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)

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 _____________

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)

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: ____
____

Name of Hospital: ______________________________ Address: ____
____

Telephone Number: _____________________________ ____

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

Reason for Admission: ____
____

PILOT APPLICATION FOR DISABILITY BENEFITS (Page 4)

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: _____________________________

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	____________________

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.

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: _____/_____/_____