Dear Colleague:

American Airlines has partnered with Harvey Watt and Company as the Claim Administrator for the Pilot Long Term Disability Plan (the Plan). We have enclosed the Claim Application along with the Application Instructions to assist you with submission of the required forms, information and evidence to support of your claim. Please complete all forms and attach the required information as directed. If the information is incomplete, it may unnecessarily delay processing of your claim.

The Plan requires you to file your application "within one (1) year after the Pilot Employee's date of Disability in order to be eligible for benefits". We recommend you return the completed application as soon as possible to help expedite the processing of your disability claim.

In addition there are several aspects of your disability claim that you should be aware of:

1) ***Initial Determination of Eligibility:*** Harvey Watt will make an initial determination of your claim for benefits based on your application for disability, the medical evidence and other information you submit in support of it.
2) ***Proof of Continuing Disability:*** Harvey Watt will verify your continued disability, when and as often as may be reasonable but not more than once during a 90 – day period. This may include regularly scheduled reports from you and your attending physician(s) as well as Independent Medical Examinations (IME's), Fitness for Duty Exams (FDE's) and other required documentation.
3) ***Return To Work (RTW):*** The RTW process can be complex however; we will continue to assist you through this process. Depending on your disability, direct interaction with the FAA may be required. For this reason, prompt updates are required to keep your claim current. By signing the attached release, your medical file will be shared with Harvey Watt to ensure your prompt return to work. You should also notify your Flight Administration office of your intent to return to work (RTW) with a probable RTW date as soon as possible.

Thank you in advance for your anticipated cooperation.

Best Regards,
Flight Administration

Enclosures

American Airlines - Pilot Long Term Disability
Claim Application Instructions

General Instructions:

Your claim application consists of four forms: (1) Employee Statement, (2) Authorization to Obtain Information, (3) Employer Statement and (4) 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.

Forms – Overview:

1) Employee Statement:

This form provides Harvey Watt with required employee information. *If you are eligible for - or - are currently receiving benefits from* Social Security, Workers' Compensation or State Disability 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 to obtain the necessary information about you to determine your eligibility for benefits. This authorization also allows Harvey Watt 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) Employer Statement:

This form is to be completed by your local Flight Administrator and provides Harvey Watt with the information regarding your last paid sick and vacation date.

4) Initial Physician's Statement: (Two-part form)

Section I - Employee 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*****. Treating or examining physicians should not be related to you by blood, marriage or a domestic partner. You may copy this form or obtain additional copies from Harvey Watt. This form must be completed without cost to either Harvey Watt or American Airlines.

Completed Application:

Please return the Employer Statement to your base Flight Administrator. The Employee Statement, Authorization and Initial Physician's Statement including all supporting documentation should be sent to Harvey Watt at:

Harvey Watt & Company – Claims Department
P.O. Box 20787 Atlanta Airport
Atlanta, GA 30320
Fax: 404-761-8326

*** 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.)**

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P. O. BOX 20787, ATLANTA, GA 30320
TELEPHONE (404) 767-7501 or (800) 241-6103 | FAX (404) 761-8326
http://www.harveywatt.com

American Airlines

AMERICAN AIRLINES PILOT LONG TERM DISABILITY
EMPLOYEE STATEMENT

*** RETURN COMPLETED FORM TO HARVEY WATT**

In order to properly process your disability claim Harvey Watt & Company must receive ALL portions of the claim application, completed in full.

EMPLOYEE:

Full Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Cellular Telephone Number: _____

Fax Telephone Number: _____ Employee Number: _____

Date of Birth: _____ Last 4 digits of Social Security Number: _____

Email Address: _____

_____

Claim Information

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): ____/____/____/____/____/____/____/____/____/____/____/____

EMPLOYEE STATEMENT - Continued

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

Complete description of Injury: _____

_____

_____

_____

Cause of Injury: _____

_____

_____

_____

Date of Accident: ____/ ____/ ____ Time of Accident: _____ Injury on Duty? 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: _____ Fax Telephone Number: _____

List any other physicians consulted for this illness or injury:

Name: _____ Address: _____

_____

Telephone Number: _____

_____

Name: _____ Address: _____

_____

Telephone Number: _____

_____

Please list <u>all</u> physicians / providers who have treated you since the beginning of your disability or disqualifying medical condition. (Attach an additional sheet if more space is needed):

Name of Physician, Provider Phone Number	**Dates of Treatment, Reason for Visit**
_____	**From, To** _____
_____	**From, To** _____
_____	**From, To** _____
_____	**From, To** _____
_____	**From, To** _____

EMPLOYEE STATEMENT - Continued

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: ____

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
Workers' Compensation	( ) Yes ( ) No	( ) Yes ( ) No	________________	( ) Yes ( ) No
State Disability	( ) Yes ( ) No	( ) Yes ( ) No	________________	( ) Yes ( ) No

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

Other earned income :	( ) 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 must be notified immediately. We require copies of all letters either denying or awarding any benefits for which you have applied.

EMPLOYEE STATEMENT - Continued

Agreement to Reimburse Overpayment of Long Term Disability Benefits

If I receive a disability benefit payment(s) greater than that which should have been paid, I understand and agree that the Plan has the right to recover such overpayment from me in any manner available, including the right to reduce or cease future payments from the Plan or from American Airlines after I return to work from LTD, and I hereby authorize the deduction of any such overpayment from either my LTD payment or payroll check.

I understand that if I fail to apply for Social Security Disability Benefits or furnish a copy of the Social Security award or denial letter within six months after the disability claim is approved, my benefits under the Plan may be offset by an estimated Social Security Disability award amount.

I understand that I am required to furnish evidence of my initial and continued disability as required and directed and that may include furnishing medical records from any or all providers of medical treatment.

I understand that I am required to pursue appropriate qualified medical care and treatment of my disabling condition. Such qualified medical care must be consistent with the nature of my illness or injury. I understand that my Disability will cease to exist if my health is restored so as not to prevent me from acting as an Active Pilot Employee in the service of the Company.

I understand that my LTD payments will cease the day prior to my release to return to work.

I understand that any disability benefit that I receive will be subject to all of the terms and conditions of the plan.

I certify that the information provided by me in support of this claim is true and correct. I understand that any intentional misrepresentation or falsification of information will be reported to American Airlines and could result in disciplinary action.

Printed Name: _____

Signature: _____

Date:____/____/_____

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http://www.harveywatt.com

American Airlines

Authorization to Disclose Information

HIPAA : This Authorization has been carefully and specifically drafted to permit disclosure of health information consistent with the privacy rules adopted and subsequently amended by the United States Department Health and Human Services pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Instructions for completing the form:
1. Complete all applicable areas of the form.
2. If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Employee/Claimant's behalf.
3. Sign this form.
4. Fax or return this form as soon as possible to expedite processing of your claim – retain original for your records.

Your refusal to complete and sign this form may affect your eligibility for benefits under your employer's disability plan.

_____ / _____ / _____

Name of Employee (Please Print) **Last 4 Digits of Social Security Number** **Claim Number**

For purposes of determining my eligibility for disability benefits, the administration of my employer's disability benefit plan (which may include assisting me in returning to work), and the administration of other benefit plans in which I participate that may be affected by my eligibility for disability benefits, I permit the following disclosures of information about me to be made in the format requested, including by telephone, fax or mail:

1. **I permit:** any physician or other medical/treating practitioner, hospital, clinic, other medical related facility or service, insurer, pharmacy benefit managers, employer, government agency, (for example, including without limitation the Pension Benefit Guaranty Corporation, Federal Aviation Administration, and Social Security Administration), group policyholder, contract holder or benefit plan administrator to disclose, exchange, discuss or release to Harvey Watt & Company ("Harvey Watt"), my employer or any, investigative agencies, attorneys, and independent claim administrators acting on Harvey Watt's behalf, any and all information about my disability claim, including health, medical, and employment information.

2. **I permit** Harvey Watt to disclose, exchange, discuss or release to my employer or to any parties required in the administration of this plan, any and all information about my disability claim, including health, medical, employment information.

This Authorization to Disclose Information Includes the Following Information:

Charts, notes, x-ray reports, operative reports, lab and pharmaceutical or medication records and all other medical information, including surgical notes, 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 or sexually transmitted 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.

I understand that I may revoke this authorization at any time by writing to Harvey Watt and Company at P.O. Box 20787, Atlanta, GA 30320, except to the extent that action has been taken in reliance on it. A revocation of this authorization or the failure to sign this authorization:

- May impair Harvey Watt's ability to evaluate or process my claim for benefits.
- May also impair the 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 Disclose Information - Continued

I understand that the information disclosed to Harvey Watt and my employer pursuant to this authorization may be subject to redisclosure and that information, once disclosed, with my authorization or as otherwise permitted or required by law may no longer be protected by federal rules governing privacy and confidentiality.

I understand and agree that this authorization will be valid for 12 months from the date I sign this form or the duration of my claim for benefits, whichever period is shorter. A photocopy of this authorization is as valid as the original form and I have a right to receive a copy upon request.

I hereby authorize any and all of my health care providers to disclose medical record information and/or protected health information to the following:

Harvey Watt & Company
Attention: Claims Department
P.O. Box 20787
Atlanta, GA 30320

Fax: 404-761-8326

I have read both pages of this authorization and understand that by my signature I agree to both pages of this authorization.

_____ _____

Signature of Employee **Date**

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http://www.harveywatt.com
American Airlines

AMERICAN AIRLINES PILOT LONG TERM DISABILITY
EMPLOYER STATEMENT

*** FORM TO BE COMPLETD BY BASE FLIGHT ADMINISTRATOR**

EMPLOYEE:

Full Name: _____

Base/Station: _____ Employee Number: _____

Date of Birth: _____ Last 4 digits of Social Security Number: _____

Email Address: _____

Claim Information

Date Sick Leave commenced: _____/_____/_____

Last daypaid sick and/or accrued vacation pay _____/_____/_____

Printed Name of Flight Administrator: _____

Signature: _____

Date: _____/_____/_____

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HARVEY WATT & CO

American Airlines

INITIAL PHYSICIAN'S STATEMENT

In order to assist us in expediting the processing of the disability claim for the employee, we require you to complete this form in full, enclose the necessary documentation and return it to us.

PLEASE RETURN COMPLETED FORM TO:

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

FAX | 404-761-8326

The patient is responsible for the completion of this form and the attachment of the necessary documentation without any expense to either American Airlines or Harvey Watt & Company.

TO BE COMPLETED BY PATIENT: (SECTION I)

Patient:

Address:

Phone Number:

Height of Patient: Weight of Patient:

Date of Birth:

Social Security Number: (last four digits)

Doctor:

Address:

Phone Number:

Fax Number:

Specialty:

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

DIAGNOSIS:

Primary:

Primary ICD-9 Code:

Primary PCT-4 Code (if applicable):

Date Patient first consulted for this disability:

Secondary:

Secondary ICD-9 Code:

Secondary PCT-4 Code (if applicable):

Date symptoms first appeared for this disability:

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

LIST ALL 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 that pertain to patient's disability. (Attach additional pages if needed.)

(c) RESTRICTIONS/LIMITATIONS: Detail all of the patient's restrictions and activity limitations that pertain to the disability.

(Attach additional pages if 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 t0 100lbs lifting; carry objects up to 50lbs

These restrictions are in effect until _____(date) or until Plan Participant is reevaluated on _____(date).

(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 patient's customary occupation: _____

Date patient was able to return to patient's customary occupation _____

Estimated date patient will be able to return to patient's 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:

(a) 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)

(b) OTHER PHYSICIANS: List the names and address of ALL consulting physicians for the listed disability

(c) PROGNOSIS: Detailed Prognosis for Return to Work

Physician completing this form confirms he or she is not related to patient by blood, marriage or a domestic partner:

Printed Name:

Signature:

Date: