carefully and keep it for future reference for benefit questions that may arise during your absence. To ensure you receive your disability benefits in a timely manner please follow the checklist below and submit all forms as early as possible during your absence.

**Important Note: Incomplete, altered, or missing forms or lack of medical information substantiating your claim will be returned to you for completion and may delay the processing of your claim and the receipt of your disability benefits. As part of your application for disability benefits, all forms must be completed. If for some reason a particular section does not apply to you, or information is not applicable, "N/A" should be written in the space to indicate that you have not overlooked that particular question.**

### COMPLETE AS SOON AS YOU EXPECT YOUR ABSENCE TO EXTEND BEYOND YOUR SICK LEAVE HOURS

- Submit these completed forms to Harvey Watt & Company in order to initiate your disability claim**

#### EMPLOYEE STATEMENT FOR DISABILITY

You must complete this form in full to apply for either Temporary Disability or for Long Term Disability benefits.

#### AUTHORIZATION TO OBTAIN INFORMATION

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

#### INITIAL PHYSICIAN STATEMENT(S)

A separate form must be completed by each one of your treating physicians. You are responsible for ensuring that these forms are completed and submitted by your treating physicians along with the appropriate supporting documentation, including but not limited to: office notes and summaries of all surgical or medical services rendered on each date, including laboratory test results and results/reports of any other tests, such as X-RAYS, EKG's, EEG'S, etc.

- Submit this completed form to the Employee Service Center:**

#### TAX SELECTION FORM

The Employee Service Center must receive this form before any benefits you may be eligible for are paid to you.

### FORM MAY BE REQUIRED FOR ONGOING DISABILITY CERTIFICATION

- Submit updated forms to Harvey Watt & Company:**

#### UPDATED PHYSICIAN STATEMENT(S)

As your claim is reviewed throughout your absence, you may be required to provide additional or updated medical information to support your disability claim. A separate form must be completed by each one of your treating physicians. You are responsible for ensuring that these forms are completed and submitted by your treating physicians along with the appropriate supporting documentation, including but not limited to: office notes and summaries of all surgical or medical services rendered on each date, including laboratory test results and results/reports of any other tests, such as X-RAYS, EKG's, EEG'S, etc.

## **PART 4: REQUIREMENTS FOR RETURNING TO WORK**

It is Delta's hope that you recover from disability and return to Active Payroll Status. The following information may help you return to work after being on either TD or LTD.

If you are out for medical reasons for four months or longer, the company Medical Director has the right to verify your medical fitness to return to work, regardless of whether you have a current first-class medical certificate. When you are cleared to return to flight status, your category is determined in accordance with the PWA.

You should notify Harvey Watt of your return to duty to ensure that your last disability check is correct. This avoids an overpayment and your obligation to reimburse the Plan. If you are receiving Delta Pilots Mutual Aid (DPMA), you should advise DPMA of your return to work to avoid overpayment of those benefits as well.

Contact the Chief Pilot Support Center to ensure that you have access to DBMS, and to determine your bid status when you return to work.

Before you return to work from your disability leave, you must obtain a release from your treating physician and present the release to your local Chief Pilot. If you do not, Delta has the right to prevent your return until you do so.

## **APPENDIX: DISABILITY CLAIM FORMS**

**PILOT APPLICATION FOR DISABILITY BENEFITS**

Delta Pilots  
Disability and  
Survivorship Plan (D&S Plan)

**Return Completed form to:**

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

**You file one application for Temporary Disability (TD) benefits, Long-Term Disability (LTD) benefits and, if applicable, Top-Up Disability benefits. TD benefits are paid first. You may be asked to provide additional information as you progress through these different types of benefits, as permitted by the D&S Plan and the Pilots Working Agreement (PWA).**

**CLAIMANT:**

Full Name: \_\_\_\_\_ Employee Number \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Secondary Telephone Number: \_\_\_\_\_

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

Email Address: \_\_\_\_\_ Base: \_\_\_\_\_

**Personal Information Required for Claim Processing/Handling**

Date you first called in sick for this Disability: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you working now? ( ) Yes ( ) No Date you either resumed work or plan to resume work: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you currently incarcerated due to conviction for a felony? [ ] Yes [ ] No. If yes, date of incarceration: \_\_\_\_\_

Anticipated Date of Release: \_\_\_\_\_

List the names, addresses and phone numbers of your current spouse/domestic partner, and children:

Name	Address	Phone Number

**Current status of your First Class 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

Has the FAA requested that you undergo an invasive medical procedure in order to be issued your first class medical certificate?  
[ ] Yes [ ] No

If Yes, please attach a copy of the correspondence from the FAA notifying you of this requirement.

**PILOT APPLICATION FOR DISABILITY BENEFITS (Page 2)**

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Complete this section 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): \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you ever received Disability Benefits for this condition ( ) Yes ( ) No.

If Yes, list the dates you received these Disability Benefits: \_\_\_\_\_

Have you received Disability Benefits from the D&S Plan for one or more of the following conditions? Check those that apply

- Psychiatric Conditions From: \_\_\_\_\_ to \_\_\_\_\_
- Alcoholism From: \_\_\_\_\_ to \_\_\_\_\_
- Drug Abuse From: \_\_\_\_\_ to \_\_\_\_\_

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Complete this section 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PILOT APPLICATION FOR DISABILITY BENEFITS (Page 3)**

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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: \_\_\_\_\_

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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: \_\_\_\_\_

Name of Hospital: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Date(s) of Admission: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ Thru: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for Admission: \_\_\_\_\_



**PILOT APPLICATION FOR DISABILITY BENEFITS (Page 4)**

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Complete this section **ONLY** if you are not under the care of a qualified health professional:

1. Are you unable to return to active payroll status due to the FAA's pending review of your application or possession of your First Class Medical Certificate? ( ) Yes ( ) No

Date of FAA's action: \_\_\_\_\_ (please enclose the communication advising you of the FAA's pending review)

2. If the answer to 1. is "Yes", did you make timely and good faith disclosures of a medical condition to the FAA, and/or your AME and/or the Delta Director – Health Services? ( ) Yes ( ) No

Date of disclosure: \_\_\_\_ Disclosure made to: \_\_\_\_\_

3. If the answer to 1. is "Yes", did you promptly contact Delta's Director – Health Services to report the FAA's pending review of your application for or possession of your First Class Medical Certificate? ( ) Yes ( ) No

Date of contact: \_\_\_\_\_

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

	Eligible?	Applied for Benefits	Application Date	Receiving	Date First Received Amount
Worker's Compensation	( ) Yes ( ) No	( ) Yes ( ) No	_____	( ) Yes ( ) No	_____
State Disability	( ) Yes ( ) No	( ) Yes ( ) No	_____	( ) Yes ( ) No	_____
Retirement (including payments from PBGC)	( ) Yes ( ) No	( ) Yes ( ) No	_____	( ) Yes ( ) No	_____

Do you have an ex-spouse that has been awarded a portion of your retirement benefits under a Qualified Domestic Relations Order?  
( ) Yes ( ) No

If Yes, list first and last name of ex-spouse: \_\_\_\_\_

If you are or become eligible to receive the benefits described above, now or in the future, Harvey Watt & Company must be notified immediately. We require copies of all letters either denying or awarding any benefits for which you have applied and supporting documentation showing the amount of the benefits you are receiving.

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**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 and following the recommendations of my treating physician, with some exceptions for invasive procedures. I also understand that I am required to promptly inform the D&S Plan Administrator and Delta Air Lines, Inc. if I regain my First Class Medical Certificate.

I understand that I am required to furnish evidence of my continued disability as required by the D&S Plan and the Delta Pilot 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 D&S Plan Administrator and Delta Air Lines, Inc., and could result in disciplinary action, up to and including termination of employment.

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

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**INITIAL PHYSICIAN'S STATEMENT**

Delta Pilots  
Disability and  
Survivorship Plan (D&S Plan)

**Return Completed form to:**

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

**The patient is ultimately responsible for the completion of the entire form and facilitating the submission of necessary documentation without any expense to either Delta Pilots Disability and Survivorship Plan or Harvey Watt & Co. Necessary documentation includes but is not limited to: office notes and summaries of all surgical or medical services rendered on each date, including laboratory test results and results/reports of any other tests, such as X-RAYS, EKG's, EEG'S, etc.**

**A separate form must be completed by each treating physician.**

***If a section is not applicable, N/A MUST be entered. Any incomplete form may be returned for completion.***

**TO BE COMPLETED BY PATIENT:**

Patient: \_\_\_\_\_

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

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

Height of Patient: \_\_\_\_\_ Weight of Patient: \_\_\_\_\_

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

Doctor: \_\_\_\_\_

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

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

Fax Number: \_\_\_\_\_

Specialty: \_\_\_\_\_  
 \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN:**

**DIAGNOSIS:**

Primary Diagnosis: \_\_\_\_\_

Primary ICD-9 Code: \_\_\_\_\_

Primary PCT-4 Code (if applicable): \_\_\_\_\_

**Date Patient first consulted for this disability:** \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

Secondary ICD-9 Code: \_\_\_\_\_

Secondary PCT-4 Code (if applicable): \_\_\_\_\_

**Date symptoms first appeared for this disability:** \_\_\_\_\_

**LIST ALL DATES OF SERVICE:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**LIST ALL LOCATIONS OF SERVICE:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**INITIAL PHYSICIAN'S STATEMENT (Page 2)**

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**Detailed description/history including the office notes and summaries of all surgical or medical services rendered on each date, including laboratory test results and results/reports of any other tests, such as X-RAYS, EKG's, EEG'S, etc. (Please attach additional pages if more space is needed.):**

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**Recommended/Prescribed treatment, including any therapy or medications (Please attach additional pages if more space is needed.):**

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**Detail all of the patient's restrictions and activity limitations (Please attach additional pages if more space is needed):**

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**Current Physical/Functional Level of Patient:**

- Sedentary            0 to 10 lbs lifting; limited standing or walking
- Light                11 to 20 lbs lifting; carry objects less than 10lbs for short periods
- Medium             21 to 50 lbs lifting; carry objects 25lbs for short periods
- Heavy               51 to 100lbs lifting; carry objects up to 50lbs

These restrictions are in effect until \_\_\_\_\_ (date) or until Plan Participant is reevaluated on \_\_\_\_\_ (date).

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**Detail all dates of hospital confinement that pertain to the listed disability. (Include admittance and discharge dates as well as the reason for the confinement.):**

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**INITIAL PHYSICIAN'S STATEMENT (Page 3)**

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**List the names and address of all consulting physicians for the listed disability:**

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**Detailed Prognosis for Return to Work:**

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**Since first being consulted on the patient's disability, please describe their condition:**

Regressed     Unimproved     Improved     Recovered

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**If you are an Aviation Medical Examiner (AME), do you believe the patient is now able to exercise the privileges of a Federal Aviation Administration First Class Medical Certificate?  Yes  No  N/A**

**Date patient was able to return to customary occupation as an airline pilot:**

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**NOTE: If duration of disability exceeds a 90-day period, all medical documentation may be requested for each subsequent 90-day period.**

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**Physician completing form:**

Printed Name:

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Signature:

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Date:

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## AUTHORIZATION TO OBTAIN / RELEASE INFORMATION

Delta Pilots  
Disability and  
Survivorship Plan (D&S Plan)

**Return Completed form to:**

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

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**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.**

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**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, pharmacy benefit manager, 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, Federal Aviation Administration, Worker's Compensation Board, etc.*)

**To give the following information:**

- Charts, notes, x-ray reports, operative reports, lab, prescription, or 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, retirement benefit amounts, other income and effective dates, etc.*)

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

- In addition, 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 (page 2)

- I understand that Harvey Watt and the D&S 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 D&S Plan strictly as it pertains to the processing of my claim for disability benefits.
- I understand that the information disclosed to Harvey Watt, Delta and/or the Plan Administrative Committee pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by the federal privacy regulation 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.
- I understand that this authorization may not be altered in any way.
- I have read both pages of this authorization and understand that by my signature I agree to both pages of this authorization.

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Printed Name of Claimant

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Employee Number

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Date of Birth

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Signature of Claimant /Guardian/Representative

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Date

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

## TAX SELECTION FORM

**Return Completed form to:**

**Delta Employee Service Center**  
P. O. Box 52049  
Phoenix, AZ 85072  
602-797-6276 (fax)

Your deduction request will be effective on the first available pay period following receipt of this form.

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**The Employee Service Center must receive the following form in order to begin paying any benefits. Incomplete forms will be returned to you for completion and may delay processing of your claim. For detailed information or any question regarding this form, please contact the Disability Department at the Employee Service Center by calling 1-800-MY DELTA.**

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**CLAIMANT:**

Full Name: \_\_\_\_\_ Employee Number \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Secondary Telephone Number: \_\_\_\_\_

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These Tax Deductions are for (choose only one):

Temporary Disability       Long Term Disability       Both, Temporary Disability and Long Term Disability

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1.) Do you authorize deduction of Federal Income Tax from your disability check?       Yes     No

2.) Do you authorize deduction of State Income Tax from your disability check?       Yes     No

3.) If Yes, indicate appropriate state: \_\_\_\_\_

Indicate deductions below:

**Federal Income Tax**

Table rate            Indicate marital status and number of exemptions  Married  Single  
Number of exemptions \_\_\_\_\_

**State Income Tax**

Table rate            Indicate marital status and number of exemptions  Married  Single  
Number of exemptions \_\_\_\_\_

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Please have my disability benefit payment sent to (choose one only)

Delta Community Credit Union Checking Account # \_\_\_\_\_  
(You must be the primary account holder)

Mailing address on file with Delta Air Lines.

Direct Deposit to another financial institution. (Complete Authorization Agreement for Automatic Deposit form)

\_\_\_\_\_  
Signature of Claimant

\_\_\_\_\_  
Date

## UPDATED PHYSICIAN'S STATEMENT

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

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**The patient is ultimately responsible for the completion of the entire form and facilitating the submission of necessary documentation without any expense to either Delta Pilots Disability and Survivorship Plan or Harvey Watt & Co. Necessary documentation includes but is not limited to: office notes and summaries of all surgical or medical services rendered on each date, including laboratory test results and results/reports of any other tests, such as X-RAYS, EKG's, EEG'S, etc.**

**A separate form must be completed by each treating physician.**

***If a section is not applicable, N/A MUST be entered. Any incomplete form may be returned for completion.***

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**TO BE COMPLETED BY PATIENT:**

Patient: _____	Doctor: _____
Address: _____	Address: _____
_____	_____
_____	_____
Phone Number: _____	Phone Number: _____
Height of Patient: _____	Weight of Patient: _____
_____	_____
Date of Birth: _____	Specialty: _____
_____	_____

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**TO BE COMPLETED BY PHYSICIAN:**

**DIAGNOSIS:**

Primary Diagnosis: _____	Secondary Diagnosis: _____
Primary Diagnosis ICD-9 Code: _____	Secondary Diagnosis ICD-9 Code: _____
Primary Diagnosis PCT-4 Code (if applicable): _____	Secondary Diagnosis PCT-4 Code (if applicable): _____
_____	_____

**DATE OF LAST MEDICAL UPDATE SUBMITTED TO HARVEY WATT:**

\_\_\_\_\_  
**LIST ALL DATES OF SERVICE SINCE \_\_\_\_\_:**  
\_\_\_\_\_  
\_\_\_\_\_

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Detailed description/history including the office notes and summaries of all surgical or medical services rendered on each date, including laboratory test results and results/reports of any other tests, such as X-RAYS, EKG's, EEG'S, etc. (Please attach additional pages if more space is needed.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**UPDATED PHYSICIAN'S STATEMENT (Page 2)**

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Recommended/Prescribed treatment, including any therapy or medications. (Please attach additional pages if more space is needed.):

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Detail all of the patient's restrictions and activity limitations. (Please attach additional pages if more space is needed.):

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**Current Physical/Functional Level of Patient:**

- Sedentary            0 to 10 lbs lifting; limited standing or walking
- Light                11 to 20 lbs lifting; carry objects less than 10lbs for short periods
- Medium             21 to 50 lbs lifting; carry objects 25lbs for short periods
- Heavy               51 to 100lbs lifting; carry objects up to 50lbs

These restrictions are in effect until \_\_\_\_\_ (date) or until Plan Participant is reevaluated on \_\_\_\_\_ (date).

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Since first being consulted on the patient's disability, please describe his/her condition

- ( ) Regressed    ( ) Unimproved    ( ) Improved    ( ) Recovered
- 

If you are an Aviation Medical Examiner (AME), do you believe the patient is now able to exercise the privileges of a Federal Aviation Administration First Class Medical Certificate? ( ) Yes ( ) No ( ) N/A

List dates of total and continuous disablement preventing engagement in his/her customary occupation as an airline pilot:

Date patient was able to return to his/her customary occupation as an airline pilot:  
\_\_\_\_\_

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NOTE: If duration of disability exceeds a 90-day period, all medical documentation will be required for each subsequent 90-day period.

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**Physician completing form:**

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

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## INSTRUCTIONS FOR PERIODIC REPORT OF DISABILITY OFFSET INCOME

The *Periodic Report of Disability Offset Income* form must be submitted as part of your documentation for initial or continued eligibility for disability benefits from the Delta Pilots Disability and Survivorship Plan (D&S Plan) in order to provide information concerning earned income from employment or self-employment (“Earned Income”) during the current calendar year. The information reported will be used to determine the initial amount of offset, if any, to your long-term disability benefits.

Your LTD benefit is offset dollar for dollar by the amount of your Earned Income from employment or self-employment that exceeds your LTD benefit. The definition of what is and is not Earned Income is provided below. For example, if your LTD benefit is \$10,000.00 per month and your Earned Income is \$10,001.00 dollars per month your monthly LTD benefit will be offset by \$1.00. Your new LTD benefit will be \$9999.00 per month.

**You are required to complete, sign and return the Periodic Report of Disability Offset Income form even if you have no actual or estimated Earned Income to report. Also, if you have updated information concerning the estimated Earned Income amount being used to offset your LTD benefit during the year, you are required to submit the form again so that the most accurate information possible is used to determine your offset. After the end of the calendar year, you will be required to submit verification and proof of your actual Earned Income and any overpayment or underpayment from the Plan will be determined at that time. Overpayments from the Plan may generally be repaid over a period of up to 48 months without interest, other than overpayments resulting from certain material misstatements or omissions made in an application or response to the Plan which are instead due and payable immediately.**

### EARNED INCOME DEFINED

#### **EARNED INCOME INCLUDES:**

1. Any salary or pay you received from any employer (excluding Delta Air Lines, Inc.) including overtime, vacation pay, bonuses, severance pay or similar payments.
2. If you are self-employed, any net profit you made from working or managing your own business. Net earnings from self-employment are shown on your Schedule SE.

Generally, all income subject to Federal employment taxes or self-employment income is considered Earned Income. It is reported on any W-2 statement issued by your employer or Schedule SE if you are self-employed.

#### **EARNED INCOME EXCLUDES:**

UNLESS received in the course of your trade or business, Earned Income excludes: any income reported on a Form 1099, such as annuities, pensions, Veterans benefits, and military retired pay, withdrawals from 401(k) plans, Social Security Disability Insurance payments, unemployment compensation, interest and dividends from savings accounts, stocks, personal loans, home mortgages, insurance proceeds, gifts, inheritances, estates, trusts, endowments, prizes, awards, gambling or lottery winnings, alimony/child support, scholarships or fellowships, pay for jury duty, capital gains from the sale of personal property, amounts received in court actions, and rents or royalties.


#### **IF YOU REQUIRE FURTHER ASSISTANCE COMPLETING THIS FORM:**

Call Harvey Watt weekdays at (404) 767-7501 or at (800) 241-6103. You may send written questions to:

Harvey Watt & Company  
P O Box 20787  
Atlanta, GA 30320

## PERIODIC REPORT OF DISABILITY OFFSET INCOME FORM

This form is required as part of your documentation for initial or continued eligibility for long-term disability benefits. The actual and estimated income reported here must be to the best of your knowledge and belief as of this time. Additionally, this form must be submitted anytime you have a material change to your estimated Earned Income to report. If you do not return this form in a timely manner, your LTD benefit payments may be affected. Return forms to Harvey Watt & Co., PO Box 20787, Atlanta, GA 30320.

<b>Disability Offset Income Certificate</b>		
Delta Air Lines Employee Number		HARVEY WATT CASE NUMBER
Last Name	First Name	Middle Initial
Address (Line 1)		
Address (Line 2)		
City	State	Zip Code
<b>I hereby report the following sources and actual and estimated amounts of earned income from employment/self-employment.</b>		
<b>EARNED INCOME FROM EMPLOYMENT AND SELF-EMPLOYMENT</b>		
<small>Please refer to the definition of Earned Income located on the instructions page.</small>		
Are you or do you expect to be self-employed or employed during the current year?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
If so, please enter your estimated Earned Income amount resulting from employment and self-employment for the current year.	\$ _____ Annual	
<b>AFFIDAVIT</b>		
<p>To the best of my knowledge and belief, the amount of actual and estimated income from employment benefits that I have reported on this form is true and correct. I understand that these self-reported amounts will be relied upon to determine my earned income offset to my disability benefits from the Delta Pilots Disability and Survivorship Plan. I further understand that I will be required to verify and submit proof of my actual year's earnings by May 15<sup>th</sup> following the end of the calendar year. At that time, my disability benefit amount will be recalculated if necessary and I may have an overpayment from the Plan that must be repaid by me without interest. If such recalculation results in an underpayment from the Plan, the Plan will pay me the additional amount without interest at that time. If a material change in my estimated income occurs after I have submitted this form, I agree to promptly notify the plan administrator of the change through submission of an updated form.</p>		
Signature of Employee	Date	
Printed Name of Employee		
Witness:		
		
Notary Public (Seal)	My Commission Expires:	

## INSTRUCTIONS FOR ANNUAL REPORT OF DISABILITY OFFSET INCOME

The *Annual Report of Disability Offset Income* survey form must be submitted as part of your application for disability benefits from the Delta Pilots Disability and Survivorship Plan (D&S Plan) to verify the amount of earned income from employment or self-employment ("Earned Income") paid to you during the most recently completed calendar year. This information is used to determine the amount of your final earned income offset against your LTD benefits paid from the D&S Plan. It is also used to estimate the offset against your LTD benefit for the remainder of the current calendar year. Additionally, the PWA requires you to report state disability benefits or workers compensation benefits received so that your LTD benefits under the D&S Plan may be appropriately offset.

Your LTD benefit is offset dollar for dollar by the amount of your Earned Income from employment or self-employment that exceeds your LTD benefit. The definition of what is and is not Earned Income is provided below. For example, if your LTD benefit is \$10,000.00 per month and you earn \$10,001.00 dollars per month from employment or self-employment, your monthly LTD benefit will be offset by \$1.00. Your new LTD benefit will be \$9999.00 per month.

Your LTD benefit is also offset dollar for dollar by the full amount of state disability benefits and workers compensation benefits.

**You are required to complete, sign and return the Annual Report of Disability Offset Income Survey (and any supporting documentation including W2s and Schedule SE if you have reported Earned Income) by May 15<sup>th</sup> of the current calendar year, even if you have no actual Earned Income benefits to report. After this information is processed your LTD benefit will be recalculated based on this information and you will be notified of any overpayment or underpayment from the Plan. This information will also be used to estimate the amount of your offset for the remainder of the current calendar year and your monthly benefits will be adjusted accordingly.**

### EARNED INCOME DEFINED

#### **EARNED INCOME INCLUDES:**

1. Any salary or pay you received from any employer (excluding Delta Air Lines, Inc.) including overtime, vacation pay, bonuses, severance pay or similar payments.
2. If you are self-employed, any net profit you made from working or managing your own business. Net earnings from self-employment are shown on your Schedule SE.

Generally, all income subject to Federal employment taxes or self-employment income is considered Earned Income. It is reported on any W-2 statement issued by your employer or Schedule SE if you are self-employed.

#### **EARNED INCOME EXCLUDES:**

UNLESS received in the course of your trade or business, Earned Income excludes: any income reported on a Form 1099, such as annuities, pensions, Veterans benefits, and military retired pay, withdrawals from 401(k) plans, unemployment compensation, interest and dividends from savings accounts, stocks, personal loans, or home mortgages, insurance proceeds, gifts, inheritances, estates, trusts, endowments, prizes, awards, gambling or lottery winnings, alimony/child support, scholarships or fellowships, pay for jury duty, capital gains from the sale of personal property, amounts received in court actions, and rents or royalties.


#### **IF YOU REQUIRE FURTHER ASSISTANCE COMPLETING THIS FORM:**

Call Harvey Watt weekdays at (404) 767-7501 or at (800) 241-6103. You may send written questions to:

Harvey Watt & Company  
P O Box 20787  
Atlanta, GA 30320

## ANNUAL REPORT OF DISABILITY OFFSET INCOME FORM

This form and the accompanying documentation are required as part of your application for long-term disability benefits. You must submit this form, as well as copies of your applicable W2s and Schedule SE **no later than May 31** even if you have no earned income or Social Security benefits to report. Any Earned Income reported must include the supporting documentation. Return forms to Harvey Watt & Co, PO Box 20787, Atlanta, GA 30320.

<b>Disability Offset Income Certificate</b>			
Delta Air Lines Employee Number		HARVEY WATT CASE NUMBER	
Last Name	First Name	Middle Initial	
Address (Line 1)			
Address (Line 2)			
City	State	Zip Code	
<b>EARNED INCOME FROM EMPLOYMENT AND SELF-EMPLOYMENT</b>			
<small>Complete this section with regard to Earned Income for the most recently completed calendar year.</small>			
Total the highest amounts (shown as "Social Security" or "Medicare Wages") shown on all your W-2s for the most recently completed calendar year			\$
Earned Income from self-employment shown on your Schedule SE for the most recently completed calendar year			\$
<b>Total Earned Income from Employment or Self-Employment</b>			<b>\$</b>
<b>You must include all supporting documentation of the Earned Income reported above, including copies of all W-2s received and a copy of your Schedule SE for the most recently completed calendar year</b>			
<b>AFFIDAVIT</b>			
<p>To the best of my knowledge and belief, the amount of actual earned income from employment and self-employment received by me as stated on this form is true and correct. I understand that the amount of earned income reported on this form will be used to determine the actual offset for other income against my LTD benefits for the preceding calendar year. To the extent that the estimates that I reported were more than or less than this actual amount, my LTD benefit will be adjusted and I may have been underpaid or overpaid from the D&amp;S Plan. I understand that the amount reported on this form will also be used to estimate my earned income for the remainder of the current calendar year for purposes of determining my LTD benefit offset for earned income.</p>			
Signature of Employee _____			Date _____
Printed Name of Employee _____			
Witness:			
		_____	
Notary Public (Seal)		My Commission Expires:	