

*An Affordable Supplemental Group Term Life Insurance
Plan for Members and Families of
US Airways Pilots Association
(USAPA)*

Made available to you through:

THE AVIATION ASSOCIATION INSURANCE TRUST

Underwritten by ReliaStar Life Insurance Company, a member of the ING family of companies

Administered by:



Secure Your Family's Future with Careful Planning

Nothing can replace the loss of a loved one, but carefully chosen life insurance coverage can ease the financial stress that death brings to a family. It can help provide the funds your spouse and dependents need for a secure, comfortable future.

By planning ahead, you can assure that your beneficiaries will have the money necessary to:

- *Maintain the standard of living you want for them.*
- *Protect your home and other assets.*
- *Pay for education, child care and household expenses.*
- *Cover funeral and probate costs, taxes, debts and other obligations.*
- *Invest for income and opportunities in coming years.*

Professionals like you take your responsibilities seriously. You want the best for your family. That's why so many successful professionals choose the ReliaStar Life Insurance Company Association Group Term Life Insurance plan. Administrative costs for group coverage are low, so you can save in premium costs and enjoy the benefits of the plan.

How much coverage may I select?

As an Active Member pilot, you and your spouse may apply for group term life insurance protection in amounts ranging from \$50,000 to \$1,500,000, in \$50,000 increments. Your spouse has the same coverage options and may apply even if you do not. You and your Spouse must be under age 65 to apply. Your spouse's coverage will terminate when he/she attains age 75.

Your dependent children may also be insured for \$5,000. You or your spouse must be insured under this program in order for your dependent children to be eligible (if both member and spouse are insured, only one can carry the dependent child coverage). One monthly premium of \$1.25 covers all eligible dependent children ages 15 days to age 21 (or to age 23 if a full-time student and wholly dependent on you for support).

When do benefits terminate?

Your insurance continues as long as you pay premiums when due and the master policy remains in force. Spouse coverage reduces to the lesser of \$25,000 or 25% at age 70, and terminates at age 75.

As long as you are an active, flying pilot, your benefits will not reduce. Retired members coverage will reduce 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.

Is there an 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 a 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.

Can I convert my insurance to an individual policy?

If you or your spouse later becomes ineligible for this group coverage, conversion to an individual life policy is allowed, without proof of good health. Converted coverage does not include the accelerated life benefit.

(turn over)

Who receives the 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.

What is the cost?

The monthly cost for you and your spouse varies by age. The monthly cost will increase as you or your spouse reaches the next age bracket. See rates below. Rates are guaranteed for first year of coverage. Contact Plan Administrator for assistance in calculating additional non-tobacco user sample monthly costs beyond those shown below, or for sample tobacco-user premiums.

Monthly Group Term Life Non-Tobacco Rates for Member and Spouse							
Age	Monthly Rate per \$1,000		Sample Monthly Premiums for Non-Tobacco Users				
	Non-Tobacco Users	Tobacco Users	\$100,000	\$200,000	\$250,000	\$350,000	\$500,000
Under 30	\$.0317	\$.0600	\$ 3.17	\$ 6.34	\$ 7.93	\$ 11.10	\$ 15.85
30-34	.0417	.0817	4.17	8.34	10.43	14.60	20.85
35-39	.0558	.1167	5.58	11.16	13.95	19.53	27.90
40-44	.0733	.1542	7.33	14.66	18.33	25.66	36.65
45-49	.1083	.2342	10.83	21.66	27.08	37.91	54.15
50-54	.1783	.3867	17.83	35.66	44.58	62.41	89.15
55-59	.3500	.7600	35.00	70.00	87.50	122.50	175.00
60-64	.7708	1.3958	77.08	154.16	192.70	269.78	385.40
65-69	1.5417	2.5208	154.17	308.34	385.43	539.60	770.85

How to Apply

- 1) **Complete the entire application form.** Simply complete the application form and mail it to Harvey Watt & Co.(see address shown below).
- 2) **Separate form.** Use a separate form for your spouse.
- 3) **Contact administrator.** Contact your Plan Administrator for additional forms, if necessary.

Underwriting Your Application

Some applicants may be required to have a medical exam (at the insurer's expense) in order to apply for coverage. For more information on medical requirements, please consult your Plan Administrator. You will be contacted by the Plan Administrator when your coverage is approved. Premiums are made through automatic bank draft through the Plan Administrator.

Exclusions

The only death claims against your group term life coverage to be denied will be for death by 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.

PLAN ADMINISTERED BY:

Harvey Watt & Co.
PO Box 20787
Atlanta, GA 30320
(800) 241-6103 Fax: (404) 761-8326
www.harveywatt.com or e-mail pilot@harveywatt.com

THE ORGANIZATION BEHIND THE COVERAGE:

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.



20 Washington Avenue South
Minneapolis, Minnesota 55401

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.**



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, 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	

- 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(es) to purchase:
 - \$5,000 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: _____

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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 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

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 _____