Symetra Life Insurance Company
777 108th Ave NE, Suite 1200| Bellevue, WA 98004

Return Applications to: Harvey Watt & Company
PO Box 20787| Atlanta, GA 30320 | Phone 1-800-241-6103 | Fax 1-404-761-8326

SUMMARY OF GROUP SHORT AND LONG TERM DISABILITY INCOME INSURANCE

For the Employees of

Republic | Aviation Health Association

For coverage effective January 1, 2015. The information in this summary may be replaced by any subsequently issued summary or policy amendment.

GROUP VOLUNTARY SHORT TERM DISABILITY INCOME INSURANCE

Eligibility

All Republic Teamsters Local 357 Pilots Considered a Full-Time Employee and receiving 75 credit hours per month as a member of the Aviation Health Association.

Definition of Disability

Due to sickness or injury the insured is considered disabled during and following the elimination period, if unable to perform with reasonable continuity the material and substantial duties of your regular occupation or you are deemed by the Federal Aviation Administration (FAA) to be mentally or physically unfit to fly as a commercial pilot while you are covered under the policy and, as a result, the income you are able to earn is less than or equal to 80% of your pre-disability earnings.

Benefits

If you become disabled due to a sickness or injury and have short term disability income coverage, benefits commence on **Day 1** as a result of an injury and **Day 8** as a result of a sickness. Symetra Life Insurance Company will pay your benefit to you while you are disabled under the terms of the policy. The short term disability income weekly benefit will be 60% of your reported earnings to a maximum of $1,500 per week. The minimum weekly benefit is $25.00. The maximum payment duration is 26 weeks. Pre-existing Conditions Limitation: 3/12

Standard Provisions

- Direct Integration with Salary Continuation, Worker's Compensation & Any Other Group Insurance Program
- Maternity is covered as any other condition.
- 14 day recurrent disability/temporary recovery.
- Cost of Living Freeze.

Rates

Rates per $10 of covered benefit:

Employee Age	Rates
Under 40	$1.020
40-49	$1.360
50-59	$2.360
60 and over	$4.120

How to Calculate Your Cost

Employee: _____ (Rate) x _____ (your basic weekly reported earnings x .60 to a maximum of $1,500) /10 = $_____ (Monthly Short Term Disability cost)

[TRUSTEES OF THE AVIATION HEALTH ASSOCIATION]

GROUP VOLUNTARY LONG TERM DISABILITY INCOME INSURANCE

Eligibility

All Republic Teamsters Local 357 Pilots Considered a Full-Time Employee and receiving 75 credit hours per month as a member of the Aviation Health Association.

Definition of Disability

During the Elimination Period and the first 48 months of disability benefits, the insured is considered disabled if he/she is unable to perform with reasonable continuity the material and substantial duties of his/her regular occupation or you are deemed by the Federal Aviation Administration (FAA) to be mentally or physically unfit to fly as a commercial pilot, and as a result, the income he or she is able to earn is less than or equal to 80% of pre-disability earnings.

After the first 48 months of disability benefits, the insured is considered disabled if he/she is unable to perform with reasonable continuity the material and substantial duties of any gainful occupation, and as a result, the income he or she is able to earn is less than or equal to 60% of pre-disability earnings.

Benefits

If you become disabled due to a sickness or injury and have short term disability income coverage, benefits being after the greater of 180 days or the end of Salary Continuation and Short Term Disability Income benefits . Symetra Life Insurance Company will pay your benefit to you while you are disabled under the terms of the policy. The long term disability income monthly benefit will be 60% of your reported earnings. The minimum monthly benefit is the greater of $100 or 10% of your gross disability payment, to a maximum of $7,500 per month. The maximum payment duration is to Social Security Normal Retirement Age, SSNRA, the age in which you are eligible for Social Security full retirement benefits.
Mental Illness/Substance Abuse limitation is 24 months lifetime. Pre-existing Conditions Limitation: 3/12.

Standard Provisions

- Maternity is covered as any other condition.
- Accumulation of the elimination period
- Waiver of Premium
- 6-month recurrent disability/temporary recovery
- Workplace Modification
- Social Security Advocacy
- Cost of Living Freeze

Rates

Rates per $100 of covered benefit:

Employee Age	Rates	Employee Age	Rates
Under 25	$0.590	45-49	$3.500
25-29	$0.590	50-54	$6.520
30-34	$0.940	55-59	$9.710
35-39	$1.450	60-64	$10.940
40-44	$2.370	65 and over	$10.940

How to Calculate Your Cost

Employee: _____ / 12 = _____
Annual Salary — Monthly Earnings (if this number is greater than $12,500, use $12,500)

_____ /100= _____
Monthly Earnings — Units

_____ x $_____ = $_____
Units — Rate — Cost per Month

This summary provides only a brief description of Disability Income Insurance coverage insured by Symetra Life Insurance Comp any under the GDC 4000 series Group Disability Income Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please call 1-800-426-7784 or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-016062-03. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Insured by Symetra Life Insurance Company

Here's How to Apply

1. **Print and complete the application in its entirety and sign and date the application.**
2. **Submit a photocopy of your most recent FAA 1st Class Medical Certificate with your application. (If you carry a Special Issuance Certificate (SODA) issued by the FAA, include a photocopy with your application).**
3. **Complete payment authorization**
    - **Write void across a blank check and attach**
    - **Complete and sign form.**
4. **Mail all of the above along with this form to:**

    Harvey W. Watt & Co
    PO Box 20787
    Atlanta GA 30320

    Or fax all of the above to: (404)-761-8326
    Or email all of the above to pilot@harveywatt.com

Note:

- **If additional information or underwriting is required, you will be notified by Harvey W. Watt & Co.**
- **Please call us 1-800-241-6103 if you have questions.**

APPLICATION FOR MEMBERSHIP IN THE AVIATION HEALTH ASSOCIATION

THE AVIATION HEALTH ASSOCIATION is an organization whose purpose is to promote the welfare and best interests of its members; to assemble and distribute information related to the health and safety of professionals in the airline industry; and to enhance social and economic conditions for its members through cooperative enterprises as a professional or commercial association. One of the benefits of membership is eligibility for group insurances. If you are not already a member of the Aviation Health Association, complete the application below.

I hereby make application for membership in the Aviation Health Association. I certify that I currently hold a valid FAA Medical Certificate that was not obtained by misstatement or concealment and that I am currently employed as a pilot or flight engineer as my primary occupation.

Printed Name: _____

Signed: _____ Date: _____

Attach Voided Check

AUTHORIZATION FOR PREMIUM PAYMENTS

Here's how to use the Pre-Authorization Premium Payment Plan:

Complete and sign the Membership Premium Payment Authorization form.

That's all there is to it. Your monthly premiums will be paid automatically, electronically. There's nothing more for you to do but to enjoy all the security of this plan.

☐ Check here if you prefer Annual Billing. (Monthly premium x 12)
Annual invoices are mailed to the address on file.

MEMBERSHIP PREMIUM PAYMENT AUTHORIZATION FORM

AUTHORIZATION AGREEMENT FOR PRE-ARRANGED PAYMENTS (ACH DEBITS) TO HARVEY W. WATT & CO.
FOR PREMIUMS DUE ON PILOT OCCUPATIONAL DISABILITY AND/OR LIFE INSURANCE

I (we) hereby authorize HARVEY W. WATT & CO. to initiate debit entries to my (our) Checking or Credit Union draft account indicated below and the bank or credit union named below, hereinafter called DEPOSITORY, to debit the same to such account.

BANK NAME _____

TRANSIT/ABA NO. _____ ACCOUNT NO. _____

This authority is to remain in full force and effect until HARVEY W. WATT & CO. and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford Harvey W. Watt & Co. and DEPOSITORY a reasonable opportunity to act on it. I (or either of us) have the right to stop payment of a debit entry by notification to DEPOSITORY at such time as to afford DEPOSITORY a reasonable opportunity to act on it prior to charging my (our) account. After account has been charged, I have the right to have the amount of the erroneous debit immediately credited to my account by DEPOSITORY, provide I (we) send written notice of such debit entry in error to DEPOSITORY within 15 days following the issuance of the account statement or 45 days after posting, whichever occurs first.

I (we) further agree that any requirement for giving notice of premiums due shall be waived as long as the authorization agreement is in effect. The debit as shown on my (our) bank or credit union account statement will constitute a receipt for the premium, but no premium or portion thereof shall be deemed to have been paid unless and until Harvey W. Watt & Co. receives actual payment at its Home Office. The use of this premium payment shall in no way alter or amend the provisions of the policy with respect to the termination of such policy upon nonpayment of the premium due.

NAME _____ EMPLOYMENT ID# _____

PLEASE PRINT

DATE _____ SIGNED X _____

SIGNED X _____

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: Benefits Division | PO Box 34690 | Seattle, WA 98124-1690
Phone 1-800-426-7784 | Fax 1-866-348-0058 | TTY/TDD 1-800-833-6388

GROUP DISABILITY INCOME INSURANCE ENROLLMENT

TO BE COMPLETED BY THE POLICYHOLDER

Policy Number 01-016062-03

Employer/Policyholder Name Aviation Health Association

Street Address | City | State | Zip Code

Employee Occupation/Job Title | Employee Date of Employment

☐ Full Time Employee ☐ Part Time Employee

Effective Date of Coverage

$_____
Hourly Rate | Class Number (if applicable)

I. EMPLOYEE/ENROLLEE INFORMATION

Name Sex ☐ M ☐ F

Street Address | City | State | Zip Code

Home Telephone Number | Date of Birth | Email Address

II. BENEFITS (Please check if you wish to enroll)

	Yes	No	Indicate the benefit amount
Voluntary Short-Term Disability Income Insurance			60%
Voluntary Long-Term Disability Income Insurance			60%

III. SELECTION/WAIVER OF GROUP INSURANCE *(Only check one box below, and sign.)*

☐ I, the undersigned, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance **(Not applicable if the Policyholder pays 100% of the required contribution).**

☐ I, the undersigned, hereby waive my right at this time to elect the insurance coverage which I did not select above. I understand that if I do not enroll within 31 days of the date I am first eligible, that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability (proof of good health) to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death. All information submitted by me on this form to the best of my knowledge and belief is true and complete.

Enrollee/Employee Signature | Date Signed

Group Benefits are insured by Symetra Life Insurance Company.

[REPUBLIC]