Wheels UP, LLC
Loss of Medical Plan
Claim Application Instructions

General Instructions:

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

Completed Application:

Remit all 3 forms including all supporting documentation* to initiate processing of your disability claim to Harvey Watt & Company. The telephone number is (800) 241 – 6103.

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

Forms – Overview:

1. Employee's Statement:

This form provides us with required claimant information. *If you are eligible for - or - are currently receiving benefits from another source (i.e.* Social Security, Worker's Compensation, State Disability, Retirement, etc.) you must attach copies of the applicable benefit determination notice. This information is necessary to assure proper documentation and processing of your claim.

2. Authorization to Obtain Information:

Your signature on this form enables Harvey Watt & 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 - 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*. 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 Wheels UP, LLC.

*** 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.)**

EMPLOYEE'S STATEMENT

Wheels UP, LLC
Loss of Medical Disability Plan

RETURN COMPLETED FORM TO:

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

In order to properly process your Loss of Medical 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 form with all necessary supporting documentation.

CLAIMANT:

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: ______________________________

Claim is for Wheels UP, LLC Loss of Medical Plan

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

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

Normal Occupation: ______________________________

Date Sick Leave commenced: _____/_____/_____ Approximate date Sick Leave exhausts: _____/_____/_______

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

Current ( ) Date _____/_____/_____ Lapsed ( ) Date _____/_____/_____ Deferred ( ) Date _____/_____/_____

Revoked ( ) Date _____/_____/_____ Denied ( ) Date _____/_____/_____

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

Nature of Illness: ______________________________

Cause of Illness: ______________________________

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

List of ALL symptoms: ______________________________

____

____

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

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

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

Complete description of Injury: ____

____

____

____

Cause of Injury: ____

____

____

____

____

Date of Accident: _____/_____/_____ Time of Accident:_________________________ OJI Accident/Injury? Yes ( ) No ( )

Location of Accident: ____

____

____

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

Name of Physician: ____
Mailing Address: ____
City:___________________________ State: __________________________ Zip Code: __________________________
Telephone Number:______________________________ Fax Telephone Number: ______________________________

List any other physicians consulted for this illness or injury:

Name: ______________________________ Address: ______________________________

____

Telephone Number: ______________________________ ______________________________

Name: ______________________________ Address: ______________________________

____

Telephone Number: ______________________________ ______________________________

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

Name of Hospital: ______________________________ Address: ______________________________

____

Telephone Number: ______________________________ ______________________________

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

Reason for Admission: ____

____

Name of Hospital: ______________________________ Address: ______________________________

____

Telephone Number: ______________________________ ______________________________

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

Reason for Admission: ____

____

Name of Hospital: ______________________________Address: ______________________________

____

Telephone Number: ______________________________ ______________________________

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

Reason for Admission: ____

____

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

Name of Physician: ________________________ Address: ________________________________

Telephone Number: ________________________

Date(s) of Treatment: _____/_____/_____, _____/_____/_____, _____/_____/_____, _____/_____/_____, _____/_____/_____

Reason for Treatment: ____

Name of Physician: ________________________ Address: ________________________________

Telephone Number: ________________________

Date(s) of Treatment: _____/_____/_____, _____/_____/_____, _____/_____/_____, _____/_____/_____, _____/_____/______

Reason for Treatment: ____

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

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

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

Other:	( ) Yes ( ) No	( ) Yes ( ) No	________________	( ) Yes ( ) No

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

If you become eligible to receive or receive these benefits or any other applicable income at a later date Harvey Watt and Wheels UP, LLC 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 any loss of medical benefit payments greater than that which should have been paid, I understand that the Plan has the right to recover such overpayment, 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 any loss of medical benefit that I receive will be subject to all of the terms and conditions of the Plan. I also 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.

Printed Name: ____

Signature: ____

Date: _____/_____/_____

Remit all forms to:

Harvey W. Watt & Co.
P. O. Box 20787
Atlanta, GA 30320

Authorization to Obtain Information

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

- Any physician, medical practitioner or health care provider that either pertains or may pertain to this reported condition.
- Any hospital, clinic, pharmacy benefit managers or other medical or medically related facility or association.
- Any insurance company that either pertains or may pertain to this reported condition.
- Any employer or Wheels UP, LLC plan sponsor.
- Any organization or entity administering a benefit program for Wheels UP, LLC.
- Any government agency, including, the Social Security Administration, Any State mandated Disability Program, the Federal Aviation Administration (FAA), Public Retirement System, etc.

To give the following information that pertains or may pertain to either 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 pharmaceutical or 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.

- Tax reporting information by submitting copies of W-2's or 1099's on an annual basis for the duration of this reported claim.

- Prognosis, treatment and therapy of any condition related to or as a result of Chemical Dependency as stated in the Wheels UP, LLC Loss of Medical Plan (the Plan) 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.

To Harvey W. Watt & Co., Inc. and/or Wheels UP, LLC and any of its subsidiaries:

- I understand that Harvey W. Watt & Co., Inc. (Harvey Watt) Wheels UP, LLC and any of its subsidiaries (Wheels UP), 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 Wheels UP, LLC. 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 become a basis for denial 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.

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 Wheels UP, LLC. Prior to any such sharing, Harvey Watt and/or Wheels UP, LLC will have an appropriate confidentiality agreement in place between it and any such party.
- I understand that the information disclosed to Harvey Watt, the Plan and/or Wheels UP, LLC 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. 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 Claimant Employee Number Date of Birth

____ ______________________
Signature of Claimant /Guardian/Representative Date Signed

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

INITIAL PHYSICIAN'S STATEMENT

Wheels UP, LLC
Loss of Medical Plan

RETURN COMPLETED FORM TO:

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

In order to assist us in expediting the processing of the loss of medical claim for the employee we require you to complete this form in full and enclose the necessary documentation and return it to us.
The patient is responsible for the completion of this form and the attachment of the necessary documentation without any expense to either Wheels UP, LLC or Harvey Watt & Company.

TO BE COMPLETED BY PATIENT: (SECTION I)

Patient: ______________________ Doctor: ______________________

Address: ______________________ Address: ______________________

Phone Number: ______________________ Phone Number: ______________________

Height of Patient: ________ Weight of Patient: ________ Fax Number: ______________________

Date of Birth: ______________________ Specialty: ______________________

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

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

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

Other:	( ) Yes ( ) No	( ) Yes ( ) No	______________	( ) Yes ( ) No

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

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

DIAGNOSIS:

Primary: ______________________ Secondary: ______________________

Primary ICD-9/10 Code: ______________________ Secondary ICD-9/10 Code: ______________________

Primary PCT-4 Code (if applicable): ______________________ Secondary PCT-4 Code (if applicable): ______________________

Date Patient first consulted for this disability: ______________________ **Date symptoms first appeared for this disability:** ______________________

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

____

LIST <u>ALL</u> 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 patient's restrictions and activity limitations. (Attach additional pages if needed.)

(d) PROGRESS: Since first being consulted on the patient's disability please describe their condition

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

(e) WORK STATUS:
Do you believe the patient is now able to perform the duties of their customary occupation as airline pilot? ( ) Yes ( ) No

Dates of Total and Continuous Disablement Preventing engagement in their customary occupation: ______

Date patient was able to return to their customary occupation______

Estimated date patient will be able to return to their customary occupation:______

Do you believe the patient is now able to perform the duties of any gainful occupation? ( ) Yes ( ) No

Dates of Total and Continuous Disablement Preventing engagement in any gainful occupation:

Date patient was able to return to any gainful occupation:

Estimated date patient will be able to return to any gainful 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

Printed Name:

Signature:

Date: