SERVING PILOTS SINCE 1951

HARVEY WATT & CO

Harvey Watt AirHealth Plans

Pilot Extended Long Term Disability Insurance

Symetra Life Insurance Company

These options are designed to provide extended disability income protection after your Harvey Watt Loss of License plans (sold separately) has been paid in its entirety. This plan may be reduced by other disability income benefits payable for the same time period. See policy for details.

08/2013

SERVING PILOTS SINCE 1951

HARVEY WATT & CO

P. O. BOX 20787, ATLANTA, GA 30320
TELEPHONE (404) 767-7501
(800) 241-6103
FAX (404) 761-8326
http://www.harveywatt.com

Extended Long Term Disability Insurance

This plan is created for pilots who would like long term disability coverage after the Harvey Watt Air Health loss of license plans (sold separately) have reached their full schedule of benefits.

Choose an available option to supplement the Harvey Watt plan you have or for which you are applying.

Two optional definitions of disability:

- Not pilot specific (Options 1-3)
- Specific to pilots (Option 4-5)

Benefit amounts available up to $6,000 or 2/3's of reported earnings.

Applying for this coverage is simple; complete the attached application, include a form of payment, and send it in along with your FAA 1st Class Medical and Special Issuance/SODA if you have one. Please review the complete brochure and policy for more info.

The salaried Harvey Watt & Co. staff is here to help answer any questions you may have and will be happy to help you compare plans. Please do not hesitate to give us a call toll free at 800-241-6103.

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 | pilot@harveywatt.com

SUMMARY OF GROUP LONG TERM DISABILITY INCOME INSURANCE

For the Members of

Aviation Health Association

For coverage effective June 1, 2013. The information in this summary may be replaced by any subsequently issued summary or policy amendment.

GROUP VOLUNTARY LONG TERM DISABILITY INCOME INSURANCE

Long Term Disability

Disability income insurance can provide a portion of the income you would lose if you became disabled and could not work. This would help to pay your everyday living expenses and it may assist you in maintaining the standard of living you and your family now enjoy.

Eligibility

All active full-time Pilot Members of the Aviation Health Association, not in any other class working 30 or more hours per week.

Benefits

Option 1: If you become disabled benefits begin after ***60 months*** of total or partial disability. 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 66.67% of your salary to a maximum of $6,000 per month. The minimum monthly benefit is the greater of $100 or 10% of your gross disability benefit. The maximum payment duration is as follows: if you are initially disabled before age 60, your benefit will last until age 65. If initially disabled after age 65, your benefits will extend beyond age 65.Pre-existing Conditions Limitation: 12/12/24.

Option 2: If you become disabled benefits begin after **54 months** of total or partial disability. 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 66.67% of your salary to a maximum of $6,000 per month. The minimum monthly benefit is the greater of $100 or 10% of your gross disability earnings. The maximum payment duration is as follows: if you are initially disabled before age 60, your benefit will last until age 65. If initially disabled after age 65, your benefits will extend beyond age 65.Pre-existing Conditions Limitation: 12/12/24..

Option 3: If you become disabled benefits begin after **12 months** of total or partial disability. 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 66.67% of your salary to a maximum of $6,000 per month. The minimum monthly benefit is the greater of $100 or 10% of your gross disability benefit. The maximum payment duration is as follows: if you are initially disabled before age 60, your benefit will last until age 65. If initially disabled after age 65, your benefits will extend beyond age 65. Pre-existing Conditions Limitation: 12/12/24.

Option 4: If you become disabled benefits begin after **60 months** of total or partial disability. 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 66.67% of your salary to a maximum of $6,000 per month The minimum monthly benefit is the greater of $100 or 10% of your gross disability benefit. The maximum payment duration is as follows: if you are initially disabled before age 60, your benefit will last until age 65. If initially disabled after age 65, your benefits will extend beyond age 65.Pre-existing Conditions Limitation: 12/12/24.

Option 5: I If you become disabled benefits begin after **54 months** of total or partial disability. 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 66.67% of your salary to a maximum of $6,000 per month. . The minimum monthly benefit is the greater of $100 or 10% of your gross disability earnings. The maximum payment duration is as follows: if you are initially disabled before age 60, your benefit will last until age 65. If initially disabled after age 65, your benefits will extend beyond age 65.Pre-existing Conditions Limitation: 12/12/24.

Definition of Disability

For Options 1-3:
Due to sickness or injury the insured is considered disabled if unable to perform with reasonable continuity the material and substantial duties of any gainful occupation and, as a result, the income you are able to earn is less than or equal to 66.67% of your pre-disability earnings.

For Option 4-5:
Due to sickness or injury the insured is considered disabled if unable to perform with reasonable continuity the material and substantial duties of any gainful occupation or 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 you are able to earn is less than or equal to 66.67% of your pre-disability earnings.

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Standard Provisions

- Maternity is covered as any other condition.
- Accumulation of the elimination period
- Six month recurrent disability/temporary recovery. Certain restrictions apply.
- Waiver of Premium
- Cost of Living Freeze
- Workplace Modification
- Vocational Rehabilitation
- Social Security Assistance
- Continuity of Coverage

Rates for Voluntary LTD

Rates per $100 of monthly covered benefit:

Employee Age	Option 1	Option 2	Option 3	Option 4	Option 5
Under 40	$0.70	$0.75	$1.24	$1.29	$1.37
40 – 49	$1.26	$1.36	$2.23	$2.30	$2.49
50 and Over	$1.81	$2.14	$4.89	$3.31	$3.92

How to Calculate Your Cost

Employee: _____ (rate) x _____ (your basic monthly gross earnings x .6667 to a maximum of $6,000) /100= $_____ Monthly Voluntary Long Term Disability cost

Maximum Payment Duration

Age When Disability Begins	Maximum Duration
Less than Age 60	To Age 65, but not less than 5 years
Age 60	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

This summary is based on proposal information only. It provides only a brief description Disability Income Insurance coverage insured by Symetra Life Insurance Company 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 01-016062-02. 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

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GROUP LONG TERM DISABILITY INCOME INSURANCE ENROLLMENT

Instructions: Complete this form entirely and return it to Harvey Watt & Company at the address provided above.

Include a copy of your most recent FAA First Class Medical Certificate with this form.

If you have a Special Issuance Authorization, please include a copy with this form.

Name of your employer		
Employer address		
City	State	Zip code
Your name *(last, first, middle)*		
Date of birth *(month, day, year)*	☐ Male ☐ Female	Basic Annual Earnings
Billing address		
City	State	Zip code
Home phone / Work phone		Email address

TYPE OF COVERAGE ENROLLING IN: (must choose only one option below)

Select your Extended Long-Term Disability **waiting period:**

☐ **Option 1:** 60 Month Wait | Available with Air Health Plan A
☐ **Option 2:** 54 Month Wait | Available with Air Health Plan B
☐ **Option 3:** 12 Month Wait | Available with LumbSum Plans
☐ **Option 4:** Extended Loss of License 60 Month Wait| Available with Air Health Plan A Only
☐ **Option 5:** Extended Loss of License 54 Month Wait | Available with Air Health Plan B Only

- Do you currently hold a valid restricted first class medical certification that was issued, or renewed by the FAA within the last 6 months from the date of this application? (glasses limitations do not apply) ☐ Yes* ☐ No
- Have you ever been denied an unrestricted first class medical certification due to FAA medical requirements? ☐ Yes* ☐ No

** If you answered "Yes" to any of the questions above, please explain:*

The following health questions must be answered fully and truthfully to the best of your knowledge and belief. If any misstatements or omissions are made, they may be the basis for later rescission of your insurance coverage. Rescission voids your coverage and claims will not be paid.

1. Are any applicants pregnant? ☐ Yes* ☐ No
   ***If yes, please give details on the next page including due date.**

2. Are any applicants currently taking any medication? ☐ Yes* ☐ No
***If yes, please give details on the next page.**

3. In the past ten years, or as indicated below, have any of the applicants been treated for, or been diagnosed by a member of the medical profession as having any of the following: ☐ Yes* ☐ No
***If yes, please indicate condition and provide details on the next page.**

a) ____ Heart Disorder, Chest Pain, Circulatory Disorder
b) ____ High Blood Pressure
c) ____ Mental & Nervous Disorder, Depression
d) ____ Alcoholism and/or Drug Habits
e) ____ Stomach, Abdominal, Intestinal Disorder
f) ____ Brain or Nervous System Disorder
g) ____ Stroke, Paralysis
h) ____ Cancer, Tumors
i) ____ Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection/Disease, or tested Positive to the AIDS virus (HIV)
j) ____ Abnormal Physical Exam, Lab or X-ray. (5 years)
k) ____ Reproductive Organ Disorder
l) ____ Sexually Transmitted Disease
m) ____ Kidney Disorder
n) ____ Liver Disorder
o) ____ Gland Disorder
p) ____ Diabetes
q) ____ Developmental Disorder
r) ____ Birth Defect
s) ____ Epilepsy, Seizures
t) ____ Lungs, Respiratory Disorder
u) ____ Bone, Joint, Connective Tissue Disorder
v) ____ Accident or Injury
w) ____ Blood Disorder
x) ____ Infectious Diseases
y) ____ Back, Neck Pain, or Discomfort

4. Have you consulted, been advised or been examined by any healthcare provider for any other medical reason within the last ten years, or as indicated above? ☐ Yes* ☐ No
***If yes, please indicate condition and provide details on the next page.**

HEALTH INFORMATION

Question # Or Letter	Name of Person	Details of Yes Answers	Onset Mo. Yr.	Duration	Degree of Recovery	Full Name and Full Address of Attending Physician

Read this information carefully, then sign and date below.

- To the best of my knowledge and belief, the information I've provided is complete and correct.
- I understand and agree that no coverage shall take effect unless this application is approved by Symetra Life Insurance Company and the first premium is paid in my lifetime.
- I understand that my coverage could be denied if any FAA medical license was issued due to my misstatement or omission on an FAA application.
- I understand my coverage begins on the "effective date" assigned by Symetra Life Insurance Company.
- I have read and understand the fraud notice applicable to me on the following page.

Your signature Date signed

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Note: We will accept an authorization form preferred by your provider's office in place of this authorization form.

SYMETRA LIFE INSURANCE COMPANY

Authorization for Release of Medical Information

Group Policy Number: 01-016062-02

Name of insured/patient (please type or print): _____ Date of birth: _____

I authorize any physician, health care professional, hospital, clinic, medical facility, laboratory, pharmacy or pharmacy benefit manager, other health care provider, insurance company, or government agency that has provided treatment, services, or payment to me or on my behalf ("My Providers") to disclose my entire medical record, medications prescribed, prescription history, and any other protected health information concerning me to Symetra Life Insurance Company, its employees, agents, or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness, excluding psychotherapy notes, and the use of alcohol, drugs, and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Symetra Life Insurance Company may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; 3) obtain reinsurance; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Symetra Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Symetra Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this Authorization to disclose information about me or to the extent that Symetra Life Insurance Company has a legal right to contest a claim under an insurance policy. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Symetra Life Insurance Company except as authorized by me or as required by law.

This Authorization complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that if I refuse to sign this authorization to release my complete medical record, Symetra Life Insurance Company may not be able to process my application, continue my coverage, or make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____ _____

Signature of Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient

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.

DEPOSITORY 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 _____