



Dear Colleague:

American Airlines has partnered with Harvey Watt and Company as the Claim Administrator for the Pilot Long Term Disability Plan (the Plan). We have enclosed the Claim Application along with the Application Instructions to assist you with submission of the required forms, information and evidence to support of your claim. Please complete all forms and attach the required information as directed. If the information is incomplete, it may unnecessarily delay processing of your claim.

The Plan requires you to file your application “within one (1) year after the Pilot Employee’s date of Disability in order to be eligible for benefits”. We recommend you return the completed application as soon as possible to help expedite the processing of your disability claim.

In addition there are several aspects of your disability claim that you should be aware of:

- 1) **Initial Determination of Eligibility:** Harvey Watt will make an initial determination of your claim for benefits based on your application for disability, the medical evidence and other information you submit in support of it.
- 2) **Proof of Continuing Disability:** Harvey Watt will verify your continued disability, when and as often as may be reasonable but not more than once during a 90 – day period. This may include regularly scheduled reports from you and your attending physician(s) as well as Independent Medical Examinations (IME’s), Fitness for Duty Exams (FDE’s) and other required documentation.
- 3) **Return To Work (RTW):** The RTW process can be complex however; we will continue to assist you through this process. Depending on your disability, direct interaction with the FAA may be required. For this reason, prompt updates are required to keep your claim current. By signing the attached release, your medical file will be shared with Harvey Watt to ensure your prompt return to work. You should also notify your Flight Administration office of your intent to return to work (RTW) with a probable RTW date as soon as possible.

Thank you in advance for your anticipated cooperation.

Best Regards,
Flight Administration

Enclosures

American Airlines - Pilot Long Term Disability Claim Application Instructions

General Instructions:

Your claim application consists of four forms: (1) Employee Statement, (2) Authorization to Obtain Information, (3) Employer Statement and (4) Initial Physician's Statement. Please **fill in every space** – do not leave any blanks. If a particular section does not apply to you, or information is not available, write “**N/A**” in the space to indicate you have not overlooked that particular question. Sign and date forms as requested. This will prevent unnecessary delays in processing of your claim.

Forms – Overview:

1) Employee Statement:

This form provides HarveyWatt with required employee information. *If you are eligible for - or - are currently receiving benefits from Social Security, Workers' Compensation or State Disability you must attach copies of the applicable benefit determination notice.* This information is necessary to assure proper documentation and processing of your claim.

2) Authorization to Obtain Information:

Your signature on this form enables Harvey Watt to obtain the necessary information about you to determine your eligibility for benefits. This authorization also allows Harvey Watt to release this information to other people or organization(s) for specific purposes concerning your disability. You will receive a copy of this authorization upon request. This form *cannot be altered* in any manner.

3) Employer Statement:

This form is to be completed by your local Flight Administrator and provides Harvey Watt with the information regarding your last paid sick and vacation date.

4) Initial Physician's Statement: (Two-part form)

Section I - Employee completes. Section II - Physician completes, including signature. This statement should be completed by each physician (if more than one) who has examined you for your disability and include the appropriate supporting medical documentation*. Treating or examining physicians should not be related to you by blood, marriage or a domestic partner. You may copy this form or obtain additional copies from HarveyWatt. This form must be completed without cost to either HarveyWatt or American Airlines.

Completed Application:

Please return the Employer Statement to your base Flight Administrator. The Employee Statement, Authorization and Initial Physician's Statement including all supporting documentation should be sent to HarveyWatt at:

Harvey Watt & Company – Claims Department
P.O. Box 20787 Atlanta Airport
Atlanta, GA 30320
Fax: 404-761-8326

*** FAILURE TO PROVIDE COMPLETE AND ACCURATE SUPPORTING INFORMATION MAY DELAY OR JEOPARDIZE THE DETERMINATION OF YOUR CLAIM. (See Physician's Statement for examples of supporting documentation.)**

**AMERICAN AIRLINES PILOT LONG TERM DISABILITY
EMPLOYEE STATEMENT**

*RETURN COMPLETED FORM TO HARVEY WATT

In order to properly process your disability claim Harvey Watt must receive all portions of the claim paperwork completed in full.

EMPLOYEE:

Full Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Cellular Telephone Number: _____

Fax Telephone Number: _____ Employee Number: _____

Date of Birth: _____ Last 4 digits of Social Security Number: _____

Email Address: _____

Claim Information

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

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

Normal Occupation: _____

Date Sick Leave commenced: ____/____/____ Approximate date Sick Leave exhausts: ____/____/____

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

Current () Date ____/____/____ Lapsed () Date ____/____/____ Deferred () Date ____/____/____

Revoked () Date ____/____/____ Denied () Date ____/____/____

Complete this section ONLY if your disability is due to ILLNESS:

Nature of Illness: _____

Cause of Illness: _____

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

List of ALL symptoms: _____

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

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

**AMERICAN AIRLINES PILOT LONG TERM DISABILITY
EMPLOYEE STATEMENT**

Complete this section ONLY if your disability is due to INJURY:

Complete description of Injury: _____

Cause of Injury: _____

Date of Accident: ___/___/___ Time of Accident: _____ Injury on Duty? Yes () No ()

Location of Accident: _____

Attending Physician Information (Attending Physician must not be related by blood, marriage or a domestic partner)

Name of Physician: _____
Mailing Address: _____
City: _____ State: _____
Zip Code: _____ Fax Telephone Number: _____

List any other physicians consulted for this illness or injury:

Name: _____ Address: _____

Telephone Number: _____

Name: _____ Address: _____

Telephone Number: _____

List all periods of hospital admission for the past five years that pertain to or may pertain to either my medically disabling condition or disqualifying condition:

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: _____

AMERICAN AIRLINES PILOT LONG TERM DISABILITY EMPLOYEE STATEMENT

PRIOR DISABILITY CLAIM HISTORY: List ALL Illnesses and Injuries for which you have filed a disability claim and/or had treatment over the past five years. Be sure to include those claims or treatment that pertain to or may pertain to either your medically disabling condition or disqualifying condition. (Please attach additional pages if more space is needed):

Name of Physician: _____ Address: _____

Telephone Number: _____

Date(s) of Treatment: _____

Reason for Treatment: _____

Name of Physician: _____ Address: _____

Telephone Number: _____

Date(s) of Treatment: _____

Reason for Treatment: _____

Name of Physician: _____ Address: _____

Telephone Number: _____

Date(s) of Treatment: _____

Reason for Treatment: _____

Are you receiving, eligible to receive or have you applied to receive benefits from: (check YES or NO)

	Eligibility	Applied for Benefits	Application Date Receiving
Social Security	() Yes () No	() Yes () No	_____ () Yes () No
Workers' Compensation	() Yes () No	() Yes () No	_____ () Yes () No
State Disability	() Yes () No	() Yes () No	_____ () Yes () No

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

Other earned income : () Yes () No () Yes () No _____ () Yes () No

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

If you become eligible to receive or receive these benefits or any other applicable income 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.

**AMERICAN AIRLINES PILOT LONG TERM DISABILITY
EMPLOYEE STATEMENT**

Agreement to Reimburse Overpayment of Long Term Disability Benefits

If I receive a disability benefit payment(s) greater than that which should have been paid, I understand and agree that the Plan has the right to recover such overpayment from me in any manner available, including the right to reduce or cease future payments from the Plan or from American Airlines after I return to work from LTD, and I hereby authorize the deduction of any such overpayment from either my LTD payment or payroll check.

I understand that if I fail to apply for Social Security Disability Benefits or furnish a copy of the Social Security award or denial letter within six months after the disability claim is approved, my benefits under the Plan may be offset by an estimated Social Security Disability award amount.

I understand that I am required to furnish evidence of my initial and continued disability as required and directed and that may include furnishing medical records from any or all providers of medical treatment.

I understand that I am required to pursue appropriate qualified medical care and treatment of my disabling condition. Such qualified medical care must be consistent with the nature of my illness or injury. I understand that my Disability will cease to exist if my health is restored so as not to prevent me from acting as an Active Pilot Employee in the service of the Company.

I understand that my LTD payments will cease the day prior to my release to return to work.

I understand that any disability benefit that I receive will be subject to all of the terms and conditions of the plan.

I certify that the information provided by me in support of this claim is true and correct. I understand that any intentional misrepresentation or falsification of information will be reported to American Airlines and could result in disciplinary action.

Printed Name: _____

Signature: _____

Date: ____/____/____



P. O. BOX 20787, ATLANTA, GA 30320 / TELEPHONE (404) 767-7501 or (800) 241-6103 / FAX(404) 761-8326 / <http://www.harveywatt.com>

HIPAA : This Authorization has been carefully and specifically drafted to permit disclosure of health information consistent with the privacy rules adopted and subsequently amended by the United States Department Health and Human Services pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Instructions for completing the form:

1. Complete all applicable areas of the form.
2. If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Employee/Claimant’s behalf.
3. Sign this form.
4. Fax or return this form as soon as possible to expedite processing of your claim – retain original for your records.

Your refusal to complete and sign this form may affect your eligibility for benefits under your employer’s disability plan.

	/	
Name of Employee (Please Print)	Last 4 Digits of Social Security Number	Claim Number

Authorization to Disclose Information

For purposes of determining my eligibility for disability benefits, the administration of my employer’s disability benefit plan (which may include assisting me in returning to work), and the administration of other benefit plans in which I participate that may be affected by my eligibility for disability benefits, I permit the following disclosures of information about me to be made in the format requested, including by telephone, fax or mail:

1. **I permit:** any physician or other medical/treating practitioner, hospital, clinic, other medical related facility or service, insurer, pharmacy benefit managers, employer, government agency, (for example, including without limitation the Pension Benefit Guaranty Corporation, Federal Aviation Administration, and Social Security Administration), group policyholder, contract holder or benefit plan administrator to disclose, exchange, discuss or release to Harvey Watt & Company (“Harvey Watt”), my employer or any, investigative agencies, attorneys, and independent claim administrators acting on Harvey Watt’s behalf, any and all information about my disability claim, including health, medical, and employment information.
2. **I permit** Harvey Watt to disclose, exchange, discuss or release to my employer or to any parties required in the administration of this plan, any and all information about my disability claim, including health, medical, employment information.

This Authorization to Disclose Information Includes the Following Information:

Charts, notes, x-ray reports, operative reports, lab and pharmaceutical or medication records and all other medical information, including surgical notes, 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 or sexually transmitted 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.

I understand that I may revoke this authorization at any time by writing to Harvey Watt and Company at P.O. Box 20787, Atlanta, GA 30320, except to the extent that action has been taken in reliance on it. A revocation of this authorization or the failure to sign this authorization:

- May impair Harvey Watt’s ability to evaluate or process my claim for benefits.
- May also impair the 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.



P. O. BOX 20787, ATLANTA, GA 30320 / TELEPHONE (404) 767-7501 or (800) 241-6103 / FAX(404) 761-8326 / <http://www.harveywatt.com>

I understand that the information disclosed to Harvey Watt and my employer pursuant to this authorization may be subject to redisclosure and that information, once disclosed, with my authorization or as otherwise permitted or required by law may no longer be protected by federal rules governing privacy and confidentiality.

I understand and agree that this authorization will be valid for 12 months from the date I sign this form or the duration of my claim for benefits, whichever period is shorter. A photocopy of this authorization is as valid as the original form and I have a right to receive a copy upon request.

I hereby authorize any and all of my health care providers to disclose medical record information and/or protected health information to the following:

**Harvey Watt & Company
Attn: Claims Department
P.O. Box 20787
Atlanta, GA 30320
FAX: 404-761-8326**

I have read both pages of this authorization and understand that by my signature I agree to both pages of this authorization.

Signature of Employee

Date



**AMERICAN AIRLINES PILOT LONG TERM DISABILITY
EMPLOYER STATEMENT**

P. O. BOX 20787, ATLANTA, GA 30320 / TELEPHONE (404) 767-7501 or (800) 241-6103 / FAX (404) 761-8326 / <http://www.harveywatt.com>

* FORM TO BE COMPLETED BY BASE FLIGHT ADMINISTRATOR

EMPLOYEE:

Full Name: _____

Base/Station: _____ Employee Number: _____

Date of Birth: _____ Last 4 digits of Social Security Number: _____

Email Address: _____

Claim Information

Date Sick Leave commenced: ____/____/____

Last day paid sick and/or accrued vacation pay ____/____/____

Printed Name of Flight Administrator: _____

Signature: _____

Date: ____/____/____

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INITIAL PHYSICIAN'S STATEMENT

RETURN COMPLETED FORM TO
Harvey Watt & Company
P. O. Box 20787
Atlanta, GA 30320 FAX | 404-761-8326

In order to assist us in expediting the processing of the disability claim for the employee, we require you to complete this form in full, enclose the necessary documentation and return it to us.

The patient is responsible for the completion of this form and the attachment of the necessary documentation without any expense to either American Airlines or Harvey Watt & Company.

TO BE COMPLETED BY PATIENT: (SECTION I)

Patient:	_____	Doctor:	_____
Address:	_____	Address:	_____
_____	_____	_____	_____
Phone Number:	_____	Phone Number:	_____
Height of Patient:	_____	Fax Number:	_____
Weight of Patient:	_____	Specialty:	_____
Date of Birth:	_____	_____	_____
Social Security Number:	_____ (last four digits)	_____	_____

TO BE COMPLETED BY PHYSICIAN, not related by blood, marriage, or a domestic partner: (SECTION II)

DIAGNOSIS:

Primary:	_____	Secondary:	_____
Primary ICD-9 Code:	_____	Secondary ICD-9 Code:	_____
Primary PCT-4 Code (if applicable):	_____	Secondary PCT-4 Code (if applicable):	_____
Date Patient first consulted for this disability:	_____	Date symptoms first appeared for this disability:	_____

LIST ALL DATES OF SERVICE: (mm/dd/yyyy)

LIST ALL LOCATIONS OF SERVICE: (facility, address)

(a) HOSPITALIZATION: 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)

(b) OTHERPHYSICIANS: List the names and address of ALL consulting physicians for the listed disability

(c) PROGNOSIS: Detailed Prognosis for Return to Work

Physician completing this form confirms he or she is not related to patient by blood, marriage or a domestic partner:

Printed Name:

Signature:

Date:
