SERVING PILOTS SINCE 1951

HARVEY WATT & CO

American Airlines

Pilot Short Term Disability Insurance

Underwritten by Symetra Life Insurance Company

Offered exclusively to All American and US Airways Pilots, not including American Eagle Pilots

Pilot Loss of License Short Term Disability Insurance: Choose one of four available waiting periods. If your employer offers you Sick Bank, choose a waiting period matching your sick bank duration. Consider contacting us to lengthen your waiting period as your sick bank grows. Longer waiting periods have lower rates. This plan may be reduced by other disability income benefits payable for the same time period. -See policy for details.

07/2013

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

As an American pilot, do you have less than 3 Months of Sick Bank Balance?

We are pleased to announce a Voluntary Pilot Short Term Disability (STD) Plan designed specifically for American Pilots brought to you by Harvey Watt & Co.

New Hires can enroll within 30 days by answering only 2 health questions.

COVERAGE & FEATURES

This plan is designed to dovetail with the American Long Term Disability plan that begins to pay benefits after 90 days of a disability. The plan features:

- 4 optional waiting periods (7, 14, 30, 60 day options) based on how much Sick Bank you have. Choose a longer or shorter waiting period based on your need.
- Plan has a loss of license definition of disability
- Two Coverage Options Available: Choose to receive tax-free Benefits of 50% or 60% of reported Income

EXAMPLE

Short Term Disability (STD) with a 14 day waiting period and a 50% benefit: The examples below are based on the maximum amount of weekly benefit available. The maximum weekly benefit is $1,730 which is 50% of $3,460 earned weekly income (nearly $180,000 annually)

Age	Cost	Calculation
40-49	$.681 per $10 of weekly benefit	$1,730/10 = 173 $0.681 x 173 = $117.81 monthly cost Benefits: $1,730 per week
50 +	$1.413 per $10 of weekly benefit	$1730/10 = 173 $1.413 x 173 = $244.45 monthly cost Benefits: $1,730 per week

For Q&A and More information http://www.harveywatt.com/AirlinesUnions/AmericanDisability

CONTACT US

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135
1-800-796-3872
TTY/TDD 1-800-833-6388

SUMMARY OF GROUP SHORT TERM DISABILITY INCOME INSURANCE

For the Employees of

AMERICAN AIRLINES PILOTS

For coverage effective April 1, 2014. The information in this summary may be replaced by any subsequently issued summary or policy amendment.

GROUP VOLUNTARY SHORT TERM DISABILITY INCOME INSURANCE

Short 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 American Airlines Pilots as Members of the Aviation Health Association with at least 72 flight hours per month

Definition of Disability

Due to sickness or injury the insured is considered disabled if you are unable to perform with reasonable continuity the material and substantial duties of your regular occupation and a reasonable employment option offered to you by the employer 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.

Benefits

If you become disabled and have short term disability coverage, depending on elimination period of your choice selected during your enrollment period, benefits will begin on either the 8th, 15th, 31st or 61st day of sickness or injury. Exhaustion of accumulated sick bank time will be required for benefits to commence. Symetra Life Insurance Company will pay your benefit to you while you are disabled under the terms of the policy.

The maximum payment durations are as follows:

- 7 day elimination period: 83 days
- 14 day elimination period: 76
- 30 day elimination period: 60 days
- 60 day elimination period: 30 days

You also have the option to choose between a 50% or 60% benefit plan, the voluntary short term disability income weekly benefit will therefore be either 50% or 60% of your salary to a maximum of $1,730 per week. The minimum weekly benefit amount is $25. The pre-existing condition limitation is 6/12.

Standard Provisions

- Pre-Existing Conditions Exclusion. Certain restrictions apply.
- 24-Hour Coverage
- Maternity is covered as any other condition
- 14 day recurrent disability/temporary recovery
- Cost of Living Freeze
- Salary Continuation, Worker's Compensation and accumulated sick leave are included as offsets

[AMERICAN AIRLINES PILOTS]

Rates for VSTD INSURANCE – 50% BENEFIT OPTION

Rates are per $10 of covered benefit:

Age	7 Day Elim. Period Rate	14 Day Elim. Period Rate	30 Day Elim. Period Rate	60 Day Elim. Period Rate
<40	$0.625	$0.463	$0.313	$0.156
40 - 49	$0.863	$0.681	$0.456	$0.231
50 and over	$1.763	$1.413	$1.044	$0.531

How to Calculate Your Cost:

Employee: _____ (rate) x _____ (your annual salary / 52 x .50 to a maximum of $1,730) /10 = $_____ Monthly Short Term Disability cost

Rates for VSTD INSURANCE – 60% BENEFIT OPTION

Rates are per $10 of covered benefit:

Age	7 Day Elim. Period Rate	14 Day Elim. Period Rate	30 Day Elim. Period Rate	60 Day Elim. Period Rate
<40	$0.638	$0.469	$0.325	$0.163
40 - 49	$0.875	$0.694	$0.469	$0.238
50 and over	$1.800	$1.438	$1.063	$0.544

How to Calculate Your Cost:

Employee: _____ (rate) x _____ (your annual salary / 52 x .60 to a maximum of $1,730) /10 = $_____ Monthly Short Term Disability cost

This summary provides only a brief description of 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 01-016062-01. 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: _____

SYMETRA
RETIREMENT | BENEFITS | LIFE

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

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 SHORT TERM DISABILITY (STD) 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 Trustees of the Aviation Health Association for All Active American and US Airways Pilots, not Including American Eagle Pilots		
Employer address c/o Harvey Watt & Company, P.O. Box 20787		
City Atlanta	State GA	Zip code 30233
Your name *(last, first, middle)*		
Date of birth *(month, day, year)*	☐ Male ☐ Female	Employee Number
Billing address		
City	State	Zip code
Home phone / Work phone	Email address	
Date of Employment / Annual Salary	Occupation/Job Title	

- Type of coverage enrolling in: **American Airlines Short-Term Disability Plan**
  Please check **ONLY ONE** option you wish to enroll

	50% Benefit Plan	60% Benefit Plan
Short-Term Disability: 7 Day Elimination Period	☐	☐
Short-Term Disability: 14 Day Elimination Period	☐	☐
Short-Term Disability: 30 Day Elimination Period	☐	☐
Short-Term Disability: 60 Day Elimination Period	☐	☐

- 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:*

IF you were hired within the preceding month and you answered "yes" and then "no" to the questions below (in that order) you do not need to answer the following health questions. You will need to sign and date the form on page (3).
IF YOU ARE *NOT* A NEW HIRE: please complete the health questions on the following page and sign and date the form on page (3).

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

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: 01-016062-01

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

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 person 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.

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 _____