Guardian

APA BENEFITS

Allied Pilots Association
Disability Plans Claims Kit Instructions

General Instructions:

Your claim kit consists of three forms: (1) Claim Form, (2) Authorization to Obtain Information, and (3) Attending 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 that you have not overlooked that particular question. *Sign and date* the forms as requested. This will prevent unnecessary delays in processing your claim.

The Plan requires certain time limits for filing written proof of your claim. To receive benefits as early as possible, your claim must be Filed prior to the exhaustion of your Elimination Period. Claims will not be eligible for payment if Filed after the later of: (1) more than 24 months after the Onset of Disability; or (2) the exhaustion of paid sick and vacation time from the Company. See the *CLAIMS PROCESSING PROVISIONS section* of the *Plan documents for complete claims processing provisions.*

Completed Form:

Please provide the Claim Form, Authorization to Obtain Information and Attending Physician's Statement forms including all supporting documentation and medical records to Guardian to initiate processing of your Disability claim. APA strongly encourages you to keep a copy of your Claim Form. If you do not hear from Guardian within 15 business days of the date that you mailed your Claim Form, you should contact Guardian to confirm that your Claim Form was received.

Guardian Life Insurance Co.
P.O. Box 14331
Lexington, KY 40512

For Questions: (866) 543-0090
Email Submission: APAGuardian@glic.com
Fax: 610-807-8270

Forms - Overview:

1. Claim Form: This form provides us with required claimant information. If you have applied for or are currently receiving Social Security benefits, please provide us with a copy of your application and/or approval letter. This information will be necessary in order for you to qualify for the POD Extended Benefit upon exhaustion of the Basic Benefit.

2. Authorization to Obtain Information: Your signature on this form enables Guardian to obtain the necessary information about you to determine your eligibility for benefits. This authorization also allows Guardian 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. Attending Physician's Statement: (Two-part form)

Section I – You complete. Section II – Your 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 or marriage. You may copy this form or obtain additional copies from Guardian. This form must be completed without cost to either Guardian or the Allied Pilots Association.

Benefit Payments:

Once you complete our Elimination Period, benefit payments will be made to the bank account on file with the Plan Administrator. If you have questions regarding which bank account you have on file, please contact NGS Insurance at 800-298-8793.

• FAILURE TO PROVIDE COMPLETE AND ACCURATE SUPPORTING INFORMATION MAY DELAY THE DETERMINATION OF YOUR CLAIM. (See Physician's Statement for examples of supporting documentation.)

Guardian

APA BENEFITS

ALLIED PILOT ASSOCIATION GRP# 550964 (PMA); 493674 (POD)
DISABILITY PLANS CLAIM FORM

RETURN COMPLETED FORM TO:
Guardian Life Insurance Co.
P.O. Box 14331
Lexington, KY 40512
Email: APAGuardian@glic.com
FAX: 610-807-8270

In order to properly process your Disability claims, we must receive all portions of the claim paperwork completed in full. We must receive the Plan Participant Statement, Attending Physician's Statement and the Authorization to Obtain Information forms with all necessary supporting documentation.

PLAN PARTICIPANT:

Full Name:		☐ PMA only ☐ POD only ☐ Both
Street Address:	City	State: Zip Code:
Telephone number:	Cellular telephone number:	Fax telephone number
Employee number **800+**	Date of birth	Check one: Captain ☐ First Officer ☐
Email address:		
Date of hire:	Last date flown:	Date you became unable to fly:
Are you working now? Yes ☐ No ☐	Date you either returned to work or plan to return to work:	
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, if applicable)

Current ☐ Date Lapsed ☐ Date Deferred ☐ Date
Revoked ☐ Date Denied ☐ Date Date of last Flight Physical ☐ Date

Complete this section ONLY if your Disability is due to a *SICKNESS*:
Nature of sickness:

Cause of sickness:

Date Sickness was first noticed:	Date first treated for sickness:

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): / / / / / /

Complete this section ONLY if your Disability is due to a PREGNANCY:
Due date: / / Date you expect to return to work: / /

☐ PMA only ☐ POD only ☐ Both

Claim Form (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:	Date first treated for Injury:

Location of accident:

Attending Physician information (Attending Physician must not be related by blood or marriage)

Name of Physician:

Mailing address (city)	State:	Zip code:

Telephone number:	Fax telephone number:

List any other Physicians consulted for this Sickness or Injury (use additional paper, if necessary):

Name of Physician:

Mailing address (city)	State:	Zip code:

Telephone number:

Name of Physician:

Mailing address (city)	State:	Zip code:

Telephone number:

List all periods of Hospital admission for the past five years that pertain to or may pertain to your Disability. Use additional paper if necessary.

Name of Hospital:

Address:	State:	Zip code:

Telephone number:	Date of admission: from: / / Thru: / /

Reason for admission:

Name of Hospital:

Address:	State:	Zip code:

Telephone number:	Date of admission: from: / / Thru: / /

Reason for admission:

Claim Form (continued)

PRIOR DISABILITY CLAIM HISTORY: List ALL Sicknesses 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 treatments that pertain to or may pertain to your Disability. (Please attach additional pages if more space is needed):

Name of Physician:			
Address:		State:	Zip code:
Telephone number:	Date(s) of treatment: / / / / / /		
Reason for admission:			

Name of Physician:			
Address:		State:	Zip code:
Telephone number:	Date(s) of treatment: / / / / / /		
Reason for admission:			

Name of Physician:			
Address:		State:	Zip code:
Telephone number:	Date(s) of treatment: / / / / / /		
Reason for admission:			

Are you receiving, eligible to receive, or have you applied to receive benefits from:

Social Security	Application Date / /	Approved Yes ☐ No ☐	Effective date of SSD Benefits	Amount of SSD Benefit

To be eligible for the POD Extended Benefit, the Plan requires the following:

- You must apply for, and be approved for, Social Security Disability (SSD) Benefits.
- You must provide Guardian with a copy of your SSD Benefits application prior to the end of the Basic Benefit period.
- Upon approval for SSD Benefits, you must provide Guardian with:
  (1) proof that the SSD Benefits are effective on or before the end of the period for which the Basic Benefit is payable or the 24-month lifetime payment maximum for Mental or Nervous Disorders and/or Limited-Term Disabilities are payable; and
  (2) a copy of the award showing the amount of the monthly SSD Benefit.

If you become eligible to receive or receive these benefits at a later date, you must notify Guardian and the Allied Pilots Association immediately. We require copies of all letters either denying or awarding any benefits for which you have applied.

I understand that any Disability benefit that I receive will be subject to all of the terms and conditions of the Plans. I certify that the information provided by me in support of this claim is true and correct.

Printed Name: _____

Signature: _____ Date: _____

NOTE: It is the claimant's responsibility to report any changes in work status in writing to: NGS Insurance Agency, Inc., P.O. Box 830836, Richardson, TX 75083-0846 Phone: 800-298-8793 Fax:972-421-0811.

Guardian®

APA BENEFITS

Allied Pilots Association
Disability Plans Authorization to Obtain Information

Remit Form to:
Guardian Life Insurance Co.
PO Box 14331
Lexington KY 40512
Email: APAGuardian@glic.com
FAX: 610-807-8270

I authorize the following persons having any records or knowledge of my health:

- Any Physician, medical practitioner, pharmacy benefit manager, or health care provider that either pertains or may pertain to this reported condition.
- Any Hospital, clinic, pharmacy or other medical or medically related facility or association that either pertains or may pertain to this reported condition.
- Any insurance company that either pertains or may pertain to this reported condition.
- Allied Pilots Association (APA) or any APA Pilot Occupational Disability or Pilot Mutual Aid Plan sponsor.
- Any organization or entity administering a benefit program for Allied Pilots Association.
- The Social Security Administration, any State mandated disability program and the Federal Aviation Administration (FAA) (with the FAA authorization limited to the two years proceeding the date of my Disability as reported for the purposes of this claim for benefits).

To give or exchange the following information that pertains, or may pertain, to my medically Disabling condition or disqualifying condition for the purpose of administering my claim:

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results; as well as summaries of diagnosis, functional status, treatment plan, symptoms, test results, prognosis and progress-to-date of any physical, psychiatric or psychological condition as required by the Plan and allowed by applicable law, but expressly *excludes* psychotherapy notes which are defined as notes recorded by a mental health professional that document or analyze the contents of a counseling session and that are separated from the rest of the medical record.
- Prognosis, treatment and therapy of any condition related to, or as a result of, Chemical Dependency under the Plan and allowed by applicable law. This information will be requested when, and only when, an investigation of Chemical Dependency becomes a bona fide concern and will be restricted to review for the eligibility and administration of Disability benefits as defined under the Plan.
- Financial information necessary for the determination of the coverage and/or benefit amount as required by the Plan.

To Guardian Life Insurance Company and/or the Allied Pilots Association Plan and any of its service providers:

- I understand that Guardian Life Insurance Company, the Allied Pilots Association (APA), the Plan and its service providers, will use the information to assist in the determination of my eligibility or entitlement for benefits.

- I understand and agree that this authorization shall remain in force throughout the duration of my claim for Plan benefits. I understand that I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to Guardian Life Insurance Company, except to the extent that it has been relied upon to disclose requested records. A revocation of the authorization or the failure to sign the authorization may impair Guardian's ability to evaluate or process my claim for benefits and may be a basis for denying my claim for benefits.

Authorization to Obtain Information (continued)

- I understand that in the course of conducting their respective business, Guardian may disclose information they have about me to non-affiliated parties, such as plan administrator or person performing business or legal services for Guardian the Allied Pilots Association, as Plan Sponsor, the Plan or its service providers. Prior to any such sharing, Guardian, the Allied Pilots Association, or the Plan will have an appropriate confidentiality agreement in place between it and any such party.

- I understand that the information disclosed to Guardian, the Allied Pilots Association, or the Plan and its service providers pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the federal privacy regulations or as otherwise permitted or required by law.

- I acknowledge that I have read this authorization. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

- I understand that Guardian may require additional information that was not originally authorized by this form and that it may be necessary for them to obtain additional authorization(s) for this purpose.

- I understand that this release may not be altered in any way.

- I understand that this authorization supersedes any authorization that was submitted prior the date of this form.

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

_____ _____

Printed name of Plan Participant Employee Number

_____ _____

Signature of Plan Participant/guardian/representative Date

_____

Printed name of guardian/representative (*if applicable*)

Guardian

Allied Pilots Association Disability Plan Attending Physician's Statement

APA BENEFITS

Send to: Group Disability Claims, P.O. Box 14331 Lexington, KY 40512
Fax: (610) 807-8270 **E-mail: APAGuardian@glic.com**

MEMBER SECTION

1. Member Name	2. DOB / /	3. Plan Numbers **550964 /493674**	4. Employee Number **800+**
5. Address City State Zip			6. Phone # ( )

PHYSICIAN SECTION

Completion of this form will help to expedite processing of the claim and reduce additional requests and follow up. Your patient is responsible for the cost of completing this form.

1. Diagnosis (including any complications) — ICD9 or DSM IV Codes:

2. Medical evidence that substantiates or contributes to this patient's inability to work (please attach results of x-rays, MRIs, EKGs, etc.)

3. Subjective Complaints

CONDITION HISTORY

4. Patient's symptoms are the result of (check all that apply)
☐ Employment ☐ Pregnancy ☐ Illness ☐ Motor Vehicle Accident ☐ Other Accident
☐ Other

5. Date symptoms first appeared or accident occurred / /

6. Date of your first evaluation for this condition / /

7. Frequency of visit/treatment for this condition
☐ Weekly ☐ Monthly ☐ Other

8. Date of most recent visit/treatment for this condition / /

9. Has this patient ever had a similar or related condition? ☐ Yes ☐ No
If "Yes", when / / Explain:

10. Was this patient referred to you by another physician? ☐ Yes ☐ No If "Yes", please supply physician's complete name and address, specialty, phone # and fax #:

11. Did you refer this patient to another physician/or provider for treatment of this or a related condition? ☐ Yes ☐ No
If "Yes", please supply the physician's/provider's complete name and address, phone # and fax #:

12. Please supply complete name, address and specialty of any other treating physicians or hospitals including phone # and fax #.

Name	Specialty	Address	Phone #	Fax #	Treatment From	Treatment To
					/ /	/ /
					/ /	/ /
					/ /	/ /
					/ /	/ /
					/ /	/ /

If additional space is needed, please attach a separate sheet

Attending Physician's Statement (continued)

TREATMENT

13. Describe this patient's treatment program: (including any surgeries with date and CPT codes)

Medications | Counseling

Therapies | Vocational rehabilitation

PROGRESS

14. Patient has ☐ Recovered ☐ Not Changed ☐ Improved ☐ Retrogressed

15. Patient is ☐ Ambulatory ☐ House Confined ☐ Other ☐ Bed Confined ☐ Hospital Confined

16. Did you place the patient on off work status? ☐ Yes ☐ No

17. If yes, what date? / /

18. Has patient been released to return to work? ☐ Yes ☐ No

If "Yes", date patient was released to return to work? / /

☐ Part Time ☐ Usual Occupation ☐ Full Time ☐ Other Occupation ☐ Other

19. If not yet released to return to work, when do you anticipate a release? / / ☐ Part Time ☐ Full Time ☐ Never

20. Degree of **mental/nervous impairment** Current GAF **(Global Assessment of Functioning)** /90 Please attach mental status exam.

Axis 1 Axis 3

Axis 2 Axis 4

21. Do you believe that this patient is competent to endorse checks and direct the use of the proceeds? ☐ Yes ☐ No

22. Degree of **Cardiac Functional Capacity** (American Heart Association)

☐ Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)

Please supply patient's: height weight blood pressure

PLEASE ATTACH PERTINENT MEDICAL RECORDS INCLUDING BUT NOT LIMITED TO PROGRESS NOTES, DIAGNOSTIC TEST RESULTS, DISCHARGE SUMMARIES, OPERATIVE REPORTS, CONSULTATION REPORTS AND MENTAL STATUS EXAM (IF APPLICABLE). THIS WILL HELP TO EXPEDITE PROCESSING OF CLAIM AND REDUCE ADDITIONAL REQUESTS AND FOLLOW UP.

PHYSICIAN INFORMATION

23. Physician's Name	24. Degree	25. Specialty		
26. Address	27. City		28. State	29. Zip
30. Telephone # ( ) -	31. Fax # ( ) -	32. Tax ID #		

33. **Remarks**

FRAUD NOTICE

Physician completing this form confirms that he or she is not related to Member by blood or marriage and certifies the information provided on this form is accurate.

✖_____ Date ____ / ____ / _____

Signature of Physician (no stamp)