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: ______________________________

Acct #: ______________________________

Note: Wings account #s must be 10-digits.

Routing. #: ______________________________

(or attach voided check/savings deposit slip)

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: ______________

Claim Updated: ☐ EDB Avail: ☐ SLOA Date: ☐ Adjusted 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

Rev. 07/2023

Delta Pilots Mutual Aid Disability Claim Form

Instructions

You must submit a completed Disability Claim Form (DCF) to the DPMA Office in order to receive DPMA benefits. Submitting an incomplete DCF will delay payment of your benefits. If you have any questions about completing this form, please contact the DPMA office prior to submitting your DCF.

Pilot Section
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 indicate the type of account, and either provide us with your routing and account number or attach a voided check or savings deposit slip.
Note: Wings account numbers must include all 10-digits.

Physician's Section
The "Physician's Section" is to be completed by your treating physician or AME. Please ensure that the physician includes all required information and that the writing is legible.

1. 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 your treatment is complete but you are awaiting FAA approval, your physician or AME must indicate "Awaiting FAA Recertification" on the DCF or you need to submit a copy of your FAA letter.
   - If your disability is permanent, please have your physician indicate "permanent disability" on the DCF.

Submitting your DCF
Completed DCFs should be submitted to the DPMA office no later than the end of each month. DCFs can be submitted via:

- Email: Claims@DPMA.org
- Fax: (404) 559-9817
- Mail: PO Box 20883, Atlanta, GA 30320
  (Please note: Due to delays with the USPS, your claim may be delayed if you choose this option.)

ATTENTION: If you do not 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'AKONiNiZIN: 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. Doodaiiclaims@dpma.org

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