SERVING PILOTS SINCE 1951

HARVEY WATT & CO

Delta Pilots Mutual Aid

GROUP TERM LIFE INSURANCE

Underwritten by Metropolitan Life Insurance Company

Dear Pilots,

We are pleased to provide you with the opportunity to enroll in the DPMA Group Term Life Insurance Program. In the past, many pilots have expressed a need to add to their life insurance program through a quality association group plan. Perhaps, you should take a few moments to consider this important benefit.

Some of the reasons why you should consider enrolling are outlined in the enclosed brochure. They include a high limit of coverage at very competitive rates, availability of coverage for your spouse and children, and a special conversion option.

Many financial planners suggest that Term Life Insurance is a most economical way to maintain an up-to-date insurance program. The enclosed brochure contains detailed information about this group program. Please take a few moments to read through it and if you have any questions, give us a call at: (800) 241-6103.

Why not take advantage of this benefit by applying today and providing your loved ones with the protection they deserve. To apply, complete the enclosed application and mail it in the convenient pre-addressed envelope.

Sincerely,

Harvey Watt & Company

L1024044327[exp1026][All States][DC,GU,MP,PR,VI]

Protect Your Family's Future With Cost-Effective Group Life Insurance

Underwritten by Metropolitan Life Insurance Company for FAA Licensed Pilots who are members of Delta Pilots Mutual Aid.

Save Three Ways With MetLife

As an FAA Licensed Pilot and a member of Delta Pilots Mutual Aid, you have the opportunity to enroll in a special group term life program and realize savings in three important ways:

1. Term insurance offers the most protection at an economical cost.
2. You get Metropolitan Life Insurance Company economical group rates as an FAA Licensed Pilot and member of the Aviation Health Association.
3. You can get the similarly economical rates on coverage for your spouse and children.

Why Do I Need Life Insurance?

If you have anyone who depends on your income, you need life insurance. It can take care of your dependents' financial need even if you're not around. Your family can use the benefits to help:

- provide a continuous source of income;
- assure your children's higher education;
- pay off the mortgage on your house;
- settle any other outstanding debts;
- pay for final expenses.

These days, when so many families depend on two incomes to make ends meet, the need for insurance on both wage earners is more important than ever. And even if one spouse is a homemaker, replacing child and home care services takes money as well.

What If I Already Have Some Life Insurance?

Then you understand how important this kind of protection really is. But you may want to take another look at how much coverage you have. Your needs may have changed since you first bought that policy. For example, your income, personal debt or family size may have increased. Experts say that you should have at least seven to ten times your annual income in life insurance.

If you need to supplement the insurance you already have, this plan offers an cost-effective and convenient way to do so.

L1024044327[exp1026][All States][DC,GU,MP,PR,VI]

DMPABROCH10/2012

Your Plan of Benefits

As an FAA Licensed Pilot under age 65 who resides in the United States, you can apply for up to $1,500,000 of coverage on yourself and coverage for your dependent children from 15 days to 21 years of age (25 if a full-time student). Your spouse under age 70 can also apply for up to $1,500,000 of coverage, even if you are not participating in the plan.

If both you and your spouse are eligible members, only one member may request coverage for your eligible children.

Life Benefits And Rates

Benefits are paid for death occurring at any time, any place, from any cause, except suicide in the first two years of coverage.

The monthly cost for you and your spouse varies by age. The monthly cost will increase as your or your spouse reach the next age bracket. The monthly premium rates are outlined below.

Monthly Rate per $1,000 of Coverage				
	Pilot		Spouse	
Attained Age	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Under 30	$ .056	$ .028	$ .056	$ .037
30 - 34	.056	.033	.056	.037
35 - 39	.074	.042	.074	.047
40 - 44	.121	.066	.121	.074
45 - 49	.205	.093	.205	.112
50 - 54	.335	.167	.335	.205
55 - 59	.521	.256	.521	.260
60 - 64	.632	.284	.632	.353
65 - 69*	1.702	.697	1.702	.945
You can purchase up to $1,500,000 of coverage, but not less than $25,000 of coverage for you or your spouse.				
Monthly Premium for $10,000 of Coverage for Dependent Children $2.00 per Family				
Dependent children are eligible if they are between the ages of 15 days and 25 years. However, children must be attending an accredited college or university on a full-time basis from age 21 to 25, and be wholly dependent on the employee for support in order to remain eligible for this coverage.				

Example for Non-Tobacco Users: You are 42 and select $250,000 of life insurance. Your spouse is 38 and selects $150,000 of life insurance. You insure your three children for $10,000. Your monthly premium is $25.55.						
Employee	=	250	x	.066	=	16.50
Spouse	=	150	x	.047	=	7.05
Children	=			2.00	=	2.00
TOTAL	=					**25.55**

Rates are guaranteed for first year of coverage. Your coverage will be reduced by 50% at age 70. Your spouse's coverage will terminate when he or she attains age 70.

A tobacco user is anyone who has smoked cigarettes, pipes or cigars or used tobacco in any form in the past 2 years
Rates shown are guaranteed until September 30,2026

All applications for coverage are subject to review and approval by MetLife. If you choose to apply for increased coverage, the increase may be subject to underwriting. MetLife will review your information and evaluate your request for coverage based upon your answers to health questions, MetLife's underwriting rules and other information you authorize us to review. In certain cases, MetLife may request additional information to evaluate your request for coverage. Coverage will be effective in accordance with the applicable policy and certificate after approval by MetLife.

Includes More Special Features

- No Cancellation for ill Health - once your coverage takes effect, you cannot be canceled due to a change in your health.
- Conversion Privilege - If coverage is terminated, conversion to an individual whole life policy is allowed, without proof of good health.
- 30 Day Free Look - you have 30 days to look over your plan of insurance and discuss it with your family and advisors. If for any reason you're not satisfied, you may return your certificate within 30 days of receipt for a full refund.

Term Of Coverage

Your coverage will go into effect on the first day of the month following approval of your application, provided you pay the required premium.

If you choose to cover your dependents, their insurance will begin on the date you become covered, or the first of the month following approval of your application to cover a dependent, whichever is later, provided the required premium is paid.

If you or your spouse are not actively at work when coverage would normally take effect, the effective date will be deferred until the first of the month after you or your spouse have worked full-time for 90 consecutive days.

If you or your spouse are unemployed and unable to carry out the normal and customary activities of a healthy person of the same age and sex, coverage will be deferred until the first of the month following your being able to carry out those activities for 90 consecutive days.

Any effective date of coverage is subject to the applicant's health remaining unchanged from the date of application.

Coverage for you or your insured spouse will remain in force unless:

- your premiums are not paid; or
- you reach the limiting age of the policy; or
- the master policy is canceled.

Your dependents coverage remains in force as long as your coverage remains in effect, premiums are paid when due and they remain eligible dependents.

Exclusion

Suicide is excluded from coverage for two years from the effective date of each person's coverage. However, if suicide is committed during the first two years, we will refund the premiums paid to the date of the death.

Here's How To Apply

1. Complete the enclosed application, answering all questions fully. Be sure that you and your spouse, if applying, each complete, date and sign a separate application.
2. Mail the completed application and payment authorization form along with a voided check in the enclosed, self-addressed envelope - today!

Coverage cannot become effective until Metropolitan Life Insurance Company grants its underwriting approval. You do not receive temporary or conditional insurance coverage just because you submit an application and pay the first premium.

If you have any questions regarding the plan, application or claims, contact the plan administrator.

Administered by:
Harvey Watt & Company
P.O. Box 82876
Atlanta, GA 30354
(800) 241-6103 or (404) 767-7501

Group Term Life Insurance Underwritten by:
Metropolitan Life Insurance Company
200 Park Avenue, New York NY 20016

This program is not available in all states or any foreign countries. Coverage may vary in some states. Please contact the plan administrator for details. This brochure is a summary of benefits only and is subject to the terms, conditions and limitations of Group Policy No. 65009-9 (Policy form LP00GP).

DPMABROCH10/2012
L1024044327[exp1026][All States][DC,GU,MP,PR,VI]

Administered by:

Harvey W. Watt & Co.
DPMA GROUP INSURANCE PLANS
PO Box 82876
Atlanta, Georgia 30354
Call Toll Free: (800) 241-6103
www.harveywatt.com

Underwritten by:

Metropolitan Life Insurance Company

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of coverage. All coverage is subject to the terms of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. Policy Form LP00GP. The group policy is situsedin the state of Georgia and is governed by its laws. The product is not available in all states.
Please keep this material as a reference for filing with your Certificate of Coverage.

Here's How to Apply

1. Print an application package for you, the Member, and your Spouse (if applying for Spouse coverage).

2. Complete the 2-page Group Term Life Application and sign and date the application.

3. Complete payment authorization (if you and your spouse apply for coverage, you only need to complete one copy of this form).
   - Complete and sign form.
   - Write void across a blank check and attach.

4. Mail all of the above to:

   Harvey W. Watt & Co – Life Insurance PO
   Box 82876
   Atlanta GA 30354
   Or fax all of the above to: (404) 761-8326

Note:

- If additional information or underwriting is required, you will be notified by Harvey W. Watt & Co.
- Please call us 1-800-241-6103 or send an email to pilot@harveywatt.com if you have questions.

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 _____

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT • CHANGE FORM
ART (STANDARD ISSUE)

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Policyholder:	Sponsoring/Participating Association (if different from Policyholder)	Group Customer #
Aviation Health Association	DPMA	**261529**

YOUR ENROLLMENT INFORMATION (To be Completed by the Member)

Name (First, Middle, Last)		Social Security # – –
Address (Street, City, State, Zip Code)	Phone #	Date of Birth (MM/DD/YYYY)
Email Address	☐ New Enrollment ☐ Change in Enrollment	Date of Membership (MM/DD/YYYY)

By applying for this insurance coverage, do you intend to replace, discontinue or change any existing life insurance or annuity contracts currently held by you? ☐ Yes ☐ No

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below.

► You must complete the Health Information section of this form and the enclosed Authorization form, if you are enrolling for any amount of Supplemental Term Life and/or Dependent Spouse/Domestic Partner Life.

Term Life Insurance

☐ Supplemental/Optional Life [1]

☐ $500,000 ☐ $750,000

OR

Enter a multiple of $50,000 with a minimum of $25,000 up to a maximum of $1,500,000. $_____

☐ Dependent Spouse/Domestic Partner [2] Life [1,3]

☐ $500,000 ☐ $750,000

OR

Enter a multiple of $50,000 with a minimum of $25,000 up to a maximum of $1,500,000. $_____

☐ Dependent Child Life [3] ($10,000)

[1] Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

[2] Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner in whom you have an insurable interest. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to your insurable interest.

[3] Amounts will be subject to state limits, if applicable.

After completion, **sign and date the form on the last page where indicated**. Make a copy for your records and return to:
Harvey W. Watt & Co.,
P.O. Box 20787, Atlanta, GA 30320 or by email to pilot@harveywatt.com or by fax to (404) 761-8326.
Phone (800) 241-6103

Dependent Information

If you are applying for coverage for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below:

Name of your Spouse/Domestic Partner (First, Middle, Last) _____ Date of Birth (MM/DD/YYYY) _____ ☐ Male ☐ Female

Name(s) of your Child(ren) (First, Middle, Last) Date of Birth (MM/DD/YYYY)

_____ _____ ☐ Male ☐ Female

_____ _____ ☐ Male ☐ Female

_____ _____ ☐ Male ☐ Female

_____ _____ ☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

Smoking Status Information for Term Life Insurance

Have you smoked cigarettes, pipes or cigars or used tobacco in any form in the past 2 years? Member ☐ Yes ☐ No Spouse/Domestic Partner ☐ Yes ☐ No

If you are changing smoking status:
Status is changing from: ☐ Smoker to Non-Smoker ☐ Non-Smoker to Smoker Change is for: ☐ Member ☐ Spouse/Domestic Partner

GEF02-1
ADM
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana;*
GEF02-1
ADM *applies to residents of Connecticut, North Dakota and Utah)*

HEALTH INFORMATION

SECTION 1

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested. For questions 5 through 11u, for "yes" answers, please provide full details in Section 2.

1. Member's height ___ feet ___ inches Spouse/Domestic Partner ___ feet ___ inches
   Member's weight ____ pounds Spouse/Domestic Partner weight ____ pounds

	Member	Spouse/Domestic Partner
2. Are you now on a diet prescribed by a physician or other health care provider?	☐ Yes ☐ No	☐ Yes ☐ No
Member: Indicate type _____		
Spouse/Domestic Partner Indicate type _____		
3. Are you now pregnant?	☐ Yes ☐ No	☐ Yes ☐ No
Member: If "yes," what is your due date (month/day/year)? _____		
Physician's name _____ Telephone: (____) ____ – ____		
Spouse/Domestic Partner:		
If "yes," what is your due date (month/day/year)? _____		
Physician's name _____ Telephone: (____) ____ – ____		
4. Are you now, or have you in the past 2 years, used tobacco in any form?	☐ Yes ☐ No	☐ Yes ☐ No
5. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes", specify "date(s) of conviction(s) (month/day/year)	☐ Yes ☐ No	☐ Yes ☐ No
Member: _____ Spouse/Domestic Partner: _____		

GEF09-1
HEA
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana;*
GEF09-1
HEA *applies to residents of Connecticut, North Dakota and Utah)*

6. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for?
   Member: ☐ declined ☐ postponed ☐ withdrawn ☐ rated ☐ modified ☐ issued other than as applied for? Indicate reason _____ ☐ Yes ☐ No ☐ Yes ☐ No
   Spouse/Domestic Partner: ☐ declined ☐ postponed ☐ withdrawn ☐ rated ☐ modified ☐ issued other than as applied for? Indicate reason _____
7. Are you now receiving or applying for any disability benefits, including workers' compensation?
   Member: If "yes" provide details _____
   Spouse/Domestic Partner: If "yes" provide details _____ ☐ Yes ☐ No ☐ Yes ☐ No
8. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs? ☐ Yes ☐ No ☐ Yes ☐ No
9. Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days? ☐ Yes ☐ No ☐ Yes ☐ No
   Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.
10. **For residents of all states except CT, please answer the following question:** Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?
    For CT residents, please answer the following question: To the best of your knowledge and belief**,** have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection? ☐ Yes ☐ No ☐ Yes ☐ No
11. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:
    a. cardiac or cardiovascular disorder? ☐ Yes ☐ No ☐ Yes ☐ No
       Member: Indicate type _____
       Spouse/Domestic Partner Indicate type _____
    b. stroke or circulatory disorder? ☐ Yes ☐ No ☐ Yes ☐ No
       Member: Indicate type _____
       Spouse/Domestic Partner Indicate type _____
    c. high blood pressure? ☐ Yes ☐ No ☐ Yes ☐ No
    d. cancer, Hodgkins disease, lymphoma or tumors? ☐ Yes ☐ No ☐ Yes ☐ No
       Member: Indicate type _____
       Spouse/Domestic Partner Indicate type _____
    e. anemia, leukemia or other blood disorder? ☐ Yes ☐ No ☐ Yes ☐ No
       Member: Indicate type _____
       Spouse/Domestic Partner Indicate type _____
    f. diabetes? ☐ Yes ☐ No ☐ Yes ☐ No
       Member: Your age at diagnosis?: _____ ☐ Check if insulin treated
       Spouse/Domestic Partner: Your age at diagnosis? _____ ☐ Check if insulin treated
    g. asthma, COPD, emphysema or other lung disease? ☐ Yes ☐ No ☐ Yes ☐ No
       Member: Indicate type _____
       Spouse/Domestic Partner Indicate type _____
    h. ulcers, stomach, hepatitis or other liver disorder? ☐ Yes ☐ No ☐ Yes ☐ No
       Member: Indicate type _____
       Spouse/Domestic Partner Indicate type _____
    i. colitis, Crohn's, diverticulitis or other intestinal disorder? ☐ Yes ☐ No ☐ Yes ☐ No
       Member: Indicate type _____
       Spouse/Domestic Partner Indicate type _____
    j. memory loss? ☐ Yes ☐ No ☐ Yes ☐ No
       Member: Indicate type _____
       Spouse/Domestic Partner Indicate type _____

k. epilepsy, paralysis, seizures, dizziness or other neurological disorder? ☐ Yes ☐ No ☐ Yes ☐ No
Member: Specify date of last seizure (month/year) _____ Indicate type _____
Spouse/Domestic Partner: Specify date of last seizure (month/year) _____ Indicate type _____

l. Epstein-Barr, chronic fatigue syndrome or fibromyalgia? ☐ Yes ☐ No ☐ Yes ☐ No
Member: Indicate type _____
Spouse/Domestic Partner Indicate type _____

m. multiple sclerosis, ALS or muscular dystrophy? ☐ Yes ☐ No ☐ Yes ☐ No
Member: Indicate type _____
Spouse/Domestic Partner Indicate type _____

n. lupus, scleroderma, auto immune disease or connective tissue disorder? ☐ Yes ☐ No ☐ Yes ☐ No

o. arthritis? ☐ Yes ☐ No ☐ Yes ☐ No
Member: ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____
Spouse/Domestic Partner: ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____

p. back, neck, knee, spinal, joint or other musculoskeletal disorder? ☐ Yes ☐ No ☐ Yes ☐ No
Member: Indicate type _____
Spouse/Domestic Partner Indicate type _____

q. carpal tunnel syndrome? ☐ Yes ☐ No ☐ Yes ☐ No

r. kidney, urinary tract or prostate disorder? ☐ Yes ☐ No ☐ Yes ☐ No
Member: Indicate type _____
Spouse/Domestic Partner Indicate type _____

s. thyroid or other gland disorder? ☐ Yes ☐ No ☐ Yes ☐ No
Member: Indicate type _____
Spouse/Domestic Partner Indicate type _____

t. mental, anxiety, depression, attempted suicide or nervous disorder? ☐ Yes ☐ No ☐ Yes ☐ No
Member: Indicate type _____
Spouse/Domestic Partner Indicate type _____

u. sleep apnea? ☐ Yes ☐ No ☐ Yes ☐ No
Member: Indicate type _____
Spouse/Domestic Partner Indicate type _____

After completing the Personal Physician and Prescription Information, please provide full details in Section 2 for "yes" answers to questions 5 through 11u.

MEMBER SECTION

Personal Physician Information

Personal Physician's Name: _____ Telephone: (____) ____–____

Approximate last visit (MM/YYYY): __/_____ Reason for visit: _____

Prescription Information

Are you currently taking any prescribed medications? ☐ Yes ☐ No If yes, list the medications.

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (____) ____–____

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (____) ____–____

☐ Check here if you are attaching another sheet for any additional medications.

SECTION 2

Please provide full details below for each "Yes" answer to questions 5 through 11u in Section 1. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information. ☐ Check here if you are attaching another sheet.

Your Date of Birth __/__/_____

Question Number	Condition/Diagnosis/Type	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Physician's Name: _____ Telephone: (____) ____-____

Approximate last visit: _____ Reason for visit: _____

Question Number	Condition/Diagnosis/Type	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Physician's Name: _____ Telephone: (____) ____-____

Approximate last visit: _____ Reason for visit: _____

SPOUSE/DOMESTIC PARTNER SECTION

Personal Physician Information

Personal Physician's Name: _____ Telephone: (____) ____–____

Approximate last visit (MM/YYYY): __/_____ Reason for visit: _____

Prescription Information

Are you currently taking any prescribed medications? ☐ Yes ☐ No If yes, list the medications.

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (____) ____–____

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (____) ____–____

☐ Check here if you are attaching another sheet for any additional medications.

SECTION 2

Please provide full details below for each "Yes" answer to questions 5 through 11u in Section 1. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information. ☐ Check here if you are attaching another sheet.

Your Date of Birth __/__/_____

Question Number	Condition/Diagnosis/Type	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Physician's Name: _____ Telephone: (____) ____-____

Approximate last visit: _____ Reason for visit: _____

Question Number	Condition/Diagnosis/Type	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Physician's Name: _____ Telephone: (____) ____-____

Approximate last visit: _____ Reason for visit: _____

FRAUD WARNINGS

Before signing this Statement of Health form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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.

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

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Maine, Tennessee and 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 or 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 Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York (only applies to Accident and Health Insurance): 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.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Pennsylvania and all other states: 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.

GEF09-1
FW
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana;*
GEF09-1
FW *applies to residents of Connecticut, North Dakota and Utah)*

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

BENEFICIARY DESIGNATION FOR MEMBER INSURANCE

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.

I understand I have the right to change this designation at any time.

☐ Check if you need more space for additional beneficiaries including contingent beneficiary information, attach a separate page. Include all beneficiary information, and sign/date the page. If you are adding contingent beneficiaries, please indicate which beneficiaries are to be considered contingent.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			**TOTAL:**	100%

DECLARATIONS AND SIGNATURE(S)

Member

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability.
2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life, insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment.
3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent is able to perform the normal activities required to be covered under the plan on the date they are enrolling for and must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized. **Hospitalized** means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.
4. If I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
5. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
6. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Member	Print Name	Date Signed (MM/DD/YYYY)

Spouse/Domestic Partner

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability.
2. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Spouse/Domestic Partner	Print Name	Date Signed (MM/DD/YYYY)

GEF09-1
DEC
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana;*
GEF09-1
DEC *applies to residents of Connecticut, North Dakota and Utah)*

AUTHORIZATION

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s) ("member", spouse, and/or any other person(s) named below). Underwriting means classification of individuals for determination of insurability and/or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:

- Any medical practitioner, facility or related entity; any insurer; MIB, LLC ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
  - personal information and data about the proposed insured including employment and occupational information;
  - medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
  - information, records and data about the proposed insured related to alcohol and drug abuse and treatment;
  - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
  - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
  - motor vehicle reports.

Note to All Health Care Providers: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- While this authorization is in force, we may use the information we receive under this authorization to improve our underwriting and claims processes generally.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured (or his/her authorized representative) has a right to receive a copy of this form.

I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.

Sign Here

Signature of Member		Date Signed (MM/DD/YYYY)
Print Name	State of Birth	Country of Birth

Sign Here

Signature of Spouse/Domestic Partner		Date Signed (MM/DD/YYYY)
Print Name	State of Birth	Country of Birth

Aviation Health Association - 261529
AUTH-ST110M-NW (06-24)

MetLife
Metropolitan Life Insurance Company, New York, NY

MIB PRE NOTICE

Information regarding your insurability will be treated as confidential. Metropolitan Life Insurance Company ("MetLife") or its reinsurers may, however, make a brief report thereon to MIB, LLC. which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of the request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at *866-692-6901 or go to its website at www.mib.com to request disclosure online. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184- 8734.

MetLife, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

MetLife

Delaware American Life Insurance Company
MetLife Health Plans, Inc.
MetLife Legal Plans, Inc.
MetLife Legal Plans of Florida, Inc.
Metropolitan General Insurance Company
Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance Company

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

SECTION 1: Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, as an executive benefit, or as otherwise made available at your work or through an association to which you belong. In this notice, "you" refers to these individuals.

SECTION 2: Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

SECTION 3: Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life insurers, a legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

SECTION 4: How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law**.** The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB, LLC ("MIB"). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. You may do so by writing to MIB LLC, 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at www.mib.com.

SECTION 5: Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it

to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

SECTION 6: Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

SECTION 7: HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act ("HIPAA") protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

SECTION 8: Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. We will provide it as long as it is reasonably locatable and retrievable. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

SECTION 9: Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. A detailed notice shall be furnished to you upon request. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.