Delta Pilots Mutual Aid
Disability Claim Form

Pilot Completes Section Below: (See directions on page 2)

I hereby authorize any hospital or any physician or the Delta Pilot Disability Plan to furnish DPMA, or permit its representative to review, any information including hospital history or medical records related to my illness or disability. A copy of this authorization shall be considered as effective and valid as the original.

If I should receive a DPMA benefit amount greater than that which should have been paid, I understand that DPMA has the right to recover such overpayment(s) to me including the right to reduce future payment(s) from The Plan, or deduct any overpayment(s) from my Delta Air Lines, Inc. paycheck and any costs associated with said recovery.

By providing my bank account number, I authorize and direct DPMA to deposit my benefit check into this account. I further authorize and direct my banking institution to refund any and all DPMA overpayments.

Name: _____

Employee Number: _____

Address: _____

_____

_____

Telephone #: _____

E-mail Address: _____

Base/Equip/Seat: _____

Payment Method:

Direct Deposit: ☐ Checking ☐ Savings

Bank Name: _____

Routing #: _____

Acct. #: _____
(or attach voided check/savings deposit slip)
Note: Wings account #s must be 10-digits.

Mail Check: ☐

☐ Check if this is updated information.

Is your claim for benefits a result of an illness/injury caused by a third party? ☐ YES ☐ NO

Pilot's Signature: _____ Date: _____

Physician Completes Section Below:

This is to certify that the above named pilot is under my care and unable to perform his/her duties as an airline pilot beginning _____ (date) through _____ (estimated return-to-work date) due to:

ICD-10 Code: ☐ Please Print Diagnosis: _____

ICD-10 Code: ☐ Please Print Diagnosis: _____

_____ Physician's Name (Print)

_____ Physician's Signature

_____ Date

_____ Street Address

_____ City/State/Zip Code

(_____) _____ Phone Number

DPMA Completes Section Below:

I certify that the above named pilot is eligible to receive DPMA benefits through: _____ / _____ / _____ (mm/dd/yy)

Approved by (print): _____ Signature: _____ Date: _____

Disability Record Updated: ☐

SLOA Date: ☐

Fraud Warning: Acceptance of payment for benefits not entitled to by the recipient is a crime and could lead to prosecution.

P.O. Box 20883 • Atlanta, GA 30320 • Phone: (888) 325-3762 • Fax: (404) 559-9817 • E-Mail: Claims@DPMA.org

Delta Pilots Mutual Aid
Disability Claim Form

Instructions

You must submit a Disability Claim Form (DCF) to the DPMA Office in order to begin receiving DPMA benefits.

1. You may receive your DPMA benefit via direct deposit to your checking or savings account, or have a check mailed to your home address. If you would like your payment deposited with a financial institution, please check the type of account, and provide your routing and checking account number or attach a voided check or savings deposit slip.
   Note: Wings account numbers must include all 10-digits.
2. The "Physician's Section" is to be completed by your treating physician. This may be your AME if he/she is the treating physician. Please ensure that the physician includes all required information and that the writing is legible. You can mail, fax or email the completed form to the DPMA office.

   You are required to provide DPMA with evidence of your disability on a DPMA DCF until your benefits expire or you return to work.
   Your claim for benefits will be valid through the date indicated by your physician or as follows:
   - If you are disabled past the date indicated by your physician on the last DCF submitted, you are required to submit an additional DCF in order to continue your DPMA benefits.
   - If the disability duration date is undetermined or unknown, you are required to submit a DCF monthly.
   - If your treatment is complete but you are awaiting FAA approval, your physician or AME must indicate "Awaiting FAA Recertification" on the DCF, and you need to submit a copy of your FAA letter. DPMA will follow up with you after 90 days if you have not submitted a copy of your FAA letter.
   - If your disability is permanent, please have your physician indicate a permanent disability on the DCF.
3. Please do not submit an incomplete DCF. Missing information in any section will delay payment of your benefits. If you have any questions about completing this form, please contact the DPMA office before you submit the DCF.
4. You are responsible for keeping your DCF current.
5. Always keep a copy of each Disability Claim Form for your records.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please contact the office at claims@dpma.org.

ATENCIÓN: si habla español, los servicios de asistencia lingüística, sin cargo, están disponibles para usted. Por favor, póngase en contacto con la oficina en claims@dpma.org.

注意：如果您會說中文，可免費獲得語言協助服務。請通過claims@dpma.org與辦事處聯繫。

PAALALA: kung Togolog nagsasalita ka , wika pagtulong na mga paglilingkod , nang walang bayad , ay magagamit sa inyo . pakiusap pagkalapat ng katungkulan sa claims @ dpma . org .

DII BAA'AKONiNiZlN: Dine' (Navajo) bizaad bee ya'n ihi'go, saad bee aka'anida'awo'igii , t'aa jiik'eh , bee na'aho'o't'i'. T'aa shoodi dadii'niigo 404-559-9421. Doodaii claims@dpma.org

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