Dear Fellow SAPA Pilots:

According to the Council for Disability Awareness, “more than 1 in 4 of today’s 20-year-olds will become disabled before they retire.” US Airlines experience shows 1 in 20 pilots are grounded by the FAA every year. FAA oversight, safety concern, and a two-month backlog of Medical Certification cases may increase the time a pilot is out of work without pay.

During illness or injury, we want you to be able to focus on recuperation, not how to pay your bills. A healthy sick bank and Long-Term Disability coverage can help, but Loss of Medical Insurance can be a lifesaver. Your SAPA representatives and pilot leadership are making a concerted effort to bring Loss of Medical (LOM) benefits to SkyWest in partnership with Harvey Watt & Co who works with virtually every major pilot group.

This plan has our FULL endorsement and has met or exceeded all comparisons with other airlines.

Key Points:

- SkyWest Long Term Disability pays a taxed LOM benefit of 60% of your base earnings up to $5,000 a month for only 24 months. Many pilots report that this is insufficient and ends too soon.
- New SAPA Loss of Medical License coverage can protect pilots and their families all the way to retirement age. Research from other airlines and associations shows overwhelmingly positive feedback on coverage through Harvey Watt.
- Insured pilots receive FAA Medical Certification Advocacy at no Doctors and nurses provide you confidential representation and advice.

Questions? Contact Harvey Watt & Co. directly at 1-800-241-6103.

Gerry Hamontree
SAPA President

PLAN FEATURES:

FAA Loss of Medical License coverage

Pays 67% of earnings up to $10,000/month tax free

Benefits begin after 6 months and continue to age 65

Benefits and premiums are based on the earnings that you report on your application - not less than $25,500 or greater than your 3 highest months averaged. You can change your earnings by contacting Harvey Watt.

Policy holders receive unlimited FAA Medical Certificate representation and confidential consultation. Call our doctors and nurses, led by two Former US Federal Air Surgeons, for simple medication questions or major medical issues requiring doctor representation to the FAA.

2 WAYS TO ENROLL:

Apply Online at HarveyWatt.com and click our SkyWest or SAPA Logo.

Submit this paper application via fax, mail, or secure upload portal at HarveyWatt.com click “*Upload*” at top right of home page:

Harvey Watt &Co
P.O. Box 82876
Atlanta, GA 30354

Email: pilot@harveywatt.com
FAX: (404) 761-8326

AUTHORIZATION FOR PREMIUM PAYMENTS

Here's how to use the Pre-Authorization Premium Payment Plan:

1. Complete and sign the Membership Premium Payment Authorization form.
2. Submit online or enclose the Membership Premium Payment Authorization form along with your completed application, in the postage paid envelope provided and mail it to Harvey Watt & Company.

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.

BANK NAME _____

ROUTING #_____ ACCOUNT #_____

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 the account has been charged, I have the right to have the amount of the erroneous debit immediately credited to my account by DEPOSITORY, provided 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 _____ EMPLOYEE ID_____

DATE _____ SIGNED x_____

SYMETRA
RETIREMENT | BENEFITS | LIFE

SERVING PILOTS SINCE 1951
HARVEY WATT & CO

SUMMARY OF GROUP LONG TERM DISABILITY INCOME INSURANCE

For the Pilots of

SkyWest Airlines

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

GROUP VOLUNTARY LONG TERM DISABILITY INCOME INSURANCE

Long Term Disability

Disability income insurance can provide a portion of the income you would lose if you became disabled and could not work. This would help to pay your everyday living expenses, and it may assist you in maintaining the standard of living you and your family now enjoy.

Eligibility

All Active Pilots of SkyWest Airlines Working 58:36 hours per bid period

Benefits

If you become disabled benefits begin after 180 days of total or partial disability. Symetra Life Insurance Company will pay your benefit to you while you are disabled under the terms of the policy. The long-term disability income monthly benefit will be 67% of your salary to a maximum of $10,000 per month. The minimum monthly benefit is $100. The maximum payment duration is to Age 65 if you are initially disabled prior to age 60. If you are initially disabled on or after age 60, your benefit will last in accordance with the duration schedule on the following page. Pre-existing Conditions Limitation: 12/24.

Definition of Disability

Due to sickness or injury the insured is considered disabled if unable to perform with reasonable continuity the material and substantial duties of your regular occupation or you are deemed by the Federal Aviation Administration (FAA) to be mentally or physically unfit to fly as a commercial pilot and, as a result, the income you are able to earn is less than or equal to 80% of your pre-disability earnings.

Standard Provisions

- Maternity is covered as any other condition.
- Accumulation of the elimination period
- Six-month recurrent disability/temporary recovery. Certain restrictions apply.
- Waiver of Premium
- Cost of Living Freeze
- Workplace Modification
- Vocational Rehabilitation
- Social Security Assistance

Rates for Voluntary LTD

Rates are per $100 of monthly covered payroll

Employee Age	Rates
Under 30	$2.065
30 to 39	$2.183
40 to 49	$2.325
50 and over	$2.478

How to Calculate Your Cost

Employee: _____ x _____ /100 = _____

(rate) (your basic monthly gross earnings) Monthly Voluntary Long Term Disability

Maximum Payment Duration

Age When Disability Begins	Maximum Duration
Less than Age 60	To Age 65, but not less than 5 years
Age 60	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

This summary is based on proposal information only. It provides only a brief description of Disability Income Insurance coverage insured by Symetra Life Insurance Company under the GDC 4000 series Group Disability Income Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please call 1-800-426-7784 or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-016062-05. 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 Avenue NE | Suite 1200 | Bellevue, WA 98004

SERVING PILOTS SINCE 1951
HARVEY WATT & CO
Return Applications to: Harvey Watt & CO
P.O. Box 82876 | Atlanta, GA 30354

GROUP LONG TERM DISABILITY INCOME INSURANCE ENROLLMENT

Policy Number: 01-016062-05

Employer/Policyholder Name: SkyWest Airlines

Base | City | State | Zip

Employee Occupation/Job Title | Employee Date of Hire

Effective Date of Coverage | ☐ Full Time Employee

$_____/ Annual Gross Earnings

I. EMPLOYEE/ENROLLEE INFORMATION

Name | Sex ☐ M ☐ F

Street Address | City | State | Zip Code

Primary Telephone Number | Date of Birth | Email

II. BENEFITS

	Yes	No	Indicate the benefit amount
Voluntary Long-Term Disability Income Insurance			67%

- Do you currently hold a valid unrestricted first-class medical certification that was issued, or renewed by the FAA within the last six months (if 40 years or older) or within the last 12 months (if under the age of 40)? ☐ 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 & include a copy of any current FAA Special Issuance or SODA letters:*

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

1. Are any applicants currently pregnant?
   ***If yes, please provide brief details and expectancy date**

   _____

2. Are any applicants currently taking any medication?
   ***If yes, please list medication prescribed**

   _____
   _____

3. In the past ten years, or as indicated below, have any of the applicants been treated for, or been diagnosed by a member of the medical industry as having any of the following:
   ***If yes, please select which condition and use the space below for extra details**

a) ____ Heart Disorder, Chest Pain, Circulatory
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/Diabetes
p) ____ Developmental Disorder
q) ____ Birth defect
r) _____ Epilepsy/Seizures
s) _____ Lungs, Respiratory Disorder
t) _____ Bone, Joint, Connective Issues
u) _____ Tissue Disorder, Accident or Injury
v) _____ Blood Disorder
w) _____ Infectious Diseases
x) _____ Back, Neck Pain or Discomfort

_____
_____

4. Have you consulted, been advised or examined by any healthcare provider for any other medical reason within the last ten years, or as indicated above?
   ***If yes, please provide details on the condition**

_____
_____
_____

Read this information carefully, then sign and date below

- To the best of 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 the 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, W ASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

NEW HAMPSHIRE: Any person who, with the 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: 01-016062-05

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