



Allied Pilots Association Pilot Occupational Disability Plan (POD) Claim Kit Instructions

General Instructions:

Your claim kit consists of four forms: (1) Claim Form, (2) Authorization to Obtain Information, (3) Initial Physician's Statement and (4) ACH Authorization for those electing automatic deposit of benefit claim payments. 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 the processing of your claim.

The Plan requires certain time limits for filing written proof of your claim. **To receive benefits as early as possible, your claim must be Filed within six months of your Onset of Disability.** Claims will not be eligible for payment if Filed after the later of: (1) more than 24 months after the Onset of Disability; or (2) the exhaustion of paid sick and vacation time from the Company. **See the CLAIMS PROCESSING PROVISIONS section of the Plan Document for complete claims processing provisions.**

Completed Kit:

Please remit the Claim Form, Authorization to Obtain Information and Initial Physician's Statement forms including all supporting documentation and medical records to initiate processing of your disability claim to Harvey Watt & Company. **APA strongly encourages you to keep a copy of your claim kit and if possible, send it to Harvey Watt by certified mail. If you do not hear from Harvey Watt within 15 business days of mailing your kit, you should contact Harvey Watt to confirm that your kit was received.**

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

Phone number: 800-241-6103
Fax number: 404-761-8326

In addition to the above forms, please remit a copy of your birth certificate and the ACH Authorization form to Web – TPA at the following mailing address:

Web – TPA
P.O. Box 1987
Grapevine, TX 76099-1987

Phone number: 800-477-8957
Fax number: 469-417-1979

Forms – Overview:

1. Claim Form: This form provides us with required claimant information. *If you are eligible for - or - are currently receiving benefits from another source (i.e. American Airlines, Social Security, etc.) you must attach copies of the benefit determination notice as it may affect the amount of your benefit.* 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 & Co. to obtain the necessary information about you to determine your eligibility for benefits. This authorization also allows Harvey Watt & Co. 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. Initial Physician's Statement: (Two-part form)

Section I - claimant 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 Allied Pilots Association.

4. ACH Authorization: Claimant must provide a completed ACH Authorization form that provides the account information necessary for proper payment of your monthly benefit payment.

* **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.)**



PILOT OCCUPATIONAL DISABILITY PLAN CLAIM FORM

Allied Pilots Association Pilot Occupational Disability Plan (POD)

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

RETURN COMPLETED FORM TO:

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

PLAN PARTICIPANT:

Full Name: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

Telephone number: _____ Cellular telephone number: _____

Fax telephone number: _____ Employee number: _____

Date of birth: _____ Current rank: _____

Email address: _____

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 ___/___/___ Date of last Flight Physical ___/___/___

Complete this section ONLY if your Disability is due to a SICKNESS:

Nature of Sickness: _____

Cause of Sickness: _____

Date Sickness was first noticed: ___/___/___ Date first treated for Sickness: ___/___/___

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): ___/___/___, ___/___/___, ___/___/___, ___/___/___



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

Complete description of Injury: _____

Cause of Injury: _____

Date of accident: ____/____/____ Time of accident: _____ Date first treated for Injury: ____/____/____

Location of Accident: _____

Attending Physician information (Attending Physician must not be related by blood or marriage)

Name of Physician: _____
Mailing address: _____
City: _____ State: _____ Zip code: _____
Telephone number: _____ Fax telephone number: _____

List any other Physicians consulted for this Sickness 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: _____



PRIOR DISABILITY CLAIM HISTORY: List ALL Sicknesses 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)

American Airlines Pilot LTD	Application Date	Approved () Yes () No	Effective date of LTD Benefits	Amount of LTD Benefit
	_____		_____	_____

Upon receipt, you must provide us with a copy of your American Airlines Pilot LTD approval or denial letter. If your LTD award later changes, you must provide us with a copy of the letter informing you of the changes. Failure to provide us with a copy of these documents may cause a delay in your receipt of POD benefits.

Social Security	Application Date	Approved () Yes () No	Effective date of SSD Benefits	Amount of SSD Benefit
	_____		_____	_____

To be eligible for the Extended Benefit, the Plan requires that you apply for and are approved for Social Security Disability (SSD) Benefits. You must provide to Harvey Watt a copy of the SSD Benefits application prior to the end of the Basic Benefits period. Upon approval for SSD Benefits, you must provide to Harvey Watt proof that the SSD Benefits are effective on or before the end of the period for which the Basic Benefit is payable or the 24-month lifetime payment maximum for Nervous Disorders and/or Limited-Term Disabilities are payable; and a copy of the award showing the amount of the monthly SSD Benefit.

If you become eligible to receive or receive these benefits or any other applicable income at a later date, Harvey Watt and Allied Pilots Association must be notified immediately. We require copies of all letters either denying or awarding any benefits for which you have applied.

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.

Printed name: _____

Signature: _____

Date: ____/____/____



Authorization to Obtain Information

I authorize the following persons having any records or knowledge of my health:

- Any Physician, medical practitioner, Pharmacy Benefit Manager, or health care provider that either pertains or may pertain to this reported condition.
- Any Hospital, clinic, pharmacy or other medical or medically related facility or association that either pertains or may pertain to this reported condition.
- Any insurance company that either pertains or may pertain to this reported condition.
- Allied Pilots Association (APA) or any APA Pilot Occupational Disability Plan sponsor.
- Any organization or entity administering a benefit program for Allied Pilots Association.
- Tax reporting information by submitting copies of W-2's or 1099's on an annual basis for the duration of this reported claim.
- The Social Security Administration, any State mandated disability program and the Federal Aviation Administration (FAA) (with the FAA authorization limited to the two years proceeding the date of my Disability as reported for the purposes of this claim for benefits).

To give or exchange the following information that pertains to or may pertain to my medically Disabling condition or disqualifying condition; and for the purpose of administering my claim, performing independent assessments, rehabilitation and return to work planning:

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results; as well as summaries of diagnosis, functional status, treatment plan, symptoms, test results, prognosis and progress-to-date of any physical, psychiatric or psychological condition as required by the Plan and allowed by applicable law, but expressly *excludes* psychotherapy notes which are defined as notes recorded by a mental health professional that document or analyze the contents of a counseling session and that are separated from the rest of the medical record.
- Prognosis, treatment and therapy of any condition related to or as a result of Chemical Dependency as stated in the Allied Pilots Association Pilot Occupational Disability Plan (POD) and allowed by applicable law. This information will be requested when and only when an investigation of Chemical Dependency becomes a bona fide concern and will be restricted to review for the eligibility and administration of receipt of occupational disability benefits as defined under the Plan.
- Financial information necessary for the determination of the Coverage and/or Benefit amount as required by the Plan.

To Harvey W. Watt & Co., Inc. and/or Allied Pilots Association and any of its subsidiaries:

- I understand that Harvey W. Watt & Co., Inc. (Harvey Watt) Allied Pilots Association and any of its subsidiaries (APA), will use the information to assist in the determination of my eligibility or entitlement for 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 benefits with Harvey Watt and/or Allied Pilots Association. 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 impair Harvey Watt's ability to evaluate or process my claim for benefits and may be a basis for denying 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.
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Authorization to Obtain Information (continued)

- I understand that in the course of conducting their respective business, Harvey Watt may disclose information they have about me to non-affiliated parties, such as a plan administrator or person performing business or legal services for Harvey Watt and/or Allied Pilots Association. Prior to any such sharing, Harvey Watt and/or Allied Pilots Association will have an appropriate confidentiality agreement in place between it and any such party.
- I understand that the information disclosed to Harvey Watt and/or Allied Pilots Association pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the federal privacy regulations or as otherwise permitted or required by law.
- I acknowledge that I have read this authorization. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.
- I understand that Harvey Watt may require additional information that was not originally authorized by this form and that it may be necessary for them to obtain additional authorization(s) for this purpose.
- I understand that this release may not be altered in any way.
- I understand that this authorization supersedes any authorization that was submitted prior 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 Plan Participant

Employee Number

Signature of Plan Participant /guardian/representative

Date

Printed name of guardian/representative (*if applicable*)



INITIAL PHYSICIAN'S STATEMENT

Allied Pilots Association
Pilot Occupational Disability Plan (POD)

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

RETURN COMPLETED FORM TO:

In order to assist us in expediting the processing of the Disability claim for the Plan Participant we ask that you complete this form in full and attach the supporting medical documentation and return it to us.

The Plan Participant is responsible for the completion of this form and the attachment of the necessary documentation without any expense to either Allied Pilots Association or Harvey Watt & Co.

TO BE COMPLETED BY PLAN PARTICIPANT: (SECTION I)

Plan Participant:

Physician:

Address:

Address:

Phone number:

Phone number:

Height:

Weight:

Fax number:

Date of birth:

Specialty:

TO BE COMPLETED BY PHYSICIAN, not related by blood or marriage: (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 Plan Participant 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) **MEDICAL HISTORY:** Detailed description, INCLUDING office notes and summaries of all surgical or medical services rendered on each date including laboratory test results and results of any other tests, such as X-RAYS, EKG's, EEG'S, etc. (Attach additional pages if more space is needed): PSYCHOTHERAPY NOTES ARE EXCLUDED FROM THIS REQUEST.

(b) **RECOMMENDED/PREScribed TREATMENT.** Include any therapy or medications. (Attach additional pages if needed.)

(c) **RESTRICTIONS/LIMITATIONS:** Detail all of the Plan Participant's restrictions and activity limitations. (Attach additional pages if 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 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).

(d) **PROGRESS:** Since first being consulted on the Plan Participant's Disability please describe their condition

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

(e) **WORK STATUS:**

Do you believe the Plan Participant is now able to perform the duties of his/her customary occupation as airline pilot? () Yes () No

Dates of total and continuous disablement preventing engagement in his/her customary occupation: _____

Date Plan Participant was able to return to his/her customary occupation _____

Estimated date Plan Participant will be able to return to his/her customary occupation: _____



(f) 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)

(g) OTHER PHYSICIANS: List the names and address of ALL consulting Physicians for the listed Disability

(h) PROGNOSIS: Detailed prognosis for return to work

Physician completing this form confirms he or she is not related to Plan Participant by blood or marriage:

Printed Name:

Signature:

Date: