DELTA PILOTS MUTUAL AID

100 Hartsfield Centre Parkway. Suite 630. Atlanta .GA 30354

Dear DPMA Member:

Following this letter, you will find information for optional group term life insurance offered through Harvey W. Watt & Co. as a special offer for DPMA members only.

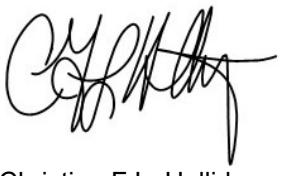
In 1998, Harvey W. Watt & Co. presented this optional group term life insurance proposal to the DPMA Board of Trustees with the hope of offering this product to DPMA members. After close examination, the Board of Trustees approved this opportunity as an additional benefit, allowing a competitive choice solely for DPMA members. Be assured, DPMA is sensitive to your privacy and does not sell or rent our member list to any entity, and neither does Harvey W. Watt & Co.

The following newly negotiated & improved features may be a competitive alternative offered during open enrollment:

+ High coverage limits and no future health questions
+ Portability: rates and coverage can be kept regardless of airline or union status
+ Competitive rates
+ No exclusions except for suicide in the first two years of coverage or increase in coverage.
+ Spouse can apply even if member does not

In addition, Harvey W. Watt & Co. also offers the informative *Aviation Medical Bulletin* free of charge to DPMA members. If you have any questions about this optional life insurance program, please contact Harvey W. Watt & Co. directly at 1-800-241-6103.

Sincerely,



Christine F.L. Holliday
Chairman, DPMA

PHONE (404) 559.9421 FAX (404) 559.9817 EMAIL: membership@dpma.org WEBSITE: dpma.org

SERVING PILOTS SINCE 1951

HARVEY WATT & CO

For members of:

Delta Pilots Mutual Aid Group Term Life Insurance

Underwritten by Metropolitan Life Insurance Company

LIMITED TIME SIMPLIFIED ISSUE OFFER

No Medical Exam · Professional Pilot Preferred Rates · Fully Portable Coverage

Dear Pilots,

For a limited time, you can apply for coverage in the Delta Pilots Mutual Aid-sponsored Group Term Life Insurance Program on a Simplified Issue basis. This means no medical exam is necessary. Applicants need only answer an abbreviated set of health questions satisfactory to the insurer. Some applicants may need additional underwriting. The other good news is that your spouse can also apply for coverage through this offer! Here's how much coverage you can apply for through this offer:

Pilot Members
$150,000 – Under age 50
$100,000 – Under age 55
$50,000 – Under age 60

Spouse of Pilot
$150,000 - Under age 50
$100,000 – Under age 55
$50,000 – Under age 60

Featuring competitive rates, portable coverage that stays with you even if you change jobs or retire, an option to elect dependent child coverage, and a conversion option. Why not take advantage of this benefit and help provide your loved ones with the protection they deserve? Read below for plan features, and see the next page for a rate chart.

Don't delay – The opportunity to participate in the program, which has been extended to your spouse, will conclude December 31, 2024.

DPMASI2024
L1024043784[exp1026][All States][DC,GU,MP,PR,VI]

Plan Highlights

- Your coverage will go into effect on the first day of the month following approval of your application by the insurer- provided you pay the required premium.
- Dependent child coverage is available, insuring all eligible children for $10,000 coverage at a monthly cost of $2.00. Eligible child is defined as your child age 15 days to 21 years who is wholly dependent on you for support, or to age 25 if a full-time student. Just check the box on the application to elect child coverage (member or spouse can elect child coverage, but not both).
- At age 70 your coverage will reduce to 50%. Spouse coverage will terminate at age 70. Coverage will otherwise remain in effect as long as premiums are paid when due and the group policy remains in force.
- Rates will increase per the rate chart as you/your spouse enters a new age bracket. There is no cancellation for ill health. Once your coverage takes effect, your coverage cannot be canceled due to a change in your health.
- Benefits are paid for all causes of death, except suicide in the first two years of your coverage or after increase in coverage.
- If you later become ineligible for coverage, conversion to an individual whole life policy, without proof of good health, is allowed.
- 30-Day free look – once you receive your certificate, review your plan to discuss with your family and advisors. If for any reason you are not satisfied, you may return your certificate within 30 days of receipt for a full refund of premiums paid- provided no claims have been submitted or paid.

Here is your Monthly Cost												
	Pilot Monthly Cost for $150,000		Pilot Monthly Cost for $100,000		Pilot Monthly Cost for $50,000		Spouse Monthly Cost $150,000		Spouse Monthly Cost $100,000		Spouse Monthly Cost $50,000	
Attained Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
Under 30	$4.20	$8.40	$2.80	$5.60	$1.40	$2.80	$5.55	$8.40	$3.70	$5.60	$1.85	$2.80
30-34	$4.95	$8.40	$3.30	$5.60	$1.65	$2.80	$5.55	$8.40	$3.70	$5.60	$1.85	$2.80
35-39	$6.30	$11.10	$4.20	$7.40	$2.10	$3.70	$7.05	$11.10	$4.70	$7.40	$2.35	$3.70
40-44	$9.90	$18.15	$6.60	$12.10	$3.30	$6.05	$11.10	$18.15	$7.40	$12.10	$3.70	$6.05
45-49	$13.95	$30.75	$9.30	$20.50	$4.65	$10.25	$16.80	$30.75	$11.20	$20.50	$5.60	$10.25
50-54	$25.05	$50.25	$16.70	$33.50	$8.35	$16.75	$30.75	$50.25	$20.50	$33.50	$10.25	$16.75
55-59	$38.40	$78.15	$25.60	$52.10	$12.80	$26.05	$39.00	$78.15	$26.00	$52.10	$13.00	$26.05
60-64	$42.60	$94.80	$28.40	$63.20	$14.20	$31.60	$52.95	$94.80	$35.30	$63.20	$17.65	$31.60

Rates shown are guaranteed until September 30, 2026. Rates increase as you enter a new age bracket. Costs shown in the shaded boxes above indicate rates for initial eligibility ages; additional rates are displayed to reflect current rates for all age brackets. (Contact plan administrator for costs over age 64.)

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.

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 sitused in the state of Georgia and is governed by its laws. The product is not available in all states.

Mail, fax, or email your completed application to Harvey Watt & Co to apply during this limited time opportunity.

**A tobacco user is anyone who has smoked cigarettes, pipes or cigars or used tobacco in any form in the past 2 years.*

Administered by:
Harvey Watt & Co
PO Box 82876, Atlanta, GA 30354

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

L1024043784[exp1026][All States][DC,GU,MP,PR,VI

2 Ways to Apply

Apply by enclosed application (1) or online (2)

1. Complete, sign, and date the application. Keep a copy of the application for your records. Complete payment authorization form:

   - Write "VOID" across a blank check and attach it to the form.
   - Complete, sign and date the form.

Return your completed application, bank draft authorization form, voided check and this completed 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**

2. Complete the online application:

Please contact us at **(800) 241-6103** or **pilot@harveywatt.com** if you have questions.

If additional information or underwriting is required, you will be notified by Harvey W. Watt & Co. To facilitate that, please provide the following information:

Name: _____ Phone:_____

Address: _____

City: _____ State: _____ Zip Code:_____

Email Address: _____

Want to learn more about our additional life insurance and disability options?

Mark below to receive additional information:

☐ Life ☐ Disability

Note: The results of this confidential Simplified Issue Application will not adversely affect your ability to renew a first class medical certificate. A possible declination only means you have not met the initial eligibility requirements for group life insurance. You are not required to report that as it is not a formal and final denial for life or health insurance as stated on the FAA Medical 8500-8 application form.

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 (LIMITED MEDICAL INFORMATION)

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

☐ Term Life[1]
Under Age 50: Enter a multiple of $5,000, up to a maximum of $150,000 $_____
Under Age 55: Enter a multiple of $5,000, up to a maximum of $100,000 $_____
Under Age 60: Enter a multiple of $5,000, up to a maximum of $50,000 $_____

☐ Dependent Spouse/Domestic Partner[2] Life [1,3]
Under Age 50: Enter a multiple of $5,000, up to a maximum of $150,000 $_____
Under Age 55: Enter a multiple of $5,000, up to a maximum of $100,000 $_____
Under Age 60: Enter a multiple of $5,000, up to a maximum of $50,000 $_____

☐ Dependent Child Life [3]

Dependent Information

If you are applying for coverage for your Spouse/Domestic Partner please provide the information requested below:
Name of your Spouse/Domestic Partner (First, Middle, Last) _____ Date of Birth (MM/DD/YYYY) _____ ☐ Male ☐ Female

Smoking Status Information

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

[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.

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 North Dakota and Utah)*

SUBMISSION INSTRUCTIONS

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

HEALTH INFORMATION

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.

Your height ___ feet ___ inches
Your weight ____ pounds

Spouse/Domestic Partner height ___ feet ___ inches
Spouse/Domestic Partner weight ____ pounds

	Member	Spouse/Domestic Partner
1. 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?	☐Yes ☐No	☐Yes ☐No
2. Are you now receiving or applying for any disability benefits, including workers' compensation?	☐Yes ☐No	☐Yes ☐No
3. Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days? **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.	☐Yes ☐No	☐Yes ☐No
4. **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
5. 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
b. stroke or circulatory disorder?	☐Yes ☐No	☐Yes ☐No
c. high blood pressure?	☐Yes ☐No	☐Yes ☐No
d. cancer, Hodgkin's disease, lymphoma or tumors?	☐Yes ☐No	☐Yes ☐No
e. diabetes?	☐Yes ☐No	☐Yes ☐No
f. asthma, COPD, emphysema or other lung disease?	☐Yes ☐No	☐Yes ☐No

If you answered "yes" to any of the above questions, a Statement of Health form must also be completed for the person to whom the "yes" applies.

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)*

FRAUD WARNINGS

Before signing this enrollment 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

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)*

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)*

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%

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)*

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any medical 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. I understand that 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 after the initial enrollment period has expired. 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)

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)*

Some services in connection with your coverage may be performed by our affiliate, MetLife Services and Solutions, LLC. These service arrangements in no way alter Metropolitan Life Insurance Company's obligation to you. Your coverage will continue to be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.

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-XDP110M-NW (06-24)

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.