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SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135

Return Applications to: Harvey Watt & Company
P0 Box 20787 | Atlanta, GA 30320
Phone 1-800-241-6103
Fax 1-404-761-8326

HARVEY WATT & CO.

GROUP DISABILITY INCOME INSURANCE ENROLLMENT

TO BE COMPLETED BY THE POLICYHOLDER

Policy Number 01-016061-00

Employer/Policyholder Name Hyannis Air Service dba Cape Air

660 Barnstable Road (Street Address) | Hyannis (City) | MA (State) | 02601 (Zip Code)

Employee Occupation/Job Title

Employee Date of Employment

Effective Date of Coverage

☐ Full Time Employee ☐ Part Time Employee

$_____/ ☐ HR ☐ WK ☐ MO ☐ YR
Basic Earnings

Class Number (if applicable)

I. EMPLOYEE/ENROLLEE INFORMATION

Name Sex ☐ M ☐ F

Street Address | City | State | Zip Code

Home Telephone Number | Date of Birth | Marital Status

Email Address Are you a pilot? ☐ Yes ☐ No

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

	Elect	Decline
Short-Term Disability Income Insurance		
Short-Term Disability Income Insurance: Core Plan 60% (Employer pays 50% of the cost)	☐	☐
Short-Term Disability Income Insurance: Buy-Up Plan 66 2/3% (Voluntary – Check one)	☐	☐

	Elect	Decline
Long-Term Disability Income Insurance. Evidence of Insurability is REQUIRED for VLTD.		
Voluntary Long-Term Disability (VLTD) Income Insurance (Voluntary – Check one)	☐	☐

Group Benefits are insured by Symetra Life Insurance Company.

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.