# Pilot Disability Salary Continuation (SALCO) or Loss of Aviation Medical Certificate Disability (LOM)

## Claim Application Instructions

**GENERAL INSTRUCTIONS:**

In preparation for your 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 to Harvey Watt & Company as early as possible during your absence.

**Important Note**: Incomplete, altered, or missing forms or lack of medical information substantiating your claim may 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, every space on every form must be completed. Sign and date forms as requested.

*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.*

Please remit the forms including all supporting documentation and medical records to initiate processing of your disability claim to Harvey Watt & Company.

Harvey Watt & Company – Claims Department
P.O. Box 20787 Atlanta Airport
Atlanta, GA 30320

Phone number: 800-241-6103
Fax number: 404-761-8326
Email: njapilot@harveywatt.com

**If you do not hear from Harvey Watt within 7 days of mailing or 3 business days of emailing your application, you should contact Harvey Watt to confirm that your application was received**.

---

**FORMS – OVERVIEW (Return ALL completed forms to Harvey Watt & Company):**

☐ **PILOT SALCO FREQUENTLY ASKED QUESTIONS (FAQ'S)**

This document is provided to answer many of the questions that normally arise when a Pilot is absent from work on medical leave and is receiving SALCO benefits. Please review it carefully and keep for your records.

☐ **DISABILITY SALARY CONTINUATION BENEFITS (SALCO SUPPLEMENTATION FORM)**

This form is required to establish your understanding of the eligibility requirements to return to work and to report your elections for use of available PTO and/or Vacation days during your absence.

☐ **EMPLOYEE'S APPLICATION FOR SALCO AND/OR LOM**

This form provides the required information to apply for SALCO and/or LOM. *If you are eligible for - or - are currently receiving benefits from another source (i.e.* Social Security, State Disability, etc.) you must attach a copy of the benefit determination notice(s) as it may affect the amount of your benefit. This information is necessary to assure proper documentation and administration of your claim.

☐ **AUTHORIZATION TO OBTAIN INFORMATION:**

Your signature on this form enables Harvey Watt & Company to obtain 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 and will be updated annually during your period of Disability.

☐ **INITIAL PHYSICIAN'S STATEMENT:** (TWO-PART FORM)

**Section I** - applicant 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 or marriage. You may copy this form or obtain additional copies from Harvey Watt & Co. This form must be completed without cost to either Harvey Watt & Co. or NetJets Aviation, Inc.

## FORM REQUIRED FOR ONGOING SALCO AND/OR LOM DISABILITY

☐ **UPDATED PHYSICIAN'S STATEMENT**

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.

## RETURNING TO WORK

NetJets hopes that you recover from your disability and return to active employment. The following information may help you return to work after being on either SALCO or LOM.

Prior to your return to work, you must provide Harvey Watt with a current fitness for duty release from your doctor, including but not limited to the enclosed Return to Work Certification and a valid First-Class Medical Certificate permitting you to return to work. Harvey Watt will advise NetJets when they are in receipt of these documents so the return to work process can begin.

If you have been on leave for 180 days or more, you will also be required to take a drug test and receive a verified negative test result before you may return to work. Failure to provide the required documents or submit to a drug screen in a timely manner will result in a delay in your return from leave and being placed back on regular payroll.

*** 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.)**

NETJETS®

**Disability Salary Continuation (SALCO) Benefits**

A crewmember who qualifies as disabled will receive SALCO benefit payments at a rate equivalent to 60 percent of his/her base salary on the date of disability for a period of 180 days. Accrued but unused Paid Time Off ("PTO") and/or Vacation days may be utilized to increase SALCO benefit payments on a day-for-day basis to a rate equivalent to 100 percent of a crewmember's base salary in effect on the date of disability.

Prior to being eligible to return to work from a medical leave of absence, a pilot must provide the leave administrator and the crew records department with a copy of his/her valid First Class Medical Certificate or – in the event a pilot is unable to qualify for a First Class Medical Certificate – a copy of his/her valid Second Class Medical Certificate, including in either case all required supporting documentation (e.g., special issuance letters). The requirement to provide a valid medical certificate and supporting documentation is inapplicable if a pilot returns to work under the same FAA Medical Certificate that was in effect on the date of disability.

Please indicate your understanding of your obligation to provide a valid medical certificate and any required supporting documentation prior to return to work from medical leave of absence by initialing the box below.

☐

Please provide the following information:

Printed Name: _____ Date: _____

Home Phone: _____ Cell Phone: _____

Email (non-Company): _____

As noted at the top of this form, accrued but unused PTO and/or Vacation days may be utilized to increase your SALCO benefit payments to 100% of your base salary in effect on the date of disability.

Supplementation (choose one):

1. ☐ I would like to supplement my absence with **my leave banks** in the following order. I understand that if I am still in SALCO status after the voluntary supplementation options I have selected below have been exhausted, my active PTO will be burned down on a per workday basis until seven (7) days remain. (please rank in numerical order, selecting **only** those banks you would like to use for supplementation)

   ☐ Active PTO (Mandatory supplementation)
   ☐ Active PTO remaining after mandatory burn (7 days) #____ days
   ☐ Long term PTO #____ days
   ☐ Vacation, prioritized in the following order (e.g., Dec. 31st week, November 26th week, etc.)

   ___Week, _____

2. ☐ I would like to supplement any month in which I will not otherwise accrue vacation and PTO, **with_____ days of accrued leave per month.** I understand that I must select at least three (3) days per month in this section in order to accrue vacation and PTO. (please rank in numerical order, selecting only those banks you would like to use for supplementation):

   ☐ Active PTO remaining after mandatory burn (7 days) #____ days

□ Long term PTO # ____ days
□ Vacation, prioritized in the following order (e.g., Dec. 31st week, November 26th week, etc.)

___Week, _____

3. □ **I do not wish to supplement my SALCO payments**. I understand that my pay will drop to 60% of my base wages after my active PTO has been burned down to seven (7) days remaining, and that I will not accrue vacation or PTO time for any month in which I do not work at least one day, or supplement with at least three days.

*If you wish to change the above selections at any point during your medical leave, or if you would like to supplement in a manner that is not specified above, please email loarequest@netjets.com.

Crewmember Signature _____ Date _____

Completed forms must be sent back to Harvey Watt or faxed to NetJets LOA dept. at **614-238-2205**

**Harvey Watt**
**800-241-6103**

# NETJETS PILOT SALCO FAQ

**NetJets LOA Team**
**Kim Blazek (614) 849-7394**
**Annie Myers (614) 849-7699**
**LOARequest@netjets.com**

**What is SALCO and how long is it in effect?**

Your SALCO (Salary Continuation) benefit is disability pay for a non-work-related illness or injury. It can extend for up to 180 days from the date of your disability (with appropriate documentation from your physician). [Ref. CBA Section 24.4(A), 24.4(A)(1)]

**How long can my medical leave last?**

Your medical leave may extend up to three years when medically necessary as determined by a medical doctor or other qualified health care professional. [Ref. CBA Section 16.3(A)]

**How much does SALCO pay?**

SALCO benefit is 60% of your base salary. [Ref. CBA Section 24.4(A)(1)] The benefit is paid by NetJets on a biweekly basis applying all payroll deductions, taxes, etc.

**Am I required to use banked time to supplement my SALCO leave?**

Per the CBA you will be required to supplement SALCO benefits with all but 7 days of accrued PTO (Active and Long-Term banks combined) if your leave is FMLA-eligible [Ref. CBA Section 16.3(B)(1)]. You may elect to first use days from your long-term PTO bank or your Active bank. (Please refer to the supplementation form in this packet.) If you do not make an election, the Company will make the election for you. You may also choose to use accrued but unused vacation to supplement SALCO benefits.

**Will I accrue vacation/sick days while on medical leave?**

Generally, you will not accrue additional PTO credits or vacation time while on an approved Leave of Absence. However, pursuant to LOA 08-002, you will accrue PTO and vacation for any month in which you utilize more than 3 supplementation days.

**What happens to the vacation that is on my schedule while I'm on medical leave?**

Any vacations that occur while you are on medical leave will automatically be banked if you don't request to use them to supplement your SALCO benefit. You will work with Bidding (bidding@netjets.com) after your return from leave to have the vacation(s) rescheduled. ***Your vacation will not be paid out where it is on your schedule unless you indicate that you want to use it to supplement your SALCO benefit.***

**What happens to my health insurance while I'm on medical leave?**

Your health insurance coverage (medical, dental, vision, Rx) remains in effect for the entire duration of your medical leave (up to 3 years).

**While on medical leave what happens to my iPhone and iPad?**

Your company-issued devices will be deactivated if you are on leave for 90 days or more. For questions regarding this, please contact Wireless Support directly at (614)239-5499. While on leave you can log in to Outlook Web Access (OWA) from any computer to access your company email. The website is OWA.netjets.com.

**What is required of me to return to work?**

Prior to your return to work, you must provide Harvey Watt with a current fitness for duty release from your doctor and a valid first-class medical certificate permitting you to return to work. Harvey Watt will advise NetJets when they are in receipt of these documents so the return to work process can begin. If you are on leave for 180 days or more, you will also be required to take a drug test and receive a verified negative test result before you may return to work. **IMPORTANT.** Please review Section 16.3(A) of the CBA regarding what happens if you provide less than 30 days-notice of your return to work date. If you have questions about this requirement in Section 16.3 (A) please contact the NetJets LOA Administrator.

**What steps should I take if I want to extend my maternity disability leave with FMLA bonding leave?**

You will need to be released by your physician before bonding leave can be granted. If you have not exhausted your FMLA allotment, please notify Unum of your intent to take bonding time (preferably with a 30-day notice). Also, please notify NetJets (LOARequest@netjets.com) of the dates you would like as bonding and if you want to supplement the FMLA.

# Important Information About NetJets' Family and Medical Leave Policy

## How is My FMLA Entitlement Calculated?

If you are eligible and your leave qualifies, you have the right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as a "rolling" 12-month period measured backward from the date of any FMLA leave usage.

## What if I Need Additional Leave?

If you need an extension of your leave, you should notify Unum. You will be required to provide additional certification of the serious health condition.

**What if I Need Work Place Assistance?** - If your leave request is for your own serious health condition and there is need for workplace assistance, please contact LOARequest@netjets.com immediately for further discussion. Unum assists your Employer in identifying reasonable modifications that may assist you in performing your job. You will receive any future communications about a workplace assistance request in a separate communication.

## How Do I Notify Unum and My Supervisor of My Return to Work (RTW) Plans?

If you are able to return to work sooner than your current estimated return to work date, you should notify Unum and your supervisor or the LOA Department as soon as practicable.

If your leave is for your own health condition, you will not be required to present your employer with a fitness-for- duty (RTW) certificate as a condition of being restored to employment, unless it is specifically requested by the LOA Department.

## How Should I Report Intermittent Absences to Unum?

If you have been approved for intermittent leave, you must notify Unum within 2 days each time you need to use intermittent leave. Please also notify your supervisor. Otherwise, your leave under the FMLA and/or State leave law, where applicable, may be delayed/denied.

## Do I Need to Use Vacation/Sick/PTO While on Leave?

You may use accrued PTO during any otherwise unpaid FMLA and/or state leave unless otherwise mandated by state law. Any days taken under FMLA and/or state leave law will be counted against your available leave, even if paid time off is utilized.

Please contact your supervisor or payroll department at (614) 239-5334 regarding how much paid time off you have available. If you do not meet the terms and conditions of your employer paid leave program for your leave, your entitlement to take unpaid FMLA will not be affected.

After you have exhausted your paid leave, the remainder of your leave will be without pay. You may use your accrued paid time off to supplement your Short-Term Disability; however, if you are receiving workers' compensation, then you may not use your accrued paid time off.

## Will My Benefits Continue While I Am on Leave?

***Health Insurance:***

During your leave, your employer will continue to pay its portion of your group health insurance premiums and you must pay your share, if any, of the health insurance premiums.

- During paid leave, your share of the premiums will continue to be paid through payroll deductions.
- During unpaid leave, your employer will provide you with information regarding arrangements for payment of your share of the premiums. Please contact your benefits department at compandbenefits@netjets.com for more information regarding payments for benefit continuation during your leave.

You have a 30-day grace period in which to make such premium payments. If you do not pay your share of the insurance premiums on a timely basis, your insurance coverage for yourself and/or your dependents may be terminated for the remainder of your leave.

***Other Benefits (Supplemental Life, Disability, etc.):*** Your employer will continue other benefits (e.g., life insurance, disability insurance, etc.) while you are on leave, provided you continue to pay the premiums for the benefits in a timely manner. Please contact your benefits department at compandbenefits@netjets.com for information regarding your other benefits during your leave.

## Are There Other Types of Leave Available?

For information regarding other types of leave possibly available through your employer, please contact LOARequest@netjets.com.

NETJETS

# EMPLOYEE'S APPLICATION FOR PILOT DISABILITY SALARY CONTINUATION (SALCO) OR LOSS OF AVIATION MEDICAL CERTIFICATE DISABILITY (LOM)

NetJets Aviation, Inc.
SALCO and LOM
Disability Plans
800-241-6103

**Return Completed form to:**

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

**THIS APPLICATION IS FOR [ ] SALCO [ ] LOSS OF MEDICAL DISABILITY**

**CLAIMANT:**

Full Name:_____Employee ID Number_____

Street Address: _____

City:_____State:_____Zip Code: _____

Telephone Number:_____Secondary Telephone Number: _____

Date of Birth:_____Email Address: _____

---

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

Date first absent from work due to Disability:____/____/____

Fleet and Rank:_____Chief Pilot_____

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

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

Current ( ) Date____/____/____ Lapsed ( ) Date____/____/____

Revoked ( ) Date____/____/____ Denied ( ) Date____/____/____

---

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

Impact of Illness (on daily functioning): _____

Cause of Illness: _____

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

List of ALL symptoms and history of illness (non-pregnancy): _____

_____

_____

_____

_____

_____

**If disability is due to pregnancy, please indicate actual/estimated delivery date:**____/____/____

Type of delivery, if applicable: [ ] Vaginal [ ] C-Section [ ] Multiple Births

---

NETJETS

**EMPLOYEE'S APPLICATION FOR SALCO OR LOM DISABILITY (Page 2)**

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

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

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

**Was this a work-related or on the job injury (OJI)? ( ) Yes ( ) No**

Complete description of Injury: _____

Cause of Injury: _____

Date of Injury:_____/_____/_____ Time of Injury:_____

Location of Injury: _____

Attending Physician Information:

Name of Physician: _____

Mailing Address: _____

City:_____State:_____Zip Code: _____

Telephone Number:_____Fax 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:_____/_____/_____Through:_____/_____/_____

Reason for Admission: _____

NETJETS

**EMPLOYEE'S APPLICATION FOR SALCO OR LOM DISABILITY (Page 3)**

Name of Hospital:_____Address: _____

_____

Telephone Number: _____ _____

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

Reason for Admission: _____

_____

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

| | Eligibility | Applied for Benefits | Application Date | Receiving | Date First Received |
|---|---|---|---|---|---|
| State Disability | ( ) Yes ( ) No | ( ) Yes ( ) No | _____ | ( ) Yes ( ) No | _____ |
| Social Security Disability | ( ) Yes ( ) No | ( ) Yes ( ) No | _____ | ( ) Yes ( ) No | _____ |
| Other | ( ) Yes ( ) No | ( ) Yes ( )No | _____ | ( ) Yes ( ) No | _____ |

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

_____

_____

If you become eligible to receive or receive these benefits at a later date, you must notify Harvey Watt & Company immediately. You must also provide copies of all letters denying or awarding any benefits for which you have applied.

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

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

I understand that I am required to furnish evidence of my continued disability and 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 could result in disciplinary action, up to and including termination of employment.

**Notification:** If applying and approved for Loss of Medical Disability benefits, these benefits will begin on the 181st day of disability in accordance with section 24.5 of the CBA.

Printed Name: _____

Signature: _____

Date:_____/_____/_____

NETJETS

# INITIAL PHYSICIAN'S STATEMENT

NetJets Aviation, Inc.
SALCO and LOM
Disability Plans
800-241-6103

**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 submitting the completed forms and necessary documentation without any expense to either the NJA SALCO or LOM Disability Plans or to Harvey Watt & Company. 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-9/10 Code:

Primary CPT-4 Code (if applicable):

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

Secondary Diagnosis:

Secondary ICD-9/10 Code:

Secondary CPT-4 Code (if applicable):

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

**LIST ALL DATES OF SERVICE:**

**DATE OF NEXT SCHEDULED VISIT:** ____/____/____

**LIST ALL LOCATIONS OF SERVICE:**

NETJETS

## INITIAL PHYSICIAN STATEMENT (Page 2)

**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.):**

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

**List all medications including name, dose, frequency and start date:**

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

**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 up to 25lbs for short periods |
| ☐ | Heavy | 51 to 100 lbs lifting; carry objects up to 50lbs |

**These restrictions are in effect until_____(date) or until Plan Participant is reevaluated on_____(date).**

**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.):**

NETJETS

## INITIAL PHYSICIAN STATEMENT (Page 3)

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

**Detailed Prognosis for Return to Work:**

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

**( ) Regressed ( ) Unimproved ( ) Improved ( ) Recovered**

**Do you believe the patient is now able to perform the duties of his/her customary occupation as a NetJets pilot? ( ) Yes ( ) No**

**Do you believe the patient is now able to exercise the privileges of a Federal Aviation Administration First Class Medical Certificate? ( ) Yes ( ) No**

**Date patient was able to return to his/her customary occupation as a NetJets pilot:**

**Estimated date patient will be able to return to his/her customary occupation as a NetJets pilot:**

**NOTE: If duration of disability exceeds a 14-day period for SALCO or 90-day period for LOM, all medical documentation may be requested for each subsequent 14-day or 90-day period.**

**Physician completing form:**

Printed Name:

Signature: Date:

NETJETS

## AUTHORIZATION TO OBTAIN / RELEASE INFORMATION

NetJets Aviation, Inc.
SALCO and LOM
Disability Plans
800-241-6103

**Return Completed form to:**

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

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

**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 or other medically-related facility or association.
- Any insurance company, employer or plan sponsor.
- Any organization or entity administering a benefit program.
- Any educational, vocational or rehabilitation organization or program.
- Any government agency, *including but not limited to, Federal Aviation Administration, Social Security Administration, Pension Benefit Guaranty Corporation, Worker's Compensation Board, etc.*)

**To give the following information:**

- Charts, notes, x-ray reports, operative reports, lab and pharmaceutical or medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Also, information regarding prognosis and treatment of any physical or mental condition relating to my request for disability leave, 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, claim status, benefit amounts and effective dates, etc.*)

**To Harvey W. Watt & Co., Inc. and/or NetJets Aviation, Inc. and any of its subsidiaries:**

- I understand that Harvey W. Watt & Co., Inc. (Harvey Watt), the NJA SALCO and LOM Disability Plans, NetJets Aviation, Inc. and any of its affiliates and subsidiaries, will use the information only to evaluate my eligibility for SALCO or LOM 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 SALCO and/or LOM 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 Plans
    - 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

NETJETS

# Authorization to Release Information (page 2)

- I understand that Harvey Watt and the SALCO and/or LOM Disability Plans may disclose medical, financial and other information contained in my disability file to NetJets, its employees or non-affiliated parties, such as a plan administrator, or persons performing business or legal services for Harvey Watt, NJA or the SALCO and/or LOM Plans strictly as it pertains to the administering of my claim for disability benefits.
- I understand that the information disclosed to Harvey Watt and/or NetJets pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the federal privacy regulations 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 may not be altered in any way.
- I understand that this authorization supersedes any authorization that was submitted prior to the date of this form.
- I have read both pages of this authorization and understand that by my signature I agree to both pages of this authorization.

| Printed Name of Claimant | Employee Number | Date of Birth |
|---|---|---|

| Signature of Claimant /Guardian/Representative | Date |
|---|---|

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

NETJETS

# UPDATED PHYSICIAN'S STATEMENT

NetJets Aviation, Inc.
SALCO and LOM
Disability Plans
800-241-6103

**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 submitting the completed forms and necessary documentation without any expense to either the NJA SALCO or LOM Disability Plans or to Harvey Watt & Company. 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 <u>PHYSICIAN</u>:**

**DIAGNOSIS:**

Primary Diagnosis: _____

Primary Diagnosis ICD-9/10 Code: _____

Primary Diagnosis CPT-4 Code (if applicable): _____

Secondary Diagnosis: _____

Secondary Diagnosis ICD-9/10 Code: _____

Secondary Diagnosis CPT-4 Code (if applicable): _____

DATE OF LAST MEDICAL UPDATE SUBMITTED TO HARVEY WATT: _____

LIST <u>ALL</u> DATES OF SERVICE SINCE_____:

Detailed description/history *<u>INCLUDING</u>* 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.):

NETJETS

## UPDATED PHYSICIAN'S STATEMENT (Page 2)

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

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

**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 up to 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).**

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

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

Do you believe the patient is now able to perform the duties of his/her customary occupation as a NetJets pilot?
( ) Yes ( ) No

**Do you believe the patient is now able to exercise the privileges of a Federal Aviation Administration First Class Medical Certificate? ( ) Yes ( ) No**

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

Actual date (if known) patient was able to return to his/her customary occupation:

Estimated date patient will be able to return to his/her customary occupation:

NOTE: If duration of disability exceeds a 14-day period for SALCO or 90-day period for LOM, all medical documentation will be required for each subsequent 90-day period.

**Physician completing form:**

Printed Name:

Signature: Date:

NETJETS®

**Return to Work Certification**

**Health Care Provider:** Please complete this form using extra sheets if needed and return to employee.

**Employee:** deliver completed form to LOA Department as soon as possible via fax to **(614) 238-2205** or email njapilot@harveywatt.com and keep a copy for your records. Failure to return this form in a timely manner will result in a delay to your return to work and your next scheduled paycheck.

**Employee Name (Print) _____**

☐ **The above employee may return to work with NO RESTRICTIONS on _____.**

☐ **The above employee may return to work WITH RESTRICTIONS from _____ to _____.**
*** Please complete the work capabilities below if there **are restrictions**:*

| **% of Workday or Repetitions/Hour** | **Occasionally 1-33% 4-6 times/hour** | **Frequently 34-66% 6-12 times/hour** | **Continuously 67-100% >12 times/hour** |
|---|---|---|---|
| Lift/Carry | | | |
| Up to 10 lbs | | | |
| 11-29 lbs | | | |
| 30+ lbs | | | |
| Bend | | | |
| Twist/Turn | | | |
| Reach below knee | | | |
| Lift above shoulders | | | |
| Push/Pull | | | |
| Squat/Kneel | | | |
| Stand | | | |
| Walk | | | |
| Sit | | | |
| Repetitive activities | | | |

☐ **No lifting greater than _____lbs.** **No use of ☐ Left ☐ Right ☐ Both ☐ Hand(s) ☐ Arm(s) ☐Leg(s) ☐Other _____.**

☐ **Change positions every _____.** ☐ **Avoid driving/operating heavy machinery**

**These restrictions are ☐ permanent ☐ temporary. Duration if temporary: _____.**

☐ **Follow-up appointment scheduled for _____.**

Health Care Provider Printed Name _____

Health Care Provider Signature _____ Date _____

Address _____ Phone _____

**Employee Signature** _____Date _____