



Delta Pilot Disability Guide

Application for Disability Benefits

Last updated August 2010



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PART 1 – BENEFIT SUMMARY

Delta Pilot Disability Benefits

You may become eligible to receive disability benefits under the Delta Pilots Disability and Survivorship Plan if you sustain an injury, become sick or pregnant, and, as a result, are unable to perform your duties of your job as a Delta Pilot. The disability benefits payments that you may be eligible to receive are based on a percentage of your wages and become payable after your disability has continued for seven days or, if later, when you exhaust accident leave or the Sick Leave credits hours that are available to you. Enclosed you will find the necessary forms needed to apply for disability benefits and high level information on your eligibility for other Delta benefits.

This is just a summary. The plan document controls in the event of any conflict between this summary and the plan document.

Temporary Disability (TD) Benefits

In order to qualify for TD benefits, you must be prevented from performing the duties of a pilot, as a result of injury, pregnancy, sickness or disease (including natural deterioration). TD benefits are payable for a maximum of 26 weeks, starting on the first day of your sick leave that leads to a qualifying disability. This is referred to as your event date. TD benefits are not payable during the first seven days of this period. Additionally, TD benefits are not paid while you are exhausting accident leave or sick leave credit hours.

If your application for TD is approved, your gross TD benefit payments will be 50% of your Final Average Earnings. Final Average Earnings are based on the highest monthly average of your Earnings in any 12 consecutive months during the last 36 months while you were on Active Payroll Status (including Accident Leave, Sick Leave and vacation). If you had less than 12 consecutive months of Earnings, then the average of Earnings in all consecutive months will be used.

Long Term Disability (LTD) Benefits

You are able to transition to monthly LTD benefits after exhausting your 26-week TD period. In order to qualify for LTD benefits, you must have met the requirements for TD benefits (whether or not you actually receive TD benefits) and not be eligible to exercise the privileges of your first class medical certificate, as determined by the Plan Administrator and subject to the medical review process. You also are deemed eligible for LTD benefits if the Company determines that you do not meet the standards established by the FAA for the issuance of a first-class medical certificate, including the FAA waiver and restriction policy.

If your application for LTD benefits is approved, your gross benefit will be 50% of the lesser of:

- The composite hourly rate in effect on your first sick day (event date) multiplied by 80 hours OR
- Your Final Average Earnings.

Disability Benefit Offsets

TD and LTD benefits are offset (reduced) by the other income benefits listed below.

- Workers' Compensation Benefits
- State Disability Benefits
- Retirement Benefits
- Earned Income (LTD only)

Earned Income

If your income earned from other employment exceeds your LTD benefit amount, then your benefit will be reduced dollar for dollar based on this earned income total. Offsets for Earned Income will only be applied when your income from employment exceeds your calculated disability benefit amount.

It is necessary that you report your earnings as specified on the attached Periodic and Annual forms. The Periodic Report of Disability Offset income form should be submitted if you are approved for LTD benefits and at any time thereafter when there is a change to your Earned Income. The Annual form must be submitted along with any applicable supporting documentation of your earnings by June 15th of the current calendar year.

Your Total Earned Income amount generally includes all income subject to Federal employment taxes or self-employment income. It is reported on any W-2 statement issued by your employer or Schedule SE if you are self-employed.

Earned Income excludes any income, unless received in the course of your trade or business, reported on a Form 1099, such as annuities, pensions, Veterans benefits, and military retired pay, withdrawals from 401(k) plans, Social Security Disability Insurance payments, unemployment compensation, interest and dividends from savings accounts, stocks, personal loans, or home mortgages, insurance proceeds, gifts, inheritances, estates, trusts, endowments, prizes, awards, gambling or lottery winnings, alimony/child support, scholarships or fellowships, pay for jury duty, capital gains from the sale of personal property, amounts received in court actions, and rents or royalties.

Other Delta Benefits

The following is an outline of Delta benefits that may be available to you while on disability status. For more details and additional information, refer to the applicable plan documents or contract language. For more information regarding benefit premiums, contact the ESC at 1-800 MY DELTA. While receiving disability benefits from the D&S Plan, you are eligible to receive employer contributions to the pilot 401(k) and defined contribution plans at the applicable rate you would receive if you were on active pay status.

Delta Group Medical, Dental, and Basic Life Insurance

While you are on an approved disability status, your healthcare and basic life insurance benefit coverage that was in place while on active status remains available for you and covered eligible dependents. You must continue to timely pay any premiums that you were paying while on active status, however they will be deducted from disability pay on a post-tax basis while you are receiving disability benefits. In order to continue to file claims against your Delta Health Care Flexible Spending Account, you will need to elect COBRA coverage while out on disability. Upon return from disability, you will need to re-confirm your elections for these accounts. If you do not elect COBRA for the period of disability, you will not be able to file claims against your Delta Health Care Flexible Spending Account for that period.

Optional Insurances

Optional insurance includes optional life insurance, spouse life, child life, group accident insurance and private pilot coverage that you may have elected. While you are on an approved disability status, your benefit coverage will continue at the same level that was in effect for you and your dependents and the applicable premiums will be deducted from your disability check, unless you elect to cancel this benefit.

In the event of death within the first 30 days following removal from the active payroll, your Group Accident, Spouse/Child Life, Private Pilot, and Optional Life Insurance will be payable to your beneficiary.

Delta Community Credit Union

You may remain an active member of the Delta Community Credit Union while on disability. If you use direct deposit to deposit your paycheck into your checking account, the entire disability check will be deposited to your checking account. Payroll deductions for loans *cannot* be made from disability benefit checks. You can make arrangements to meet your loan obligations during your absence by contacting the credit union directly.

Delta Employee ID

While on TD, Delta identification cards may be retained for identification purposes. Once you are absent from work for over 180 days, you must return your employee identification card to your Chief Pilot's office until you return to work.

Other Payroll Deductions

Deductions for Delta Pilots Savings Plan or any other deduction such as these are not continued while receiving disability benefits. If you have a 401(k) loan outstanding when you begin receiving disability benefits, you will be sent a coupon book to continue making those payments.

Pass Travel

While on approved Temporary Disability, you continue to be eligible for active employee pass travel privileges on Delta; interline travel is not permitted. Once you transition to Long Term Disability, your travel privilege is determined by your age and years of service on your event date, as follows:

- If you are at least age 50 with 10 years of consecutive service at the time your approved disability leave began, you are eligible for the same pass privileges as a regular Delta retiree
- If you are under age 50 but have at least nine years of consecutive service at the time your approved disability leave began, you are eligible for 18 S3B domestic / transoceanic flight days every pass anniversary year
- If you have less than 9 years of service at the time your approved disability leave began, you receive 18 S3B domestic / transoceanic flight days every pass anniversary year for the length of your completed years of service only

All travel for you, your spouse, and eligible dependent children will be classified as SA-3B while on approved long term disability status. You will be penalized a fee of \$150 for exceeding their boarding priority allotment, if you travel using an incorrect boarding classification.

Delta Pilots Mutual Aid

Delta Pilots Mutual Aid (DPMA) is a voluntary organization with a Board of Trustees consisting of Delta pilots. It is not affiliated with Delta Air Lines, Inc. or ALPA. DPMA is "pilots helping pilots" and provides a monetary disability benefit to qualifying members who exhaust their Delta provided sick pay and remain unable to work due to a disability. The DPMA benefit is paid in addition to TD and LTD benefits. All DPMA members are limited to a combined total of twenty-four months (730 days) of benefits in their lifetime. If you are a member and need to file for this benefit, please contact the DPMA directly by calling 404-559-9421 or accessing their website at www.dpma.org.

PART 2: CONTACT INFORMATION

If you have any questions concerning the information in this Disability Guide, please contact the appropriate area listed below.

Benefit Type all steps on the scale.	Contact
<p>Disability Certification</p> <ul style="list-style-type: none"> • Disability Plan guidelines • Application for TD or LTD • Disability Recertification 	<p>Harvey Watt & Company P. O. Box 20787 Atlanta, GA 30320 FAX (404)761-8326 PHONE (404) 767-7501 or (800) 241-6103</p>
<p>Disability Benefits</p> <ul style="list-style-type: none"> • Disability Benefit Payments • Disability Overpayments • Coordination of offsets 	<p>Delta Employee Service Center P.O. Box 52049 Phoenix, AZ 85072 1-800 MY DELTA (1-800-693-3582)</p>
<p>Medical</p> <ul style="list-style-type: none"> • Delta Account-Based Healthcare Plan (DABHP) <ul style="list-style-type: none"> – Gold HRA Medical Option, Silver HRA Medical Option, Gold OOA HRA Medical Option, Diamond HSA Medical Option, Ruby HSA Medical Option, PPO Option A • Delta Pilots Medical Plan (DPMP) <ul style="list-style-type: none"> – Network Option, OOA Option, Option N • Health Plan Hawaii 	<p>UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 877-683-8555 www.myHealthcareView.com</p> <p>Hawaii Medical Service Association 818 Keeaumoku Street Honolulu, HI 96814 Current Members: 808-948-6372 Prospective Members: 808-948-6111 www.hmsa.com</p>
<p>Vision</p>	<p>Davis Vision Vision Care Processing Unit P.O. Box 1525 Latham, NY 12201 800-947-9955 www.davisvision.com</p>
<p>Pilots Savings Plan [401(k)]</p>	<p>Fidelity: 800-554-0262</p>

<p>COBRA</p> <ul style="list-style-type: none"> • Medical Options • Dental Options • Davis Vision Plan • Full Purpose Healthcare FSA • Limited Purpose Healthcare FSA 	<p>SHPS COBRA Continuation Services P.O. Box 105413 Atlanta, GA 30348-5413 866-334-2942</p>
<p>Delta Community Credit Union (DCCU) Loan</p>	<p>Delta Community Credit Union P.O. Box 20541 Atlanta, GA 30320 Credit Union Loans – Dept. 930/ATG 404-715-4725 or 1-800-544-3328</p>
<p>Delta Employee Assistance Program (EAP)</p>	<p>OptumHealth Behavioral Solutions 800-533-6939 www.liveandworkwell.com (access code 226310) Fax: 915-781-1085 https://www.myuhc.com/</p>
<p>Group Accident Insurance Accident Insurance for Private Pilots Beneficiary Information</p>	<p>The Prudential Insurance Company of America (Prudential) 877-232-3561 https://giselfservice.prudential.com</p>
<p>Automobile/Homeowner Voluntary Personal Insurances</p>	<p>Progressive (Auto): 1-800-888-7764 Travelers (Auto/Homeowner): 1-877-754-0476</p>
<p>Flexible Spending Accounts (FSAs)</p> <ul style="list-style-type: none"> • Full Purpose Healthcare FSA • Limited Purpose Healthcare FSA • Dependent Care FSA 	<p>UnitedHealthcare Member Services P.O. Box 981178 El Paso, TX 79998-1178 877-683-8555 Fax: 915-781-1085 www.myHealthcareView.com</p>
<p>Eligibility and Enrollment Issues Qualified Life Events</p>	<p>Delta Air Lines, Inc. Employee Service Center P.O. Box 52060 Phoenix, AZ 85072 1-800 MY DELTA (1-800-693-3582)</p>

Additional frequently called phone numbers can be accessed on DeltaNet.

PART 3: PILOT CHECKLIST

In preparation for your continued 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 as early as possible during your absence.

Important Note: Incomplete, altered, or missing forms or lack of medical information substantiating your claim will 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. 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.

COMPLETE AS SOON AS YOU EXPECT YOUR ABSENCE TO EXTEND BEYOND YOUR SICK LEAVE HOURS

Submit these completed forms to Harvey Watt & Company in order to initiate your disability claim

EMPLOYEE STATEMENT FOR DISABILITY

You must complete this form in full to apply for either Temporary Disability or for Long Term Disability benefits.

AUTHORIZATION TO OBTAIN INFORMATION

This authorization allows Harvey Watt & Co. to release your information to appropriate parties or organization(s) for specific purposes. Your signature on this form enables Harvey Watt & Co. to obtain the necessary information to determine your eligibility for benefits.

INITIAL PHYSICIAN STATEMENT(S)

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.

Submit this completed form to the Employee Service Center:

TAX SELECTION FORM

The Employee Service Center must receive this form before any benefits you may be eligible for are paid to you.

FORM MAY BE REQUIRED FOR ONGOING DISABILITY CERTIFICATION

Submit updated forms to Harvey Watt & Company:

UPDATED PHYSICIAN STATEMENT(S)

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.

PART 4: REQUIREMENTS FOR RETURNING TO WORK

It is Delta's hope that you recover from disability and return to Active Payroll Status. The following information may help you return to work after being on either TD or LTD.

If you are out for medical reasons for four months or longer, the company Director – Health Services (DHS) has the right to verify your medical fitness to return to work, regardless of whether you have a current first-class medical certificate. When you are cleared to return to flight status, your category is determined in accordance with the PWA.

You should notify Harvey Watt of your return to duty to ensure that your last disability check is correct. This avoids an overpayment and your obligation to reimburse the Plan. If you are receiving Delta Pilots Mutual Aid (DPMA) or other private benefits, you should advise DPMA of your return to work to avoid overpayment of those benefits as well.

Contact the Chief Pilot Support Center to ensure that you have access to DBMS, and to determine your bid status when you return to work.

Before you return to work from your disability leave, you must obtain a release from your treating physician and present the release to your local Chief Pilot. If you do not, Delta has the right to prevent your return until you do so.

EMPLOYEE'S APPLICATION FOR TEMPORARY OR LONG TERM DISABILITY

Delta Pilots
Disability and
Survivorship Plan

Return Completed form to:

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

This application is for **Temporary Disability** **Long Term Disability**

CLAIMANT:

Full Name: _____ Employee Number _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Secondary Telephone Number: _____

Date of Birth: _____

Email Address: _____ Base: _____

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

Date you first called in sick for this Disability: ____/____/____ Approximate date Sick Leave exhausts: ____/____/____

Normal Occupation and Position: _____

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

Date of Planned Retirement: ____/____/____ Furlough Date (if applicable): ____/____/____

Current status of your FAA 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 ____/____/____

Complete this section **ONLY** 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): ____/____/____, ____/____/____, ____/____/____, ____/____/____

EMPLOYEE'S APPLICATION FOR TEMPORARY OR LONG TERM DISABILITY (Page 2)

Complete this section **ONLY** 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: _____

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: _____

EMPLOYEE'S APPLICATION FOR TEMPORARY OR LONG TERM DISABILITY (Page 3)

Name of Hospital: _____ Address: _____

Telephone Number: _____

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

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
Worker's Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
State Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Retirement	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

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

If you become eligible to receive or receive these benefits at a later date, Harvey Watt & Company must be notified immediately. We require copies of all letters either denying or awarding any benefits for which you have applied.

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.

I understand that I am required to furnish evidence of my continued disability as required by the Delta Pilots Disability and Survivorship Plan and the Pilots 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 Delta Pilots Disability and Survivorship Plan and Delta Air Lines, Inc., and could result in disciplinary action, up to and including termination of employment.

Notification: If applying for Long Term Disability benefits, these benefits will not start until your Temporary Disability benefits have been exhausted.

Printed Name: _____

Signature: _____

Date: ____/____/____

INITIAL PHYSICIAN'S STATEMENT

Delta Pilots
Disability and
Survivorship Plan

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 the completion of the entire form and facilitating the submission of necessary documentation without any expense to either Delta Pilots Disability and Survivorship Plan or Harvey Watt & Co. 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 Code: _____

Primary PCT-4 Code (if applicable): _____

Date Patient first consulted for this disability: _____

Secondary Diagnosis: _____

Secondary ICD-9 Code: _____

Secondary PCT-4 Code (if applicable): _____

Date symptoms first appeared for this disability: _____

LIST ALL DATES OF SERVICE:

LIST ALL LOCATIONS OF SERVICE:

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 or medications (Please attach additional pages if more space is 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 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).

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.):

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 airline 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 an airline pilot:

Estimated date patient will be able to return to his/her customary occupation as an airline pilot:

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

Physician completing form:

Printed Name:

Signature:

Date:

AUTHORIZATION TO OBTAIN / RELEASE INFORMATION

Delta Pilots
Disability and
Survivorship Plan

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 & Co. to obtain necessary information to determine your eligibility for TD or LTD benefits. This authorization also allows Harvey Watt & Co. 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 or other medical or medically-related facility or association.
- Any insurance company.
- Any employer or plan sponsor.
- Any organization or entity administering a benefit program.
- Any educational, vocational or rehabilitation organization or program.
- Any government agency (*for example, but not limited to, the Pension Benefit Guaranty Corporation, Worker's Compensation Board, etc.*)

To give the following information:

- Charts, notes, x-ray reports, operative reports, lab and medication records and all other medical information about me, including 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 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 Board, claim status, benefit amounts and effective dates, etc.*)

To Harvey W. Watt & Co., Inc. and/or Delta Air Lines and any of its subsidiaries:

- In additional, I authorize the Pension Benefit Guaranty Corporation to provide information to Delta regarding retirement benefits being paid to me by them on behalf of the terminated Delta Pilots Retirement Plan.
- I understand that Harvey W. Watt & Co., Inc. (Harvey Watt), the Delta Pilots Disability and Survivorship Plan, Delta Air Lines and any of its subsidiaries, will use the information only to evaluate my eligibility for temporary or long-term 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 temporary and/or long-term 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 Plan
 - 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

Authorization to Release Information (page 2)

- I understand that Harvey Watt and the Disability and Survivorship Plan may disclose medical, financial and other information contained in my disability file to Delta, its employees or non-affiliated parties, such as a plan administrator, ALPA or persons performing business or legal services for Harvey Watt, Delta or the Disability and Survivorship Plan strictly as it pertains to the processing of my claim for disability benefits.
- I understand that the information disclosed to Harvey Watt and/or Delta pursuant to this authorization may be subject to redisclosure with my authorization 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 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

Signature of Claimant /Guardian/Representative

Date

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

TAX SELECTION FORM

Return Completed form to:

Delta Employee Service Center
Dept. 951 - Disability
P. O. Box 20706
Atlanta, GA 30320
404-773-3046 (fax)

Your deduction request will be effective on the first available pay period following receipt of this form.

The Employee Service Center must receive the following form in order to begin paying any eligible benefits. Incomplete forms will be returned to you for completion and may delay processing of your claim. For detailed information or any question regarding this form, please contact the Disability Department at the Employee Service Center by calling 1-800-MY DELTA.

CLAIMANT:

Full Name: _____ Employee Number _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Secondary Telephone Number: _____

These Tax Deductions are for (choose only one):

Temporary Disability Long Term Disability Both, Temporary Disability and Long Term Disability

- 1.) Do you authorize deduction of Federal Income Tax from your disability check? Yes No
- 2.) Do you authorize deduction of State Income Tax from your disability check? Yes No
- 3.) If Yes, indicate appropriate state: _____

Indicate deductions below:

Federal Income Tax

Table rate Indicate marital status and number of exemptions Married Single
Number of exemptions _____

State Income Tax

Table rate Indicate marital status and number of exemptions Married Single
Number of exemptions _____

Please have my disability benefit payment sent to (choose one only)

Delta Community Credit Union Checking Account # _____
(You must be the primary account holder)

Mailing address on file with Delta Air Lines.

Direct Deposit to another financial institution. (Complete Authorization Agreement for Automatic Deposit form)

Signature of Claimant

Date

UPDATED PHYSICIAN'S STATEMENT

Delta Pilots
Disability and
Survivorship Plan

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 the completion of the entire form and facilitating the submission of necessary documentation without any expense to either Delta Pilots Disability and Survivorship Plan or Harvey Watt & Co. 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: _____	Doctor: _____
Address: _____	Address: _____
_____	_____
_____	_____
Phone Number: _____	Phone Number: _____
Height of Patient: _____	Weight of Patient: _____
_____	_____
Date of Birth: _____	Specialty: _____
_____	_____

TO BE COMPLETED BY PHYSICIAN:

DIAGNOSIS:

Primary Diagnosis: _____	Secondary Diagnosis: _____
Primary Diagnosis ICD-9 Code: _____	Secondary Diagnosis ICD-9 Code: _____
Primary Diagnosis PCT-4 Code (if applicable): _____	Secondary Diagnosis PCT-4 Code (if applicable): _____
_____	_____

DATE OF LAST MEDICAL UPDATE SUBMITTED TO HARVEY WATT: _____

LIST ALL DATES OF SERVICE SINCE _____:

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.):

UPDATED PHYSICIAN'S STATEMENT (Page 2)

Recommended/Prescribed treatment, including any therapy or medications. (Please attach additional pages if more space is 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 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 airline 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:

Date 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 90-day period, all medical documentation will be required for each subsequent 90-day period.

Physician completing form:

Printed Name:

Signature:

Date:

INSTRUCTIONS FOR PERIODIC REPORT OF DISABILITY OFFSET INCOME

The *Periodic Report of Disability Offset Income* form must be submitted as part of your documentation for initial or continued eligibility for disability benefits from the Delta Pilots Disability and Survivorship Plan (D&S Plan) in order to provide information concerning earned income from employment or self-employment ("Earned Income") during the current calendar year. The information reported will be used to determine the initial amount of offset, if any, to your long-term disability benefits.

Your LTD benefit is offset dollar for dollar by the amount of your Earned Income from employment or self-employment that exceeds your LTD benefit. The definition of what is and is not Earned Income is provided below. For example, if your LTD benefit is \$10,000.00 per month and your Earned Income is \$10,001.00 dollars per month your monthly LTD benefit will be offset by \$1.00. Your new LTD benefit will be \$9999.00 per month.

You are required to complete, sign and return the Periodic Report of Disability Offset Income form even if you have no actual or estimated Earned Income to report. Also, if you have updated information concerning the estimated Earned Income amount being used to offset your LTD benefit during the year, you are required to submit the form again so that the most accurate information possible is used to determine your offset. After the end of the calendar year, you will be required to submit verification and proof of your actual Earned Income and any overpayment or underpayment from the Plan will be determined at that time. Overpayments from the Plan may generally be repaid over a period of up to 48 months without interest, other than overpayments resulting from certain material misstatements or omissions made in an application or response to the Plan which are instead due and payable immediately.

EARNED INCOME DEFINED

EARNED INCOME INCLUDES:

1. Any salary or pay you received from any employer including overtime, vacation pay, bonuses, severance pay or similar payments.
2. If you are self-employed, any net profit you made from working or managing your own business. Net earnings from self-employment are shown on your Schedule SE.

Generally, all income subject to Federal employment taxes or self-employment income is considered Earned Income. It is reported on any W-2 statement issued by your employer or Schedule SE if you are self-employed.

EARNED INCOME EXCLUDES:

UNLESS received in the course of your trade or business, Earned Income excludes: any income reported on a Form 1099, such as annuities, pensions, Veterans benefits, and military retired pay, withdrawals from 401(k) plans, Social Security Disability Insurance payments, unemployment compensation, interest and dividends from savings accounts, stocks, personal loans, or home mortgages, insurance proceeds, gifts, inheritances, estates, trusts, endowments, prizes, awards, gambling or lottery winnings, alimony/child support, scholarships or fellowships, pay for jury duty, capital gains from the sale of personal property, amounts received in court actions, and rents or royalties.


IF YOU REQUIRE FURTHER ASSISTANCE COMPLETING THIS FORM:

Call Harvey Watt weekdays at (404) 767-7501 or at (800) 241-6103. You may send written questions to:

Harvey Watt & Company
P O Box 20787
Atlanta, GA 30320

PERIODIC REPORT OF DISABILITY OFFSET INCOME FORM

This form is required as part of your documentation for initial or continued eligibility for long-term disability benefits. The actual and estimated income reported here must be to the best of your knowledge and belief as of this time. Additionally, this form must be submitted anytime you have a material change to your estimated Earned Income to report. If you do not return this form in a timely manner, your LTD benefit payments may be affected. Return forms to Harvey Watt & Co., PO Box 20787, Atlanta, GA 30320.

Disability Offset Income Certificate		
Delta Air Lines Employee Number		HARVEY WATT CASE NUMBER
Last Name	First Name	Middle Initial
Address (Line 1)		
Address (Line 2)		
City	State	Zip Code
I hereby report the following sources and actual and estimated amounts of earned income from employment/self-employment.		
EARNED INCOME FROM EMPLOYMENT AND SELF-EMPLOYMENT		
<small>Please refer to the definition of Earned Income located on the instructions page.</small>		
Are you or do you expect to be self-employed or employed during the current year?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
If so, please enter your estimated Earned Income amount resulting from employment and self-employment for the current year.	\$ _____ Annual	
AFFIDAVIT		
<p>To the best of my knowledge and belief, the amount of actual and estimated income from employment benefits that I have reported on this form is true and correct. I understand that these self-reported amounts will be relied upon to determine my earned income offset to my disability benefits from the Delta Pilots Disability and Survivorship Plan. I further understand that I will be required to verify and submit proof of my actual year's earnings by May 15th following the end of the calendar year. At that time, my disability benefit amount will be recalculated if necessary and I may have an overpayment from the Plan that must be repaid by me without interest. If such recalculation results in an underpayment from the Plan, the Plan will pay me the additional amount without interest at that time. If a material change in my estimated income occurs after I have submitted this form, I agree to promptly notify the plan administrator of the change through submission of an updated form.</p>		
Signature of Employee	Date	
Printed Name of Employee		
Witness:		
		_____
Notary Public (Seal)		My Commission Expires:

INSTRUCTIONS FOR ANNUAL REPORT OF DISABILITY OFFSET INCOME

The *Annual Report of Disability Offset Income* survey form must be submitted as part of your application for disability benefits from the Delta Pilots Disability and Survivorship Plan (D&S Plan) to verify the amount of earned income from employment or self-employment ("Earned Income") paid to you during the most recently completed calendar year. This information is used to determine the amount of your final earned income offset against your LTD benefits paid from the D&S Plan. It is also used to estimate the offset against your LTD benefit for the remainder of the current calendar year. Additionally, the PWA requires you to report state disability benefits or workers compensation benefits received so that your LTD benefits under the D&S Plan may be appropriately offset.

Your LTD benefit is offset dollar for dollar by the amount of your Earned Income from employment or self-employment that exceeds your LTD benefit. The definition of what is and is not Earned Income is provided below. For example, if your LTD benefit is \$10,000.00 per month and you earn \$10,001.00 dollars per month from employment or self-employment, your monthly LTD benefit will be offset by \$1.00. Your new LTD benefit will be \$9999.00 per month.

Your LTD benefit is also offset dollar for dollar by the full amount of state disability benefits and workers compensation benefits.

You are required to complete, sign and return the Annual Report of Disability Offset Income Survey (and any supporting documentation including W2s and Schedule SE if you have reported Earned Income) by May 15th of the current calendar year, even if you have no actual Earned Income benefits to report. After this information is processed your LTD benefit will be recalculated based on this information and you will be notified of any overpayment or underpayment from the Plan. This information will also be used to estimate the amount of your offset for the remainder of the current calendar year and your monthly benefits will be adjusted accordingly.

EARNED INCOME DEFINED

EARNED INCOME INCLUDES:

1. Any salary or pay you received from any employer including overtime, vacation pay, bonuses, severance pay or similar payments.
2. If you are self-employed, any net profit you made from working or managing your own business. Net earnings from self-employment are shown on your Schedule SE.

Generally, all income subject to Federal employment taxes or self-employment income is considered Earned Income. It is reported on any W-2 statement issued by your employer or Schedule SE if you are self-employed.

EARNED INCOME EXCLUDES:

UNLESS received in the course of your trade or business, Earned Income excludes: any income reported on a Form 1099, such as annuities, pensions, Veterans benefits, and military retired pay, withdrawals from 401(k) plans, unemployment compensation, interest and dividends from savings accounts, stocks, personal loans, or home mortgages, insurance proceeds, gifts, inheritances, estates, trusts, endowments, prizes, awards, gambling or lottery winnings, alimony/child support, scholarships or fellowships, pay for jury duty, capital gains from the sale of personal property, amounts received in court actions, and rents or royalties.


IF YOU REQUIRE FURTHER ASSISTANCE COMPLETING THIS FORM:

Call Harvey Watt weekdays at (404) 767-7501 or at (800) 241-6103. You may send written questions to:

Harvey Watt & Company
P O Box 20787
Atlanta, GA 30320

ANNUAL REPORT OF DISABILITY OFFSET INCOME FORM

This form and the accompanying documentation are required as part of your application for long-term disability benefits. You must submit this form, as well as copies of your applicable W2s and Schedule SE **no later than May 31** even if you have no earned income or Social Security benefits to report. Any Earned Income reported must include the supporting documentation. Return forms to Harvey Watt & Co, PO Box 20787, Atlanta, GA 30320.

Disability Offset Income Certificate			
Delta Air Lines Employee Number		HARVEY WATT CASE NUMBER	
Last Name	First Name	Middle Initial	
Address (Line 1)			
Address (Line 2)			
City	State	Zip Code	
EARNED INCOME FROM EMPLOYMENT AND SELF-EMPLOYMENT			
Complete this section with regard to Earned Income for the most recently completed calendar year.			
Total the highest amounts (shown as "Social Security" or "Medicare Wages") shown on all your W-2's for the most recently completed calendar year			\$
Earned Income from self-employment shown on your Schedule SE for the most recently completed calendar year			\$
Total Earned Income from Employment or Self-Employment			\$
You must include all supporting documentation of the Earned Income reported above, including copies of all W-2 received and a copy of your Schedule SE for the most recently completed calendar year			
AFFIDAVIT			
<p>To the best of my knowledge and belief, the amount of actual earned income from employment and self-employment received by me as stated on this form is true and correct. I understand that the amount of earned income reported on this form will be used to determine the actual offset for other income against my LTD benefits for the preceding calendar year. To the extent that the estimates that I reported were more than or less than this actual amount, my LTD benefit will be adjusted and I may have been underpaid or overpaid from the D&S Plan. I understand that the amount reported on this form will also be used to estimate my earned income for the remainder of the current calendar year for purposes of determining my LTD benefit offset for earned income.</p>			
Signature of Employee _____			Date _____
Printed Name of Employee _____			
Witness:			
		_____	
Notary Public (Seal)		My Commission Expires:	



Deposit Agreement Form – Non – Credit Union Form

Step 1: Enter your Employee Number and Employee Name

Employee Number:	Employee Name:
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Start Deposit

Stop Deposit

Change Deposit

Authorization Agreement

I hereby authorize Delta Air Lines, Inc. to initiate automatic deposits to my account at the financial institution named below. I also authorize Delta Air Lines, Inc. to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Delta Air Lines, Inc. responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Delta Air Lines, Inc. receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Important Information About Direct Deposit

Direct Deposit of net pay can be made to only one account that is not a credit union account. Direct Deposit can be made to a checking/share draft with the Delta Community Credit Union and to an account with another financial institution. Payroll deductions to Delta Community Credit Union Savings and/or loans will not be affected by enrolling in Direct Deposit with another institution.

STEP 2: Banking information

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____ Checking Savings

STEP 3: Signature

Authorized Signature (Primary): _____ Date: _____

STEP 4: Attach a voided check or deposit slip(only savings)

Please attach a voided check for a checking account or deposit slip form for a savings account

Return form to: Delta Air Lines, P.O. Box 20706, Atlanta, GA 30320-6001. If you have questions, please contact 1-800-MyDelta or email Payroll.ATL831@Delta-Air.com