INITIAL PHYSICIAN'S STATEMENT

Alaska Airlines, Inc.
Pilots Long Term
Disability Plan
800-241-6103

Return Completed form to:

Harvey W. Watt & Co.
P. O. Box 82876
Atlanta, GA 30354
FAX (404)761-8326

The patient is ultimately responsible for submitting the completed forms and necessary documentation without any expense to either the Pilots Long Term Disability Plan or to Harvey Watt & Company. Necessary medical documentation may be requested for the LISTED DISABILITY ONLY. Medical documentation may include 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:

Date of Birth:

Doctor:

Address:

Phone Number:

Fax Number:

Specialty:

TO BE COMPLETED BY PHYSICIAN:

DIAGNOSIS:

Primary Diagnosis:

Primary ICD-9/10 Code:

Primary CPT-4 Code (if applicable):

Date Patient first consulted for this disability:

Secondary Diagnosis:

Secondary ICD-9/10 Code:

Secondary CPT-4 Code (if applicable):

Date symptoms first appeared for this disability:

LIST ALL DATES OF SERVICE related to the listed disability:

DATE OF NEXT SCHEDULED VISIT for the listed disability: / /

LIST ALL LOCATIONS OF SERVICE for the listed disability:

Any changes to this LTD claim application and accompanying forms and documents require the advance approval of the Alaska Airlines Pilots Retirement Board.

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Detailed description/history *INCLUDING* the office notes and summaries of all surgical or medical services for the listed disability 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 for the listed disability, including any therapy (Please attach additional pages if more space is needed.):

List all medications for the listed disability including name, dose, frequency and start date:

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

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.):

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

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Detailed Prognosis for Recovery:

_____
_____
_____
_____
_____
_____
_____
_____

If you are an FAA designated Aviation Medical Examiner, do you believe the patient is now able to exercise the privileges of a Federal Aviation Administration First Class Medical Certificate, first or second class? ( ) Yes ( ) No

_____

NOTE: If duration of disability exceeds a six-month period for Long Term Disability, continuing medical documentation for the listed disability may be requested for each subsequent six-month period.

Physician completing form:

Printed Name:

_____

Signature: Date:

_____ _____