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: _____

INITIAL CLAIM FORM/BANKING UPDATE

Payment Method:

Direct Deposit: ☐ Checking ☐ Savings

Bank Name: _____

REQUIRED: Please attach/submit one of the following:

- Voided Check
- Deposit Slip
- Bank Verification Letter
- Direct Deposit Form

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 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: ☐ Initial DCF ☐ DCF Update ☐

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

Rev. 05/2026

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 a voided check, deposit slip, bank verification letter, or direct deposit form.

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 by the end of each month you exhaust sick leave or your prior claim form is certified through. 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'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. Doodaiiclaims@dpma.org

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