

US Airways Pilots Association (USAPA) Group Term Life Insurance 10-Year Level Premium

For Association Members and Their Families
Issued by ReliaStar Life Insurance Company, a member of the ING family of companies.

Administered by:



ABOUT LIFE INSURANCE

Life insurance provides basic protection for your loved ones if something happens to you. The loss of your income could create immediate financial hardship and lifestyle changes for your family. Life insurance helps assure your family can maintain financial security and meet financial obligations.

While a large percentage of U.S. households have life insurance, the average amount of coverage is often inadequate to meet family needs or pay off debt.

Life insurance can help you:

Protect your family: Your family depends on your income. Life Insurance helps replace that income when they need it most.

Protect your home: For most families, their home is the largest asset. Life insurance can enable your family to remain in their home, pay the mortgage and avoid the trauma of relocation.

Protect children's education: Covering the soaring cost of education becomes even more difficult when there is a loss of income. Life insurance helps secure your children's future.

Settle expenses: Life insurance can also help cover financial expenses, such as medical bills and funeral costs, as well as unplanned expenses and unforeseen financial crisis.

HELP PROVIDE SECURITY AT AFFORDABLE RATES

The plan provides members with term life insurance protection in the amount you select, from \$300,000 to \$1,500,000, in \$50,000 increments. Your premium may stay level for up to 10 years. With our plan, the initial premium may not change for the first 10 years. However the insurance company does reserve the right to change premium rates, but may only do so for all insureds covered under the group policy and with 60 days written notice.

This group coverage is available to you as a member of the US Airways Pilots Association. Administrative costs for group coverage are low, so you can save on premium costs and enjoy the benefits of the plan.

Spouse and Child Coverage

Spouses can apply for coverage amounts of \$300,000 to \$1,500,000 in \$50,000 increments. The member does not need to be insured for the spouse to be eligible.

One premium provides \$5,000 of life insurance on each dependent child age 15 days but less than 21 years of age and for student dependents age 21 but less than 23 years of age.

Covered members or spouses may apply for this coverage, which costs \$0.50 monthly.

Eligibility for this Plan

USAPA active member pilots under age 65 who are actively at work are eligible to apply for coverage. Your spouse is eligible to apply for coverage under age 65 if you are a member and your spouse is able to conduct the normal activities of a person of like age gender, and is in good health.

Level term for 10 Years

At the end of the level term period, evidence of insurability is required to enter another level term period (subject to the maximum age to begin a level term period). If evidence of insurability is not provided or not approved by ReliaStar Life, rates will be based on the five-year age brackets for the insured's current age.

Continuous Coverage

Coverage will not reduce during your level term period for member or spouse. If the level term rate period has expired, coverage for retired members will begin reduction at age 65 as follows: at age 65 reduces to the lesser of \$50,000 or 50%; at age 70-79, coverage reduces to one-half of the amount in effect when you were age 65-69; at age 80 and above, coverage reduces to one-half of the amount in effect when you were age 70-79. Coverage will reduce on your premium due date following the age attainment when reduction begins.

Spouse coverage, if no longer in a level term period, will reduce to the lesser of \$25,000 or 25% at age 70; spouse coverage terminates at age 75.

Upon termination or at time of reduction, the insured may convert to an individual whole life policy, without proof of good health. Coverage is subject to renewal of the group policy issued to the Aviation Association Insurance Trust and timely premium payment.

Ownership Transfer Available

The provisions of this group policy allow you to transfer ownership of coverage to your spouse, business partner, professional corporation or a trust. Transfer of ownership could result in a tax advantage for you. Contact your tax advisor for details.

ADDITIONAL BENEFITS

Accelerated Life Benefit

The plan automatically includes an Accelerated Life Benefit. If you are terminally ill and have a life expectancy of 24 months or less, you can receive a portion of your death benefit before dying. You can receive payment of up to 50 percent of your coverage to a maximum payout of \$100,000. All remaining insurance benefits will be paid to your beneficiary when you die.

Payment of Proceeds

You designate your beneficiary. Your spouse, if insured, also designates a beneficiary. You or your covered spouse can change beneficiaries by giving written notice to ReliaStar Life, unless you provide otherwise in your original designation. The certificate-holder that includes dependent child coverage will be the beneficiary of elected children's insurance.

Non-Tobacco User Monthly Premium Cost in \$50,000 Increments

For a 10-Year Level Rate Period

Issue Age	Face amounts \$300,000 - \$499,000				Face amounts \$500,000 - \$1,500,000			
	Member		Spouse		Member		Spouse	
	Non-Tob	Tobacco	Non-Tob	Tobacco	Non-Tob	Tobacco	Non-Tob	Tobacco
20	2.21	6.88	1.96	5.92	2.04	6.63	1.75	5.67
21	2.21	6.88	1.96	5.92	2.04	6.63	1.75	5.67
22	2.21	6.88	1.96	5.92	2.04	6.63	1.75	5.67
23	2.21	6.88	1.96	5.92	2.04	6.63	1.75	5.67
24	2.21	6.96	1.96	5.92	2.04	6.67	1.75	5.67
25	2.21	6.96	1.96	5.92	2.04	6.67	1.75	5.67
26	2.21	7.00	1.96	5.92	2.04	6.71	1.75	5.67
27	2.21	7.00	1.96	5.92	2.04	6.71	1.75	5.67
28	2.21	7.04	1.96	5.96	2.04	6.79	1.75	5.71
29	2.21	7.08	1.96	5.96	2.04	6.83	1.75	5.71
30	2.21	7.17	1.96	6.00	2.04	6.88	1.75	5.75
31	2.21	7.17	1.96	6.00	2.04	6.88	1.75	5.75
32	2.21	7.17	1.96	6.00	2.04	6.88	1.75	5.75
33	2.21	7.17	1.96	6.00	2.04	6.88	1.75	5.75
34	2.21	7.17	1.96	6.00	2.04	6.88	1.75	5.75
35	2.21	7.42	1.96	6.17	2.04	7.13	1.75	5.92
36	2.29	7.75	2.04	6.50	2.08	7.46	1.83	6.25
37	2.38	8.25	2.13	7.00	2.17	7.96	1.92	6.75
38	2.54	8.88	2.29	7.67	2.33	8.54	2.08	7.38
39	2.71	9.67	2.46	8.38	2.50	9.33	2.29	8.08
40	2.92	10.54	2.67	9.08	2.71	10.21	2.46	8.79
41	3.13	11.58	2.88	9.88	2.92	11.25	2.67	9.54
42	3.46	12.79	3.13	10.67	3.25	12.42	2.92	10.33
43	3.75	14.17	3.46	11.58	3.54	13.75	3.21	11.21
44	4.13	15.67	3.75	12.54	3.88	15.25	3.54	12.17
45	4.50	17.25	4.04	13.58	4.29	16.79	3.83	13.21
46	4.92	19.00	4.33	14.67	4.67	18.54	4.13	14.25
47	5.46	20.96	4.67	15.83	5.21	20.46	4.42	15.42
48	5.96	22.96	5.00	17.08	5.71	22.46	4.75	16.67
49	6.50	25.08	5.29	18.38	6.25	24.54	5.04	17.92
50	7.17	27.21	5.71	19.67	6.92	26.63	5.46	19.21
51	7.92	29.29	6.13	21.00	7.58	28.63	5.88	20.54
52	8.67	31.29	6.63	22.42	8.33	30.63	6.33	21.88
53	9.50	33.42	7.13	23.88	9.21	32.71	6.83	23.29
54	10.42	35.83	7.71	25.29	10.08	35.04	7.42	24.75
55	11.46	38.50	8.29	26.88	11.08	37.71	8.00	26.29
56	11.71	41.54	8.92	28.33	12.17	40.67	8.58	27.71
57	13.54	44.79	9.54	29.75	13.12	43.92	9.25	29.13
58	14.83	48.50	10.33	31.29	14.46	47.54	9.96	30.63
59	16.29	52.79	11.13	33.21	15.83	51.75	10.79	32.50
60	18.00	57.83	12.00	35.75	17.54	56.71	11.67	34.96
61	20.04	63.29	13.33	38.96	19.54	62.13	12.96	38.17
62	22.38	69.25	14.71	42.79	21.83	67.96	14.33	41.96
63	24.96	76.25	16.33	47.17	24.42	74.83	15.92	46.21
64	27.92	85.00	18.00	52.13	27.29	83.42	17.54	51.08

HOW TO APPLY

Complete the entire application form

Simply complete the application form and return it in the envelope provided.

Send no Premium

Your coverage will become effective upon the insurer's approval of your application and receipt of your premium. You will be billed monthly by Harvey Watt & Co.

Contact administrator

Some applications may be required to have a medical exam in order to apply for coverage. Contact Harvey Watt & Co., for more information on medical requirements.

Exclusions

The only exclusion under the group term life policy is suicide within the first two years of coverage. Please read your insurance certificate for details. For information on termination of coverage, also consult your certificate.

Rates are guaranteed for first year of coverage.



20 Washington Avenue South
Minneapolis, MN 55401

ReliaStar Life Insurance Company, a member of the ING family of Companies, is a wholly owned indirect subsidiary of ING Groep, N.V., an Amsterdam-based global leader in integrated financial services, providing banking, insurance and asset management businesses in more than 50 countries worldwide. Each insurer is solely responsible for the financial obligations under the policies and contracts it issues.

This brochure is for summary purposes only. For a complete description of benefits and limitations, please read your Certificate of Insurance. Policy Form LP08GP.



Harvey Watt & Co.

PO Box 20787
Atlanta, GA 30320
1-800-241-6103

Fax: 404-761-8326

www.harveywatt.com

Email: pilot@harveywatt.com



Group Term Life Application for 10-Year Level Term Rate

Please complete the entire application. Minimum coverage amount with this application is \$300,000. The proposed insured should fill out this application. *Please print clearly in dark ink and mail to Harvey Watt & Company, PO Box 20787, Atlanta, GA 30320-0787. Phone: 800-241-6103 or 404-767-7501; Fax: 404-761-8326.*

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Tell us about yourself

Name of Association

Aviation Association Insurance Trust

66234-8

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		Email Address	

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

Name	Address		
City	State	Zip	

➤ Indicate amount of life insurance applied for. If you are currently insured under this Group Policy and are applying for entry into a 10-year level term rate period, indicate your amount of total life coverage requested (include current and additional amount desired, if applicable). If approved, your total amount of life coverage under this group policy will enter a 10-year level term rate period.

\$ _____
in \$50,000 increments

➤ Check box(es) to purchase:

\$5,000 Dependent Child Insurance

(check only if applying for dependent child coverage for the first time under this Group Policy)

➤ 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: _____

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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

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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
Signature of Owner (if other than yourself)	Date signed

Here's How to Apply

1. **Print and complete the application in its entirety and sign and date the application.**
2. **Complete payment authorization**
 - **Write void across a blank check and attach**
 - **Complete and sign form.**
3. **Mail all of the above to:**
Harvey W. Watt & Co – USAPA 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.**

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 _____