Harvey Watt AOPA 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 AOPA 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.

Rev 08/2013

**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 Members of the

# Aircraft Owners & Pilots 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 ***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 2**: If you become disabled benefits begin after ***40 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 ***30 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 4**: 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 5**: 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 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 Options 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 | $0.75 | $0.87 | $0.98 | $1.37 | $1.29 |
| 40 – 49 | $1.36 | $1.61 | $1.79 | $2.49 | $2.30 |
| 50 and Over | $2.14 | $2.85 | $3.44 | $3.92 | $3.31 |

## How to Calculate Your Cost

Employee: _____ x _____/100= $_____

(rate) x (your basic monthly gross earnings x .6667 to a maximum of $6,000) = 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 1-800-241-6103 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**



[AVIATION HEALTH ASSOCIATION - AOPA

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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:** 54 Month Wait | Available with AOPA Plan A
☐ **Option 2:** 40 Month Wait | Available with AOPA Plan B
☐ **Option 3:** 30 Month Wait | Available with AOPA Plan B
☐ **Option 4:** Extended Loss of License 54 Month Wait | AOPA Plan A-65 (available with AOPA Plan-A Only)
☐ **Option 5:** Extended Loss of License 60 Month Wait | AOPA Plan-C-65 | (available with AOPA Plan-C 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 |
|---|---|---|---|---|---|---|
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**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

**Please read the following notice that we are required by law to give to you.**

Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA: For your protection California law requires the following to appear hereon: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information for payment of a loss is guilty of a crime and may be subject to fines and confinement in prison.

MAINE, TENNESSEE, WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW HAMPSHIRE: Any people who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NEW YORK: The following applies to health insurance only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

RHODE ISLAND, WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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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