Group Disability Insurance **Voluntary Long Term Disability**

SUMMARY OF BENEFITS Class 1

Sponsored By: **Trustees of the Aviation Health Association**
Effective Date: **November 1, 2021**
Policy Number: **01-020340-00**

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

Benefit Highlights:

Benefit Amount

30% of Salary up to $6,000 per month

Guaranteed Issue

$6,000

Elimination Period

365 days (number of days you must be disabled to collect disability benefits)

Maximum Payment Duration

Social Security Normal Retirement Age (SSNRA):

Age at Disability	Maximum Payment Duration
Less than age 60	To SSNRA
60	60 months or to SSNRA, greater of
61	48 months or to SSNRA, greater of
62	42 months or to SSNRA, greater of
63	36 months or to SSNRA, greater of
64	30 months or to SSNRA, greater of
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Accumulation of Elimination Days

You can satisfy the days of your elimination period with either total (off work entirely) or partial (working some hours at your current job) disability.

Pre-Existing Condition

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

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

Survivor Income Benefit	A survivor benefit may be paid to your beneficiary if you should die while receiving qualifying disability payments.
Benefit Limitations	Mental Illness: 24 Months Per Lifetime Substance Abuse: 24 Months Per Lifetime

Eligibility

All Active Full-Time UPS Management Pilots as Members of the Aviation Health Association working a minimum of 30 hours per week.

Standard Provisions:

- Maternity is covered the same as any other condition.
- 6 months recurrent disability/temporary recovery
  - If the insured recovers and returns to work, and the same sickness or injury causes the disability to occur again within 6 months of the date the prior disability ended, Symetra will resume monthly payments if the insured is covered under the policy for the period of temporary recovery.
- Waiver of premium
  - Premium payments for coverage are suspended for an insured while he/she is receiving disability income payments under this policy.
- Cost of living freeze
  - Except for increases in income earned (or received from any form of employment) once other income amounts have been subtracted from the gross monthly disability payment, the insured's payment will not be further reduced due to a cost-of-living increase in any other income amounts.
- Vocational rehabilitation
  - Provides assistance through services such as testing and training as well as job modification and placement.
- Social Security assistance
  - Helps an insured obtain Social Security disability benefits.
- Continuity of coverage

Contact Information for Claims

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

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

Rates for Voluntary Long Term Disability coverage

Monthly rate per $100 monthly covered payroll: $1.015

How to Calculate Your Cost

1.015	x	_____ /100	=	_____
(rate)		(Your basic monthly gross earnings to a maximum of $20,000)		Monthly Voluntary Long Term Disability Cost

This summary provides only a brief description of the Disability Income Insurance coverage insured by Symetra Life Insurance Company under the GDC 4000 series Group Disability Income Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-020340-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Insured by Symetra Life Insurance Company

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

Return Applications to: Harvey Watt & Company
PO Box 20787| Atlanta, GA 30320 | Phone 1-800-241-6103 | Fax 1-404-761-8326

GROUP DISABILITY INCOME INSURANCE ENROLLMENT

Instructions: Complete this form entirely and return it to Symetra Life Insurance Company at the address provided above.

Include a copy of your most recent FAA First Class Medical Certificate with this form. If you have a Special Issuance Authorization, please include a copy with this form.

Name of your employer
Trustees of the Aviation Health Association - 01-020340-00

Employer address
1212 Bank for Savings Building

City	State	Zip code
Birmingham	AL	35203

Your name *(last, first, middle)*

Date of birth *(month, day, year)*	☐ Male ☐ Female	Base Annual Earnings

Billing address

City	State	Zip code

Home phone	Work phone	Email address

- Type of coverage enrolling in: ☑ Vol LTD Income Insurance – 30.00% to $6,000 Max

- Do you currently hold a valid restricted first class medical certification that was issued, or renewed by the FAA within the last 6 months from the date of this application? (glasses limitations do not apply) ☐ Yes* ☐ No

- Have you ever been denied an unrestricted first class medical certification due to FAA medical requirements? ☐ Yes* ☐ No

** If you answered "Yes" to any of the questions above, please explain:*

The following health questions must be answered fully and truthfully to the best of your knowledge and belief. If any misstatements or omissions are made, they may be the basis for later rescission of your insurance coverage. Rescission voids your coverage and claims will not be paid.

1. Are you applicant pregnant? ☐ Yes* ☐ No
   ***If yes, please give details on the next page including due date.**

2. Are you applicant currently taking any medication? ☐ Yes* ☐ No
   ***If yes, please give details on the next page.**

3. In the past ten years, or as indicated below, have you been treated for, or been diagnosed by a member of the medical profession as having any of the following: ☐ Yes* ☐ No
***If yes, please indicate condition and provide details on the next page.**

a) Heart Disorder, Chest Pain, Circulatory Disorder
b) High Blood Pressure
c) Mental & Nervous Disorder, Depression
d) Alcoholism and/or Drug Habits
e) Stomach, Abdominal, Intestinal Disorder
f) Brain or Nervous System Disorder
g) Stroke, Paralysis
h) Cancer, Tumors
i) Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection/Disease, or tested Positive to the AIDS virus (HIV)
j) Abnormal Physical Exam, Lab or X-ray. (5 years)
k) Reproductive Organ Disorder
l) Sexually Transmitted Disease
m) Kidney Disorder
n) Liver Disorder
o) Gland Disorder
p) Diabetes Developmental
q) Disorder Birth Defect
r) Epilepsy, Seizures
s) Lungs, Respiratory Disorder
t) Bone, Joint, Connective
u) Tissue Disorder
v) Accident or Injury
w) Blood Disorder
x) Infectious Diseases
y) Back, Neck Pain, or Discomfort

4. Have you consulted, been advised or been examined by any healthcare provider for any other medical reason within the last ten years, or as indicated above? ☐ Yes* ☐ No
***If yes, please indicate condition and provide details on the next page.**

HEALTH INFORMATION

Question # Or Letter	Name of Person	Details of Yes Answers	Onset Mo. Yr.	Duration	Degree of Recovery	Full Name and Full Address of Attending Physician

Read this information carefully, then sign and date below.

- To the best of my knowledge and belief, the information I've provided is complete and correct.
- I understand and agree that no coverage shall take effect unless this application is approved by Symetra Life Insurance Company and the first premium is paid in my lifetime.
- I understand that my coverage could be denied if any FAA medical license was issued due to my misstatement or omission on an FAA application.
- I understand my coverage begins on the "effective date" assigned by Symetra Life Insurance Company.
- I have read and understand the fraud notice applicable to me on the following page.

Your signature Date signed

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Note: We will accept an authorization form preferred by your provider's office in place of this authorization form.

SYMETRA LIFE INSURANCE COMPANY

Authorization for Release of Medical Information

Group Policy Number: 01-020340-00

Name of insured/patient (please type or print): _____ Date of birth: _____

I authorize any physician, health care professional, hospital, clinic, medical facility, laboratory, pharmacy or pharmacy benefit manager, other health care provider, insurance company, or government agency that has provided treatment, services, or payment to me or on my behalf ("My Providers") to disclose my entire medical record, medications prescribed, prescription history, and any other protected health information concerning me to Symetra Life Insurance Company, its employees, agents, or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness, excluding psychotherapy notes, and the use of alcohol, drugs, and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Symetra Life Insurance Company may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; 3) obtain reinsurance; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Symetra Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Symetra Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this Authorization to disclose information about me or to the extent that Symetra Life Insurance Company has a legal right to contest a claim under an insurance policy. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Symetra Life Insurance Company except as authorized by me or as required by law.

This Authorization complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that if I refuse to sign this authorization to release my complete medical record, Symetra Life Insurance Company may not be able to process my application, continue my coverage, or make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____ _____

Signature of Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient