

Harvey Watt & Co.

Aviation Health Association Group Term Life Insurance

*Underwritten by:
ReliaStar Life Insurance Company
A Member of the ING Family of Companies*

Group Term Life Insurance

from Harvey Watt & Co.



for members of

Aviation Health Association

Dear Pilot,

We are pleased to provide you with the opportunity to enroll in the Aviation Health Association-sponsored 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,

Pat Hiebel, CLU ChFC
President

Protect Your Family's Future With Affordable Group Life Insurance

Underwritten by ReliaStar Life Insurance Company for FAA Licensed Pilots who are members of The Aviation Health Association.

Save Three Ways With ReliaStar

As an FAA Licensed Pilot and a member of the Aviation Health Association, 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 ReliaStar's 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 affordable and convenient way to do so.

Your Plan of Benefits

As an FAA Licensed Pilot under age 65 who resides in the United States, you can apply for up to \$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 65 can also apply for up to \$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.

Attained Age	Monthly Rate per \$1,000 of Coverage			
	Pilot		Spouse	
	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	.260	.521	.260
60 - 64	.632	.353	.632	.353
65 - 69*	1.702	.949	1.702	.949

You can purchase up to \$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.

*On the premium due date after you or your spouse reaches age 65, the amount of insurance will be reduced to the lesser of 50% of the Benefit or to a maximum Benefit of \$50,000. Coverage terminates at age 70.

The Aviation Health Association Term Life Plan 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;
- you reach age 70;
- 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 ReliaStar 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 do not qualify for coverage, your payment will be refunded.

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

Administered by:

Harvey Watt & Company
P.O. Box 20787
Hartsfield-Jackson International Airport
Atlanta, GA 30320-0787
(800) 241-6103 or (404) 767-7501

Underwritten by:

ReliaStar Life Insurance Company
Minneapolis, MN

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).

Aviation Health Association Group Term Life Plan



Since 1951

Administered by:

Harvey W. Watt & Co.
AHA GROUP INSURANCE PLANS
PO Box 20787, Atlanta Airport
Atlanta, Georgia 30320
Call Toll Free: (800) 241-6103
www.harveywatt.com

Underwritten by:

ReliaStar Life Insurance Company
(a member of the ING family of companies)

This information is a brief description of benefits only and is subject to the terms, conditions and limitations set forth in Group Policy number 65009-9 (Policy form LP00GP). The Group Policy is subject to the laws and jurisdiction of the state in which it is issued. Additional information is contained in the Certificate of Insurance which is issued to the persons who become insured under the plan.

The availability of this offer may change and coverage may not be 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 Application for Membership in the Aviation Health Association.**
- 3. Complete the 2-page Group Term Life Application and sign and date the application.**
- 4. 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.**
- 5. Mail all of the above to:**

**Harvey W. Watt & Co – Life Insurance
PO Box 20787
Atlanta GA 30320**

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 if you have questions.**

APPLICATION FOR MEMBERSHIP IN THE AVIATION HEALTH ASSOCIATION

THE AVIATION HEALTH ASSOCIATION is an organization whose purpose is to promote the welfare and best interest of its members; to assemble and distribute information related to the health and safety of professionals in the airline industry; and to enhance social and economic conditions for its members through cooperative enterprises as a professional or commercial association. One of the benefits of membership is the eligibility for group insurances. If you are not already a member of The Aviation Health Association, complete the application below.

I hereby make application for membership in the Aviation Health Association. I certify that I currently hold a valid FAA Medical Certificate that was not obtained by misstatement or concealment and that I am currently employed as a pilot or flight engineer as my primary occupation.

Date: _____

Printed Full Name: _____

Address: _____ City: _____ State/Zip: _____

Signature X _____

Return to: Harvey W. Watt & Co.
P.O. Box 20787
Atlanta, GA 30230

Group Term Life Application

Please complete the entire application. The proposed insured should fill out this application. *Please print clearly in dark ink and mail to Harvey Watt & Company, P.O. Box 20787, Atlanta, GA 30320-0787. Phone 800-241-6103 or 404-767-7501. Fax 404-761-8326.*

1

Aviation Health Association

65009-9

Tell us about yourself

You are applying as: Association Member Spouse of Member

Your Name (<i>last, first, middle</i>)		<input type="checkbox"/> Female <input type="checkbox"/> Male	Name of Member
Date of Birth	Height	Weight	Social Security Number
Address			
City		State	ZIP
Home Phone	Work Phone	E-mail Address	

Owner (if other than yourself.) *The owner controls all rights to the certificate.*

Name	Address	
City	State	ZIP

➤ If you are a **new** applicant, indicate **initial** amount of coverage applied for: \$ _____
in \$5,000 increments

➤ If you are **increasing** coverage, indicate amount of **additional** coverage applied for with this application: \$ _____
in \$5,000 increments

➤ Check box to purchase:
 \$10,000 Dependent Child Insurance

➤ Have you used tobacco products of any kind in the last 12 months Yes No

➤ Are you currently working at least 30 hours per week at your regular occupation and place of business? Yes No

➤ Will any of the insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force? Yes No

If yes, please explain: _____

2

Beneficiary information

List one or more beneficiaries below. List the percent each will receive. The total must equal 100 percent. *Beneficiary for dependent coverage will be the certificate holder.*

Name	Address	Relationship	Percent

ReliaStar Life Insurance Company • Box 20 • Minneapolis, MN 55440

Please complete and sign back of application.

3

Provide us with this health information

- a.) Have you, for any condition during the past 12 months, consulted a physician/health practitioner, received surgical or medical care, or taken prescribed medication? Yes No
- b.) Have you ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), disorders of the immune system or tested positive for antibodies to the HIV virus? Yes No
- c.) Have you ever been diagnosed with or been treated for: disease or disorder of heart; lungs; nervous/mental system (including anxiety and depression); liver; kidneys; stomach; colon or genito-urinary system; stroke; high blood pressure; cancer or tumor; diabetes; or arthritis? Yes No
- d.) Have you ever sought help or received counseling or treatment for alcohol or drug use, or are you currently using illegal drugs? Yes No
- e.) Have you ever applied for insurance that was declined, postponed or modified in any way? Yes No

If you answered "yes" to any of the questions above, please give full details below.
Attach additional sheets if needed.

Q#	Name	Conditions/illness/treatment	Date(s) of treatment	Physician/health practitioner's name and complete mailing address

f.) List the name and address of your regular physician/health practitioner and the date you last consulted him or her:

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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 ReliaStar Life Insurance Company and the first premium is paid in my lifetime.
- I understand my coverage begins on the "effective date" assigned by ReliaStar Life.

Authorization and Acknowledgment – Please read and sign below.

For underwriting and claim purposes, I give my permission to: Any physician, or any other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, Inc. (MIB), Department of Motor Vehicle Records, employer or any other organization or person to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including ChoicePoint or any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or any non-medical information, including motor vehicle records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about the same persons.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employer, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. As it relates to the incontestability clause, this form will be valid for 30 months from the date shown below or for two years from the date coverage is made effective, whichever is earlier.

I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

Any person who knowingly and with intent to defraud, submits an application or files a statement of claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.

Your Signature	Date Signed
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Signature of Owner (if other than yourself)	Date Signed
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ATTACH VOIDED CHECK

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. Write VOID across one of your blank checks.
3. Enclose the Membership Premium Payment Authorization form and the voided check, along with your completed application.

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.

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 & COMPANY to initiate debt 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 NAME _____ BRANCH _____

CITY _____ STATE _____ ZIP _____

TRANSIT/ABA NO. _____ 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 reasonable opportunity to act on it. I (either of us) has 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, 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(s) _____ EMPLOYMENT I.D. # _____

DATE _____ SIGNED X _____

SIGNED X _____