DALRC Retiree Assistance Program, Inc.
Grant Guidelines and Application

Effective January 1, 2025

Purpose

The 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 Apply for a Grant

You are eligible to apply for a grant from RAP if you meet **each** of the requirements listed below.

- Your **annual gross income** in 2024 did not exceed (a) **$56,475,** if you are single; or (b) **$76,650**, if you are married and living with your spouse.

- You expect your **annual gross income** in 2025 will not exceed (a) **$56,475**, if you are single; or (b) **$76,650** if you are married and living with your spouse.

- You are a member of the Community of Delta Retirees, as defined below.
  Category 1 – You were a domestic employee of Delta Air Lines, Inc. and now are classified by Delta as a retiree and served a minimum of 10 years with Delta, which may include service with any airline that was acquired by or merged with Delta (NWA, PAA, WAL, or NEA).
  Category 2 – You are the spouse of a retired Delta employee covered by Category 1 (above); or the surviving spouse, who has not remarried, of a Delta retiree covered by Category 1 (above).

- If you are eligible for Medicare coverage, you must be enrolled in Medicare Part B.

(NOTE: 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.)

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 to (a) reimburse the monthly premiums for Medicare Part B coverage and/or health insurance coverage; (b) reimburse prescription drug copays or full amount not paid by insurance, and (c) reimburse dental copays and other dental expenses, not paid by insurance, for dentures or crowns PROVIDED the grantee has dental insurance. A RAP grant may not be used for any other purpose.

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 twelve months following the date of approval.

Renewal of Grant

Renewal of a grant is not automatic. It is the grantee's responsibility to apply for a new grant in a timely manner. This is important because the beginning date of a new grant is not retroactive to the termination date of a previous grant which will result in a gap in benefits.

Grant Benefits/Payments

A twelve-month grant may include one or more of the following benefits:

Medicare Part B and Other Health Insurance Premiums – Reimbursement of monthly Medicare Part B and other health insurance premiums. The maximum monthly premium reimbursement amount in 2025 is $527.68. This is equal to the sum of:

- $185.00, which is the standard monthly premium for Medicare Part B coverage in 2025, and
- $342.68, which is the total monthly premium in 2025 to purchase from the Insurance Trust for Delta Retirees its (a) Supplement-Type Standard Plan + Rx; (b) Delta Dental PPO (Ground & Flight Attendant), and (c) Vision Plan.

Prescription Medications – Reimbursement of prescription drug copays, or full amount, not paid by insurance ($2,500 twelve-month grant maximum). Must be supported by an itemized receipt. Over-the-counter products are not eligible.

Dental Expenses – Reimbursement of dental copays and other dental expenses, not paid by insurance, for dentures or crowns ($3,000 twelve-month grant maximum) PROVIDED grantee has dental insurance. Must be supported by an itemized receipt.

NOTE: The Board of Directors reserves the right to change the maximum payment amounts at any time.

Change of Circumstances

During your grant period, circumstances may change which could affect your grant eligibility. For example, life events such as death or divorce could change the original qualification and affect the continuation of a grant. The receipt of substantial financial assets from an inheritance or sale of property also could affect the continuation of a grant.

If your circumstances change, you must notify RAP immediately. If you fail to do so, the Board of Directors may, 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.

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.

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 or Fraudulent Applications

Upon becoming aware that an application for a grant contains a material misstatement or a material omission, the Board of Directors may reject the application and suspend eligibility for all future grant applications. If it is discovered a grant that previously was approved contains a material misstatement or a material omission, the Board of Directors may, 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 twelve consecutive month period, not a calendar year.

- **If I qualify for a RAP grant, will I automatically qualify for another grant after twelve months?**
  No. You must reapply by submitting a new grant application. It is important to submit a new application in a timely manner because the beginning date of a new grant is not retroactive to the termination date of a previous grant which will result in a gap in benefits.

- **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. Applicant must sign and initial page 11.

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. Both applicants must sign and initial 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. **FIRST TIME APPLICANTS ONLY:** To be considered for a grant you must provide sufficient health/medical documentation from the most recent 12 months to validate the reason health/medical issues have created your financial hardship.

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. **FIRST TIME APPLICANTS ONLY:** To be considered for a grant you must provide sufficient health/medical documentation from the most recent 12 months to validate the reason health/medical issues have created your financial hardship.

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.

GROSS MONTHLY HOUSEHOLD 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.

Gross Monthly Household 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 - 1st		
Auto - 2nd		
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 Auto		
Auto Payment, 2nd Auto		
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)		
TOTAL		

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 the account number on the bank statement.
- Copies of your most recent bank statement and all of your most recent credit card bills and loan payment statements. Also, a copy of your most recent financial statement from each of your savings, retirement or other investment accounts. Be sure to completely black out all account numbers on the statements.
- A copy of your most recent IRS Form 1040, 1040A, 1040EZ or 1040SR. Be sure to completely black out all references to your Social Security number.
- A copy of your most recent statement from the Social Security Administration titled **"Your New Benefit Amount".**
- A copy of your health insurance cards or a statement from your health insurance company that lists the types of coverage (medical, prescription drug, dental, vision) for which you are insured. Be sure to completely black out your insurance number.
- **FIRST TIME APPLICANTS ONLY**: To be considered for a grant you must provide sufficient health/medical documentation from the most recent 12 months to validate the reason medical/health issues have created your financial hardship.

Applicant's Certification

Applicant(s) Must 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 and/or further information available to RAP through investigation of public records or other sources. 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 making 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 and effective: January 1, 2025