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

Harvey Watt & Company
PO Box 20787 Atlanta, GA 30320
Phone 1-800-241-6103 | Fax 1-404-761-8326
pilot@harveywatt.com

Group Disability Insurance
SUMMARY OF BENEFITS

Voluntary Short Term Disability
Class 1, 2, 3

Sponsored By: **Trustees of the Aviation Health Association**
Effective Date: **January 1, 2023**
Policy Number: **01-016062-04**

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Eligibility

All full time pilots of Omni Air International working a minimum of 60 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.

Benefit Highlights

Benefit Amount	60% of Salary up to $1,500 per week
Minimum Benefit Amount	$25
Elimination Period & Maximum Payment Duration	7 Day Elimination Period: 12 weeks 14 Day Elimination Period: 11 weeks 30 Day Elimination Period: 9 weeks
Accumulation of Elimination Days	You can satisfy the days of your elimination period with either total (off work entirely) or partial (working some hours at your current job) disability.

Standard Provisions

- Maternity is covered the same as any other condition.
- 14 day recurrent disability / temporary recovery
- Cost of living freeze
  - Except for increases in income earned (or received from any form of employment) once other income amounts have been subtracted from the gross monthly disability payment, the insured's payment will not be further recued due to a cost of living increase in any other income amounts.

Pre-Existing Condition

This plan will cover a disability if it is caused by, contributed to by, or results from a pre-existing condition and the disability begins after being insured for 12 consecutive months from his/her effective date of coverage. If the time period requirements are not met, the disability is excluded from coverage under the plan.

Pre-Existing Condition means a sickness or injury for which the insured received treatment within 3 months prior to his/her effective date of coverage. Treatment includes consultation, care, or services from a doctor, or other medical professional recommended by a doctor. It also includes being prescribed medicines, taking prescribed medicines (or the fact that the insured should have been taking prescribed medicines, but chooses not to), and receiving diagnostic measures.

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Contact Information for Claims

Phone: 1-877-377-6773
Fax: 1-877-737-3650

Symetra Life Insurance Company
Life and Absence Management Center
P.O. Box 1230
Enfield, CT 06083-1230

Rates for Voluntary Short Term Disability Coverage

Monthly rates per $10 weekly covered benefit:

Age	7 Day Elimination Period Rate	14 Day Elimination Period Rate	30 Day Elimination Period Rate
< 40	$0.830	$0.650	$0.510
40 - 49	$1.110	$0.880	$0.690
50 - 59	$1.900	$1.530	$1.190
60 +	$3.030	$2.450	$1.890

Calculating Your Cost

(rate) x (your annual salary/52 x .60 to a maximum of $1,500) / 10 = $ Monthly Voluntary Short Term Disability Cost

This summary provides only a brief description of the 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 contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-016062-04. 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. **Complete payment authorization**
    - **Write void across a blank check and attach**
    - **Complete and sign form.**
3. **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 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

Policy Number 01-016062-04

Employer/Policyholder Name Omni Air International/ 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

$ _____
Annual Earnings or 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 to indicate which plan you would like to enroll in: Only check one box)

	7 day EP	14 day EP	30 Day EP	Indicate the benefit amount
Voluntary Short-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.

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 (BANK) NAME _____

ROUTING # _____ 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 _____

SIGNATURE _____ DATE_____