DALRC Retiree Assistance Program, Inc.
Assistance Grant Guidelines and Application
Effective April 1, 2020

Purpose

DALRC Retiree Assistance Program, Inc. (RAP) provides financial assistance for qualified members of the Community of Delta Retirees who are experiencing financial difficulties due to severe health or medical issues.

Eligibility to Receive a Grant

You are eligible to receive a grant under RAP if you meet **each** of the following three conditions:

- Your **annual gross income** in 2019 did not exceed (a) **$49,000**, if you are single; or (b) **$65,000**, if you are married.
- You expect your **annual gross income** in 2020 will not exceed (a) **$49,000**, if you are single; or (b) **$65,000**, if you are married.
- You are a member of the Community of Delta Retirees, as defined below.

If your annual gross income exceeds the applicable amount, RAP's Board of Directors may (a) deny your application; or (b) approve a reduced grant.

Community of Delta Retirees

You are a member of the Community of Delta Retirees if you are in one or more of the following categories:

Category 1 – You were a domestic employee of Delta Air Lines, Inc. (**Delta**) whose employment ended:

- at or after age 50 with at least 25 years of service; or
- at or after age 52 with at least 10 years of service.

Category 2 – You are the spouse of a former Delta employee covered by Category 1 (above); or the surviving spouse, who has not remarried, of a former Delta retiree covered by Category 1 (above).

Category 3 – You (a) were receiving a RAP grant on December 31, 2017; and (b) continue to be a member of the Community of Delta Retirees as defined under the Guidelines in effect on that date.

Types of Grants

A person may file an individual application if he or she is (a) an eligible former Delta employee; (b) the spouse of an eligible former Delta employee; or (c) the surviving spouse, who has not remarried, of an eligible former Delta employee. An eligible former Delta employee and his or her spouse may file a joint application, subject to both qualifying for financial assistance.

Use of Grant
A RAP grant may be used **only** to pay the monthly premiums for Medicare Part B coverage and health insurance. For these purposes, health insurance means medical, prescription drug, dental and vision insurance.

A RAP grant may not be used for any other purpose. This means you may not use a RAP grant to pay (a) Medicare or health insurance deductibles and copayments; or (b) any other health related expense that is not paid by Medicare or health insurance.

Every request for a RAP payment must be substantiated by an invoice or other proper documentation confirming (a) that, to the extent applicable, Medicare Part B coverage, as well as medical, prescription drug, dental and vision insurance is in effect; and (b) that the related premium becomes due and payable on or after the grant's effective date.

Duration of Grant

The RAP Board of Directors may approve a grant at any time during the calendar year. The grant period is valid for up to 12 months following the date of approval.

Renewal of Grant

Renewal of a grant is not automatic. It is the applicant's responsibility to apply for a renewal grant in a timely manner. This is important because the renewal grant is limited to paying monthly Medicare Part B and health insurance premiums that become due and payable on or after the effective date of the renewal grant.

Maximum Monthly Grant Payment
The maximum monthly payment in 2020 for a RAP grant is $526.55. This is equal to the sum of:

- $144.60, which is the standard monthly premium for Medicare Part B coverage in 2020; and
- $381.95, which is the total monthly premium in 2020 to purchase from the Insurance Trust for Delta Retirees its (a) Supplement-Type Enhanced Plan, which includes medical and prescription drug coverage with no deductibles and copayments (subject to certain exceptions); (b) MetLife Dental PPO (ground and flight attendant); and (c) EyeMed Vision Plan. The Supplement-Type Enhanced Plan provides greater benefits than the Insurance Trust's other medical and prescription drug plans.

The Insurance Trust for Delta Retirees provides group health insurance plans to approximately 25,000 Delta retires and their spouses who are age 65 or older. To obtain additional information about these plans, call the Insurance Trust's Retiree Service Center at 1-877-325-7265, or visit its website at **www.itdr.com**.

The Board of Directors may change the maximum monthly payment at any time. It applies whether or not you are eligible to participate in Medicare.

RAP does not recommend any particular insurance provider, or any specific insurance plan. The decision on who to purchase insurance from, and which insurance plan to purchase, is solely up to you. RAP suggests you consider more than one insurance provider and different insurance plans when determining the insurance that best meets your needs. You may wish to contact a licensed broker in your state to assist in making these decisions.

Approval of Application

In order to be considered, an application must first be accepted by the RAP Board of Directors. The Board will not accept an application until it is completed and accompanied by all required documents. Submission of an

incomplete application will delay Board action. Board action and notification to the applicant will normally occur within two weeks after the application is accepted. Distribution of the grant will normally begin within two weeks after the application is approved.

Grant Payments

Grant payments for Medicare Part B premiums are paid to the grantee if, as is typically the case, these premiums are deducted from the grantee's Social Security check.

Grant payments for health insurance premiums are paid to (a) the insurance company if these premiums are paid by check; and (b) the grantee if these premiums are automatically deducted from the grantee's bank account, in which case the grantee must submit the bank statement showing the deduction.

Administration

RAP is administered by the RAP Board of Directors, which has the sole and absolute authority and discretion to interpret, amend, and make exceptions to RAP, including these Guidelines and existing grants. All decisions by the RAP Board of Directors are final and binding.

Erroneous Applications

Upon becoming aware that an application for which a grant was approved contains a material misstatement or a material omission, the Board of Directors will, at its sole discretion, take such action as it deems prudent and reasonable to recover the funds and related expenses incurred in such recovery. By failing to take immediate action, the Board does not waive its right to take action at a later date.

Confidentiality

The information provided in an application is confidential and will be treated as confidential within the RAP organization. Access to this information will only be by specific authority of the RAP Board of Directors or as required by law.

Frequently Asked Questions

- **Can a retiree and his or her spouse apply for separate (individual) grants during the same grant period? –** Yes, subject to each qualifying for a grant.
- **I am a widowed (widower) retiree. If I remarry, will my new spouse be eligible for a RAP grant?** – Yes, provided you and your new spouse each meet the eligibility requirements.
- **I am a surviving spouse of a retiree. If I remarry, will my new spouse be eligible for a RAP grant?** – No. You become ineligible for a grant upon remarriage unless your new spouse meets the eligibility requirements.
- **Is there a deadline to apply for a RAP grant?** – No. Grants are generally awarded based on a 12 consecutive month period, not a calendar year.
- **If I qualify for a RAP grant, will I automatically qualify for another grant after 12 months?** No. You must reapply by submitting another grant application. It is important to submit an application for a renewal grant in a timely manner because the renewal grant may only be used to pay Medicare Part B and health insurance premiums that become due and payable on or after the effective date of the renewal grant.
- **Can Delta provide me with information regarding RAP or RAP grants?** – No. Delta has no part in the administration of the DALRC Retiree Assistance Program, Inc. RAP is administered by an independent Board of Directors who are not paid for serving in that role. Direct any questions to the RAP Board of Directors.

IMPORTANT INSTRUCTIONS

Please read this entire page before proceeding.

Mail only Pages 5 through 11 of this application, along with the required documents described on Page 11, to the following address:

DALRC Retiree Assistance Program, Inc.
155 Westridge Parkway, Suite 220
McDonough, GA 30253

If this is an individual application for a retiree or survivor, you must complete Section A of page 5 of this application. If this is an individual application for a spouse, you must complete Section B of page 5 of this application.

If this is a joint application in which the retiree and spouse are both applying for a grant, the retiree must complete Section A of page 5 and the spouse must complete Section B of Page 5 and also sign Page 11.

For purposes of this document:

- **"Retiree" means a former Delta employee who is a member of the Community of Delta Retirees.**
- **"Spouse" means the spouse of a Delta retiree.**
- **"Survivor" means the surviving spouse, who has not remarried, of a Delta retiree.**

Section A: RETIREE OR SURVIVOR STATEMENT OF NEED

IMPORTANT: Submit only Pages 5 through 11 of this application. If this is a joint application, the spouse must complete Section B of this page

NAME OF RETIREE OR SURVIVOR: _____

Briefly describe the health/medical issues necessitating your request for financial assistance and the reason it has caused a financial hardship. If necessary, use the reverse side. If you are a first-time applicant, in order to be considered for a grant you must include copies of the most recent 3 months of medical billings to prove the validity of your following statement of need.

Section B: SPOUSE STATEMENT OF NEED

IMPORTANT: A spouse must complete Section B of this page and also sign Page 11.

NAME OF SPOUSE: _____

NAME OF RETIREE:_____

Briefly describe the health/medical issues necessitating your request for financial assistance and the reason it has caused a financial hardship. If necessary, use the reverse side. If you are a first-time applicant, in order to be considered for a grant you must include copies of the most recent 3 months of medical billings to prove the validity of your following statement of need.

IMPORTANT: This application is for:

Circle One (Or Two If Your Spouse Is Also Applying)

Retiree Spouse Survivor

PERSONAL INFORMATION

Retiree/Survivor Last Name		**Retiree/Survivor First Name**	
Retiree Date of Birth		**Marital Status**	
Retiree Date of Hire		**Retirement Date**	
Spouse Last Name		**Spouse First Name**	
Spouse Date of Birth			

Address Line 1	
Address Line 2	
City, State, Zip Code	

Home Phone		**Preferred Phone**	
Cell Phone		**Email Address**	

If you or your spouse is employed, complete the following

Your Employer	
City, State, Zip Code	
Spouse's Employer	
City, State, Zip Code	

Other Business Activity

Yes ___ No ___ If yes, briefly describe the business or enterprise and the nature of your involvement. Use the back or a separate sheet if necessary.

CURRENT GROSS MONTHLY INCOME

Common income or expense categories are listed in the following charts. Absence of a pre-printed category in a chart does not relieve the applicant of the responsibility to report it.

Current Monthly Income

Source	Retiree or Survivor Gross Monthly Income	Spouse Gross Monthly Income
Retirement Pension		
Social Security		
Social Security Disability		
PBGC		
Child Support		
Survivor's Income		
Investments, stocks, bonds		
Alimony		
Interest		
Other Employment		
Other Business Income		
Income from 401k		
Income from IRA		
Disability Insurance		
Trust		
Other (Specify)		
Total Gross Monthly Income		

If additional space is required, use the reverse side on this page

Cash Assets

Cash on Hand:	Retiree or Survivor	Spouse
Checking Account		
Savings Account		
Certificates of Deposit (market value)		
Stocks/Bonds/Mutual Funds (market value)		
401K		
IRA		
Money Market Fund		
Health Savings Account		
Debts owed to you		
Cash Value of Whole Life Insurance Policy		
Other Assets (Specify)		
Total		

Non-Cash Assets

Combined Assets	Market Value	Balance Owed
Primary Residence		
Second Home / Vacation Property		
Auto		
Motorcycle		
Boat		
Airplane		
Recreational Vehicle		
Other Real Estate		
Other Assets (List)		
Total Non-Cash Assets		

Monthly Household Expenses

Item	Monthly Expense	Past Due Balance
Rent/Mortgage		
Utilities (electricity, gas, water)		
Telephone, Cable, Internet, Television		
Food		
Homeowner's / Renter's Insurance Premiums (monthly)		
Real Estate Tax (monthly)		
Auto Insurance (monthly)		
Auto Payment, 1st Car		
Auto Payment, 2nd Car		
Auto Gas		
Medical expenses and copays not covered by health insurance		
Hygiene and medical supplies required due to health issues		
Health Insurance Premiums (monthly)		
Medicare Insurance Premium (monthly)		
Other (explain on reverse side)		

Loan Expenses (Include Auto, Credit Cards, Personal Loans, etc.)

Creditor	Monthly Payment	Past Due Amount	Balance

Health Insurance Profile

This page must be completed in its entirety. If you have one or more types of the insurance listed, enter the appropriate information. Should you not have a policy type that is listed, enter "NONE"

Health Insurance Profile					
Medicare Part B	**Retiree/Survivor**		**Spouse**		
I have Medicare Part B		(Yes)		(Yes)	
I do NOT have Medicare Part B		(No)		(No)	
Monthly Premium (if Applicable)	$		$		

Medical Insurance	**Retiree/Survivor**	**Spouse**
Name of Insurance Company		
Name of Plan		
Monthly Premium (if Applicable)	$	$

Drug Plan Insurance	**Retiree/Survivor**	**Spouse**
Name of Insurance Company		
Name of Plan		
Monthly Premium (if Applicable)	$	$
Dental Insurance	**Retiree/Survivor**	**Spouse**
Name of Insurance Company		
Name of Plan		
Monthly Premium (if Applicable)	$	$

Vision Plan Insurance	**Retiree/Survivor**	**Spouse**
Name of Insurance Company		
Name of Plan		
Monthly Premium (if Applicable)	$	$

IMPORTANT: You must submit the following documentation with your application. You also may be asked to provide additional documentation during the approval process.

- A copy of your and/or your spouse's Delta Retiree ID card (if applicable).
- A copy of your and your spouse's Driver's Licenses.
- A copy of your and/or your spouse's most recent Delta pension pay statement and/or other pension statements.
- A copy of your health insurance premium bill. If the premium is automatically deducted from your bank account, send a copy of your bank statement displaying the premium deduction. Be sure to completely black out all account number(s) on bank statement (s).
- 1st time applicant only - copies of the most recent 3 months of medical billings to prove the validity of your statement of need.
- A copy of your most recent bank statement and all of your most recent credit card bills and loan payment statements. Black out all account numbers.
- A copy of your most recent IRS Form 1040, 1040A, or 1040EZ. Be sure to completely black out all references to your Social Security number.
- A copy of your most recent statement from Social Security titled **"Your New Benefit Amount".**
- Copies of applicable Medicare Part B premium and health insurance premium documents to support expenses for which you are requesting reimbursement.

Applicant's Certification

Read and Initial Each Item

_____I understand grants must be approved by the RAP Board of Directors (Board) and that the Board's decision will be based on information provided in the application. I also understand that the decision(s) of the Board are final and not subject to challenge in any forum.

_____I understand the Board in its sole discretion may modify or terminate my grant at any time after it is approved, including to delay, reduce or eliminate any payment under my grant.

_____I agree that this application, together with any enclosures or attachments, become the property of RAP, whether or not my application for a grant is approved, and that the application, together with any enclosures or attachments, will not be returned.

_____I agree to notify RAP if my circumstances change and I no longer qualify for a grant.

_____I understand and agree that knowingly or intentionally make a false statement on this application for a financial grant from RAP may constitute fraud.

_____I understand and agree that if my RAP application contains a material misstatement or a material omission, the Board may, at its sole discretion, require me to repay all or part of any RAP grants that I received.

_____I understand that the Board decision may or will be based on any information submitted by me, including Personal Health Information (PHI), and that I have voluntarily disclosed such information to RAP and consent to RAP using such PHI in any Board decision.

_____I understand that RAP does not act as a "Covered Entity "under HIPPA regulations, but that RAP shall treat PHI as confidential and will not disclose such information to an unrelated third party, other than to RAP's consultants, auditors or attorneys.

I certify that I understand all initialed items above and agree to all the terms and that all information provided in this application is, to the best of my knowledge, true and accurate.

_____ _____

Retiree or Survivor's Signature **Date Signed**

_____ _____

Spouse's Signature **Date Signed**

Revised: April 1, 2020