Delta Employee & Retiree Care Fund
Grant Application

You hereby acknowledge and agree that in order to complete this Delta Care Fund (the " Care Fund") Grant Application, you may be required to submit personal data to the Care Fund. By submitting any such personal data to the Care Fund, you agree to allow the Care Fund to process your personal data and to transfer your personal data to the Care Fund's headquarters in Atlanta, Georgia, U.S.A. or to any other location in the world for any purpose related to the evaluation of your Grant Application and/or any grant you receive from the Care Fund. "Personal data" means any information relating to you including, without limitation, employment, income, financial, health and medical information. "Process" in relation to personal data means the following operations: collection, recording, organization, storage, amendment, retrieval, consultation, use, disclosure, and similar operations.

You additionally hereby authorize the Care Fund to verify any information provided on the Grant Application, in its sole discretion. In connection with any such inquiry, the Care Fund will avoid disclosing any personal data unless the Care Fund determines that such disclosure is necessary in order to properly evaluate your Grant Application.

Care Fund applicants should read the Care Fund Grant Application Instructions and Care Fund Grant Guidelines posted on Deltanet before proceeding with this application (see Deltanet > Company Info > Delta People Care > Care Fund).

MUST BE READ AND SIGNED BY ALL APPLICANTS:

I hereby authorize the Care Fund to verify any information provided on the Grant Application, in its sole discretion. In connection with any such inquiry, the Care Fund will avoid disclosing any personal data unless the Care Fund determines that such disclosure is necessary in order to properly evaluate my Grant Application.

In the event the Care Fund determines in its sole discretion that any information or personal data provided by me as part of my application may be falsified or fraudulent, the Care Fund reserves the right to provide all information provided by me or associated with my application to proper authorities for prosecution or to Delta Air Lines, Inc. which may result in an employment action against me.

I hereby certify that I have read the Care Fund Grant Application Instructions and Care Fund Grant Guidelines posted on Deltanet and that the information contained in this application and the supporting documents is accurate and true to the best of my knowledge.

I attest that I will immediately notify the Delta Care Fund of any changes to the information provided in my application. I understand that the Delta Care Fund reserves the right to request repayment of all or part of the grant if:

1. I receive funds based upon false statements in my application or falsified supporting documents.
2. I receive funds from another source to satisfy the same financial obligations as stated in this application.
3. I receive funds from a future settlement as a result of the circumstances that led to my request, approval and receipt of grant funds.

If you do not agree with this statement, your Grant Application will not be processed.

_____ _____

Applicant's Signature (Required) *Date*

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You will be required to fax application and supporting documentation requested in the instructions. After completing this application, you will be contacted by the Care Fund and may be asked to provide additional supporting documentation.

When faxing any documents, you must print 'CARE FUND', YOUR FIRST AND LAST NAME AND EMPLOYEE ID NUMBER at the top of each page of the application and supporting documentation you submit. You may Fax the documents to 866-726-2413 (domestic), or 602-797-6025 (International).

For help completing this application contact the Delta Care Fund at 404-715-1726.

Other resources, in addition to the Care Fund:

EAP - The Employee Assistance Program (EAP) can provide a variety of resources including free counseling and a financial planning referral.

You can reach them at 800-533-6939 24 hours a day, seven days a week. Applicants are encouraged to request a free financial planning session when submitting a grant application.

UPLIFT - Delta's Uplift program rewards you financially for promoting the Delta SkyMiles Credit Card from American Express. Get started today by creating your account at www.deltauplift.com and check out the Uplift page on Deltanet for complete details. For login, redemption or general assistance, please contact the help desk at support@deltauplift.com or call 1-800-667-1068 (9AM – 6PM EST, M-F).

DALRC Retiree Assistance Program, Inc. (RAP) - RAP is a separate charitable organization whose mission is to offer financial assistance to Delta's domestic retirees, spouses and survivors who have fallen on financial hard times due to health-related circumstances. This non-profit organization is administered by volunteers who are Delta retirees and is funded by donations from both active employees and retirees. Program details are available at www.dalrc.org.

Fields marked with an asterisk (*) are required.

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Applicant Information

Employee Number

Full Name

Preferred Name

Job Title

Contact Information

Home Phone Number

Email Address

Mobile Phone Number

Office Phone Number

Address Line 1

Zip Code

Address Line 2

County

City

State

Employment Date and Other Personal Information

Initial Hire Date

Full Time/Part Time

Date of Birth

Leave Status (i.e., STD, LTD, OJI, etc.)

Delta Retiree? (yes/no)

Marital Status

Delta Retirement Date

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Enter total number of people living in your household who are dependent on you for financial support:

Number of dependents _____

Dependent Information

Dependent Name	*Relationship Status*	*Date of Birth*	*Age*	*Enrolled in Medical/Dental Benefits?*	*Enrolled in Pass Travel Privileges?*

Please identify any other household members who are dependent on you and are <u>not</u> eligible for Delta pass privileges, or Health & Welfare benefits, by name, relationship, age.

Dependent Name	*Relationship Status*	*Date of Birth*	*Age*

Have you or any other family members ever received financial assistance from the Delta Care Fund?

☐ *Yes* ☐ *No*

Are you a partner in any partnership or an owner or part-owner of any other business?

☐ *Yes* ☐ *No*

If Yes, Please Describe:

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Hardship Details

Use this section to provide details about your hardship. Please provide as many details as possible so that the Grant Evaluation Committee will have a clear understanding of your situation.

1. In order to be qualified to receive a grant from the Delta Care Fund, you, your spouse or domestic partner, or one or more of your dependents must have suffered a particular and extraordinary hardship. Please indicate which circumstance created your hardship. If more than one circumstance applies, select other and specify.

☐ *Accident* ☐ *Fire* ☐ *Illness* ☐ *Injury* ☐ *Disaster* ☐ *Other (Specify Below)*

2. When did event happen that created the hardship for which you are requesting assistance? (Enter date only in box below)

Month/Day/Year: | |

3. Describe in detail the reason for your request and provide any details that will assist the Delta Care Fund to evaluate your request.

4. List all the actions you and your household have taken or plan to take to offset the financial impact of your hardship. This may include assets or stocks sold, 401(K) withdrawals, loans, additional employment, or increasing hours worked.

5. Describe any losses, costs, and/or expenses you have incurred in connection with your hardship. If possible, include any actual or estimated values associated with such losses, costs and/or expenses.

6. What is the total amount of financial assistance you are requesting from the Delta Care Fund? | |

7. (Administrator use only)

8. (Administrator use only)

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9. List bills in the order that you need them to be paid if funds are granted.

Priority	*Payable To*	*Amount to be Paid*	*Reason*

10. Approved grants are paid to the applicant by issuing a check mailed to home address listed on this application or by an electronic transfer of funds into applicant's bank account.

Select circle preferred method of payment:

[1] Payment by Check (mailed) or

[2] Deposit Funds Electronically (into your bank account)

Complete following section if you selected Deposit Funds Electronically:

Include a voided check or bank document
(Document must include applicant's name and address)

Account Type:

Bank Name:

Account number:

Routing Number:

Example of routing and account number

International Applicants Only:

SWIFT Code(Int'l only):

Bank Address(Int'l only):

Bank Phone Number(Int'l only):

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11. Are you being evicted or foreclosed?

☐ *Yes* ☐ *No*

Enter the date of eviction or foreclosure: _____

Total Monthly Household Income

Use this section to provide all sources of income you and your spouse or domestic partner receive each month. Gross monthly pay is your income before any taxes and deductions. You must provide all sources of support your household receives each month. Enter all amounts in your local currency.

Applicant's Monthly Income

Gross Delta Pay (Pre-tax)		***Gross Non-Delta Pay (Pre-tax)***	
Pension		*Alimony*	
Child Support		*Worker's Compensation*	
Trust		*Social Security Income*	
Disability Insurance			

Other	*Description*	*Amount*

Spouse or Domestic Partner's Monthly Income

Spouse or Domestic Partner Gross Delta Pay (Pre-tax)		***Spouse or Domestic Partner Gross Non-Delta Pay (Pre-tax)***	
Pension		*Alimony*	
Child Support		*Worker's Compensation*	
Trust		*Social Security Income*	
Disability Insurance			

Other	*Description*	*Amount*

* ***Total Monthly Income:***

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Total Monthly Household Expenses (List all combined monthly expenses for applicant & spouse or domestic partner)

	Monthly Expenses	*Past Due Amount Owed*	*Total Loan or Balance Owed*
Housing Expenses			
Mortgage			
Rent			
Renter/Home Insurance			
Electricity			
Heat (Natural Gas, Oil)			
Water			
Garbage			
Transportation Expenses			
Vehicle Loan Payment			
Vehicle Lease Payment			
Total Vehicle Insurance			
Total Gasoline Expense			
Public Transportation Expense			
Communication Expenses			
Cable			
Internet			
Bundle(Cable/Internet/Phone)			
Landline			
Mobile			
Child Expenses			
Child Care			
Child Support Payment			
Child Activities			
Other Child Expenses/Description			
Medical/Insurance Expenses			
Medication Expense Not Covered by Insurance			
Medical Expenses Not Covered by Insurance			
Dental Expenses Not Covered by Insurance			
Vision Expense Not Covered by Insurance			
Medical/Dental/Vision Insurance Premiums			
Other Premiums (Life, STD, LTD, etc.)			

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Miscellaneous		
Food		
Alimony		

* ***Total Monthly Expenses:***	

Loans

Loan Type	*Monthly Expenses*	*Past Due Amount Owed*	*Total Loan or Balance Owed*	*Provider Name*

Credit Cards

Issuer	*Monthly Expenses*	*Past Due Amount Owed*	*Total Loan or Balance Owed*	*Description of Charges*

Other Expenses

Description	*Monthly Expenses*	*Past Due Amount Owed*	*Total Loan or Balance Owed*

Total Monthly Expenses:	
Total Monthly Income:	
Income Minus Expenses	

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Total Assets (Applicant and Spouse or Domestic Partner)

Use this section to detail your household's current assets. Provide requested details for you and your spouse or domestic partner.

	Employee Amount	*Spouse/Domestic Partner*
Cash (Including Checking/Savings Account Balance):		
Investments (Market Value):		

Home

Market Value:	
Balance Owed:	
Equity:	

Vehicles

Type of Vehicle	*Year of Vehicle*	*Model of Vehicle*	*Market Value*	*Amount Owed*
			$	$
			$	$

Other Assets

Description	*Market Value*	*Balance Owed*	*Equity*
	$	$	$
	$	$	$

Prior to submitting your application, please read the following statements.

I understand that the Delta Care Fund reserves the right to request repayment of all or part of the grant if:

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2. *I receive funds from another source to satisfy the same financial obligations as stated in this application.*
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I hereby certify that the information contained in this application and the supporting documents is accurate and true to the best of my knowledge. I attest that I will immediately notify the Delta Care Fund of any changes to the information provided in my application.

Sign below if you agree with this statement. If you do not agree with this statement, you cannot submit your Grant Application.

_____ _____

Applicant's Signature (Required) *Date*