

APPLICATION FORM FOR DELTA AIR LINES 1114 COMMITTEE HARDSHIP FUND

The purpose of this hardship fund is to provide temporary assistance in 2007 for non-pilot retirees, their survivors, and their spouses enrolled in the Delta Family Care Medical Plan (for those under 65) or (starting in 2007) enrolled in the DALRC Health Plan for Delta Retirees (for those age 65 and older) who face serious hardship because of their financial situation, medical needs, and the cost increases for medical and prescription drug benefits that become effective on January 1, 2007. The hardship fund can be used to pay a portion or all of your medical premium costs for 2007. No payment will be made for Dental or Vision coverage

1. Application must be completed neatly and accurately. Please print or type.
2. All requested materials must be included. Any documents missing from the application may prevent processing of the application, and if you are submitting the application without the requested materials, please provide an explanation of why the requested materials are missing. Attachments should be stapled to this application in the order they are requested on the application form. Be sure your name appears at the top of each attachment.
3. No materials will be returned so please do not send originals.
4. Applications for hardship payment must be received by the 1114 Committee no later than February 28, 2007. No applications will be accepted after that date. Applications will be considered before that date, and will be reviewed as soon as December 10, 2006. Your chances of favorable consideration may be improved by your completing this application earlier than the February deadline. Applications should be sent to the address below:

Delta Section 1114 Non-Pilot Committee of Retirees
c/o Farella, Braun & Martel LLP
235 Montgomery St., 18th Floor
San Francisco, CA 94104

5. If your application is approved, payment will be made for you to the Plan Administrators if you are in the 65 and older DALRC Benefits Plan. The Committee is currently working with Delta to arrange for payment to be made to the Delta Family Care Medical Plan on your behalf if you are under 65 and enrolled in that Plan. Future monthly payments will then be reduced to reflect your hardship payment. YOU ARE RESPONSIBLE FOR PAYING YOUR HEALTH CARE PREMIUMS. IN 2007 YOU MUST ENROLL IN THE DELTA FAMILY CARE MEDICAL PLAN (FOR THOSE UNDER 65) OR IN THE DALRC MEDICAL PLAN FOR DELTA RETIREES (FOR THOSE 65 AND OLDER) TO BE ELIGIBLE FOR PAYMENTS FROM THIS HARDSHIP FUND.
6. Decisions by the committee will be final.

Applicant's Last Name _____

TO BE COMPLETED BY APPLICANT
PLEASE PRINT OR TYPE

Applicant Name:

Last _____ First _____

Middle _____

Delta Employee Number _____

Mailing address:

Street
address _____

City _____ State _____ ZIP _____

Home Phone _____ Daytime phone _____

Email address _____

The best way and time to contact me is:

Age on January 1, 2007: _____

I am a: (check as appropriate)

Delta non-pilot retiree ___ Survivor of a Delta non-pilot retiree ___

This application is for:

___ myself ___ myself and my spouse

I am filing for the following reason: check one

Financial Hardship ___ Other _____

Please briefly explain below (also feel free to use and attach a separate additional page) and attach any supporting documents not requested below:

Applicant's last name: _____

If you answered no just above did you (or your spouse, if you are a surviving spouse) retire before November 2, 1993? Yes___ No___

Were you enrolled in Delta medical and prescription drug benefits in 2006?

Yes _____ No _____

If not, why not? _____

Are you married? Yes_____ NO_____

How many dependents do you have? _____

How much did you pay monthly for your Delta medical and prescription drug benefit premiums in 2006 (not including vision and dental premiums or prescription co-pay costs)? \$_____

My total expected monthly payment for medical and prescription drug coverage premiums in 2007 is \$_____/Month. (Do NOT include dental and vision premiums.)

What is your current monthly income from pension, social security, investments, interest income and other income? \$_____

Are you or your spouse on Medicaid? Yes_____ No_____

Are you or your spouse disabled? Yes_____ No_____

If so what is the disability? _____

Are you or your spouse currently employed?

Full time_____ Part time_____ Estimated annual earnings \$_____

Applicant's last name: _____

Please attach: (1) a copy of your Delta Air Lines Retiree ID card
(2) a copy of your November 2006 (or other 2006 monthly) Delta Pension check stub
(3) attach a copy of your 2005 IRS form 1040 or 1040A (tax returns) plus schedules A and B (if filed) for those tax returns (Social Security or tax identification numbers should be deleted or marked out.) Provide the same items for 2006 if you have filed your 2006 tax returns before this application is submitted
(4) a self-addressed stamped envelope. Approvals or rejection notices will be mailed before May 31, 2007, and some interim approvals may be granted earlier than that.

NOTE: The review committee reserves the right to request additional information as needed.

What other information would you like us to be aware of in deciding on your application? Please describe briefly and feel free to use and attach a separate additional page.
