EMPLOYEE'S STATEMENT

Southwest Airlines Co.
Loss of License Plan

Return Completed form to:

Harvey W. Watt & Co.
P. O. Box 82876
Atlanta, GA, 30354
PH. (800) 241-6103
FAX (404) 761-8326
southwest@harveywatt.com
www.harveywatt.com

In order to properly process your disability, claim we must receive all portions of the claim paperwork completed in full. We must receive a) the Employee's Statement, b) Physician's Statement and c) the Authorization to Obtain Information form with all necessary supporting documentation.

CLAIMANT:

Full Name: _____ Employee Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Secondary Telephone Number: _____

Date of Birth: _____

Email Address: _____ Personal Email Address: _____

Sources of ALL disability insurance you carry: _____

Claim is for Southwest Airlines Co. Loss of License Plan

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

Date Long Term Coverage became effective: ___/___/___ Are you working now? ( ) Yes ( ) No

Normal Occupation: _____

Date you either resumed work or plan to resume work: ___/___/___

List name of employers and dates of employment: _____

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 all symptoms: _____

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

If yes list dates of previous treatment(s): ___/___/___, ___/___/___, ___/___/___, ___/___/___

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

Complete Description of Injury: _____

Cause of Injury: _____

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

Location of Accident: _____

Attending Physician Information:

Name of Physician: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Telephone Number: _____

List any other physicians consulted for this illness or injury:

Name: _____ Address: _____

Telephone Number: _____

Name: _____ Address: _____

Telephone Number: _____

Name: _____ Address: _____

Telephone Number: _____

List all periods of hospital admission for the past five years:

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: _____

List ALL Illnesses and Injuries for which you have had treatment over the past five years. (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:

	Eligibility	Applied for Benefits	Application Date	Receiving Benefits
Social Security	( ) Yes ( ) No	( ) Yes ( ) No	_____	( ) Yes ( ) No
Worker's Compensation	( ) Yes ( ) No	( ) Yes ( ) No	_____	( ) Yes ( ) No
State Disability	( ) Yes ( ) No	( ) Yes ( ) No	_____	( ) Yes ( ) No
Retirement	( ) Yes ( ) No	( ) Yes ( ) No	_____	( ) Yes ( ) No
Other:	( ) Yes ( ) No	( ) Yes ( ) No	_____	( ) Yes ( ) No

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

If you become either eligible to receive or begin receiving any of these benefits at a later date, both Harvey W. Watt & Co., Inc and Southwest Airlines Co. must be notified immediately. **We require <u>copies</u> of all letters either denying or awarding any benefits for which you have applied.**

Printed Name: _____

Signature: _____

Date: ____/____/____