



# 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/was under my care or medically unable to exercise the privileges of his/her FAA 1st class medical beginning \_\_\_\_\_ (date) and is estimated to be able to return to work \_\_\_\_\_ (date or timeframe) 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: (404) 559-9421 ext 1 • Fax: (404) 559-9817 • E-Mail: Claims@DPMA.org



# Delta Pilots Mutual Aid Disability Claim Form Instructions

A completed Disability Claim Form (DCF) must be submitted to the DPMA Office 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:** DCCU checking account numbers cannot be your employee number and 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. 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 to continue your DPMA benefits by that date.
  - If your treatment is complete but you are awaiting FAA approval, your physician or AME may indicate "Awaiting FAA Recertification" for the through (estimated return to work) date. If you are submitting an **update to your initial claim**, a copy of your FAA letter or a letter from your AME/AMAS stating you are awaiting FAA recertification is acceptable to continue DPMA benefits.
  - If your disability is permanent, have your physician indicate "permanent disability", or if it will be for greater than one year, have your physician indicate "over one year" 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](mailto: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](mailto: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](mailto: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](mailto: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](mailto:claims@dpma.org) .

DII BAA'AKONiNiZIN: Dine' (Navajo) bizaad bee ya'n ihi'go, saad bee aka'anida'awo'igii , t'aa jiiik'eh , bee na'aho'o't'i'. T'aa shoodi dadii'niigo 404-559-9421. [Doodaiiclaims@dpma.org](mailto:Doodaiiclaims@dpma.org)

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