

***Harvey W. Watt & Co.***

**United Parcel Service Company  
Management Pilots**

**Group Long Term Disability**

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# Long Term DISABILITY

## GROUP LONG TERM DISABILITY

### *Summary of Benefits*

### UNITED PARCEL SERVICE COMPANY (UPSCO) MANAGEMENT PILOTS

#### HOW MUCH INSURANCE WILL COVERED EMPLOYEES HAVE?

For a disabling condition, your eligible employees income/*basic monthly earnings* will be replaced by 30% to a *maximum monthly benefit of \$ 6,000*. Benefits will be payable upon completion of an *elimination period of 365 days*.

#### HOW LONG WILL COVERED EMPLOYEES RECEIVE BENEFITS?

#### Maximum Benefit Duration To Age 65

#### THE FOLLOWING FEATURES ARE INCLUDED, AT NO EXTRA COST:

- *Accumulation of Elimination Period*
- *Continuity of Coverage*
- *Minimum Monthly Benefit*
- *Maternity Treated as Any Other Illness*
- *Survivor Benefit*
- *Recurrent Disability*
- *Rehire Provision*
- *Waiver of Premium*

Rehabilitative Programs are included to aid severely disabled employees trying to return to the workforce. These programs include:

Work Station Analysis  
Therapy  
Counseling  
Vocation Evaluation

Clinical Selection  
Internal Career Development  
Job Preparation  
Aptitude Testing

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## **DEFINITION OF DISABILITY**

Under the **Long Term 'Income Protection' disability with Progressive Partial disability**, due to injury or sickness, eligible employees:

Satisfy the elimination period by the inability to perform either or both of the following:

1. one or more of the material duties of **'Own Occupation'** on a full-time or part-time basis; or
2. any of the material duties of **'Own Occupation' or 'Any Occupation'**.

After the elimination period is satisfied the disabled employee:

1. Will be paid benefits according to the inability to perform the material duties of the employee's **'Own Occupation'**. *And* is not tested to perform **'Any Occupation'**. There is no change in the disabled employee's **'Own Occupation'** to **'Any Occupation'** for which that employee is reasonably suited by training, education or experience; and
- or**
2. Will receive benefits, as long as earnings are less than 80% of the indexed total earnings.

### **"Monthly Benefit Calculation":**

For disabled employees who are unable to perform each of the material duties of their own occupation because of injury or sickness and who have suffered an earnings loss of 20% or greater, the monthly benefit amount will be determined as follows:

1. Multiply the disabled employee's basic earnings by the benefit percentage elected.
2. Take the lesser of:
  - a. the amount figured in step 1 above; or
  - b. the maximum monthly benefit shown in this proposal, page and then
3. Deduct any income the insured is eligible to receive from other income benefits, from the amount.

The monthly benefit will never be less than the minimum monthly benefit shown in this proposal.

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**FEATURES INCLUDED IN THIS PLAN, AT NO EXTRA COST:**

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Accumulation of Elimination Period: an eligible employee can return to work during the elimination period for a specified period of time without having to begin a new elimination period. The days can be consecutive or intermittent, however they must be for the same disability.

Continuity of Coverage (No Loss/No Gain): an eligible employee will not lose coverage due to a change in carriers. This feature protects employees who are actively at work and or have a change in pre-existing conditions during a change in insurance carriers.

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## **.... AND THERE ARE MORE FEATURES**

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Maternity Treated as Any Other Illness: any disability caused by pregnancy or complications of pregnancy is covered and considered as any other sickness.

Minimum Monthly Benefit: eligible employees are guaranteed a minimum monthly benefit of \$50.

Recurrent Disability: this allows continuation of totally disabled employee's benefits if there is a return to work for less than six months, and has a recurrence of the same total disability. We will consider this a continuation of the same disability and a new elimination period will not have to be completed.

Rehire Provision: this allows for an employee who is rehired by a former employer within the same policy year of the termination date, all previous service in an eligible class will apply towards the waiting period to determine the eligibility date.

Three Month Survivor Benefit: a lump sum benefit equal to three times the insured's gross monthly benefit is payable to an 'eligible survivor' or estate, provided the employee was disabled continuously for six months and was receiving a monthly benefit at the time of death.

Waiver of Premium: premium for a claimant is waived while benefits are payable.

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## **.... AND THERE ARE PROGRAMS AVAILABLE, AT NO EXTRA COST**

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**Rehabilitative Employment Programs:** we have a rehabilitative program to aid severely disabled employees who are trying to return to the workforce. This program is specifically designed to assist individuals who wish to explore vocational options and to move them back to the mainstream of a productive lifestyle. Services include:

Work Station Analysis identifies modifications or adaptive aids to enable the performance of job functions.

Therapy strengthens or restores lost capabilities.

Counseling helps eligible employees recognize and maximize abilities while making the transition back to the workforce.

Vocational Evaluation identifies transferable skills and training requirements.

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**... AND THE REHABILITATION PROGRAMS CONTINUE:**

*Clinical Selection* coordinates the rehab program with appropriate agencies, schools, or private rehabilitation companies.

*Internal Career Development* explores options with the employer such as suitable jobs within the company, on-the-job training, and trial work periods.

*Job Preparation* helps with resumé preparations, job-hunting, and interviewing skills.

*Aptitude Testing* evaluates an individual's suitability for other vocations.

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## **EXCLUSIONS/LIMITATIONS**

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### *Pre-Existing Conditions Exclusions Are:*

A pre-existing condition is a sickness or injury for which the employee received medical treatment, consultation, care, or services, including diagnostic measures, or took prescribed drugs or medicines during a specified period just prior to the plan effective date.

### *3/12 Pre-Existing Conditions Exclusion*

If an employee received treatment within the three months prior to the plan effective date and becomes disabled for the same condition, treated for, within the first 12 months of coverage, no benefits are payable.

### *24 Month Mental Illness and Drug & Alcohol Limitation*

Any disability resulting from a mental illness or drug & alcohol problem is limited to 24 months, unless hospital confined at the end of the 24 month period. If the insured is still disabled when he is discharged, the monthly benefit will be paid for a recovery period of up to 90 days. The monthly benefit will not be payable beyond the maximum benefit. Subject to a load, this limitation can be removed for groups over 25 lives.

### *General Exclusions Include:*

Those disabilities caused by or resulting from:

- War, declared, undeclared, or any act of war;
- *Intentionally* self-inflicted injuries;
- *Active* participation in a riot plan.

Policy issued by:

**The United States Life Insurance Company in the City of New York**

New York, New York

Policy Form Number G-19000

[www.americangeneral.com/employeebenefits](http://www.americangeneral.com/employeebenefits)

American General Life Companies, [www.americangeneral.com](http://www.americangeneral.com), is the marketing name for the insurance companies and affiliates comprising the domestic life operations of American International Group, Inc., including The United States Life Insurance Company in the City of New York.

American General Life Companies insurers offer a broad spectrum of life insurance, fixed annuities, accident and health products and worksite benefits to serve the financial and estate planning needs of customers throughout the United States.

The underwriting risks, financial and contractual obligations and support functions associated with products issued by The United States Life Insurance Company in the City of New York are its responsibility. The United States Life Insurance Company in the City of New York is authorized to do an insurance business in New York. Policies are not available in all states.

This is a summary only of products and services offered. Actual offerings may vary by group size and are subject to state insurance law, and the benefits/provisions as described may vary due to such law. All products are subject to the terms, conditions, limitations and exclusions of the policy. Please see policy and certificate for details.

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## **SOME BASIC DEFINITIONS FOR YOU AND YOUR EMPLOYEES:**

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**Basic Monthly Earnings:** the eligible employee's rate of earnings, as reported by the employer, in effect, just prior to the date disability begins. It does not include bonuses, overtime pay, commissions, and other extra compensation.

**Benefit:** once the Insurance Company receives proof that an eligible employee is disabled, due to a sickness or injury, and requires the regular attendance of a physician, the Company will pay the eligible employee a monthly benefit after the completion of an elimination period.

**Benefit Duration:** the maximum length of the benefit period.

**Benefit Percentage:** the percentage of covered salary allowed under the contract to determine an eligible employee's payable benefit.

**Disability:** this represents the amount of time a disabled employee is considered disabled according to the eligible employee's ability to perform the duties of 'own occupation' or 'any occupation', if applicable. Also, the elimination period may be completed with days of total or partial disability, whichever is indicated in the Benefit Summary.

**Eligible Class:** the category in which an insured is placed in the insurance plan in order to determine the amount of insurance for which that employee is eligible under this plan.

**Eligibility:** the purpose of LTD is to reasonably replace earned income which is lost due to a disability. Income must be generated as a result of 'active employment'. Active employment means:

- Working for the employer on a full-time basis and paid regular earnings; and
- Working at least the minimum number of hours shown in the plan specifications; and either
- At the employer's usual place of business; or
- At a location to which the employer's business required the employee to travel.

**Elimination Period:** the period of consecutive days of disability for which no benefit is payable. The elimination period begins the first day of disability and will continue for the number of days specified under this plan.

**Maximum Monthly Benefit:** the amount any eligible employee can receive under this plan, as indicated in the Benefit Summary.

## **Here's How to Apply**

- 1. Complete the entire application. Be sure to sign and date the application.**
- 2. Complete payment authorization form**
  - **Complete, sign and date the form.**
  - **Write void across a blank check and attach it to the form.**
- 3. Mail all of the above to:**

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

**Or fax them 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.**

**The United States Life Insurance Company in the City of New York**

New York, New York

Administrative Office: 3600 Route 66, P.O. Box 1583, Neptune, NJ 07754-1583

**GROUP POLICY NO.:** \_\_\_\_\_ **SOCIAL SECURITY NO.:** \_\_\_\_\_

Use this form to give a statement for any combination of: yourself, your spouse and/or your eligible children. In all cases you must complete the EMPLOYEE/MEMBER DATA section. *Please print or type all information requested.*

**EMPLOYEE/MEMBER DATA**

1. Your full name: \_\_\_\_\_ Salary: \_\_\_\_\_ Male  Female
2. Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
3. Employed by: \_\_\_\_\_ Date employed: \_\_\_\_\_
4. Are you now working at least 30 hours per week with your present employer? Yes  No  Job Title \_\_\_\_\_

**PERSONAL DATA**

5. Give the following details about: \_\_\_\_\_ Spouse's full name: \_\_\_\_\_
  - a. yourself if you are giving a statement of insurability:
  - b. your spouse if she or he is giving a statement of insurability:

Date of Birth	Place of Birth	Height	Weight	Date of Birth	Place of Birth	Height	Weight
Month/Day/Year		Ft. In.	Lbs.	Month/Day/Year		Ft. In.	Lbs.

- c. your eligible children if they are giving a statement of insurability:

Child's name	Date of Birth	Child's name	Date of Birth	Child's name	Date of Birth	Child's name	Date of Birth

**INSURABILITY QUESTIONS**

In the following questions, "person" refers to each person (you only, your spouse and/or each eligible child) who is giving a statement of insurability. Answer each question by checking the "Yes" or "No" box, as it applies.

6. WITHIN THE PAST 7 YEARS, HAVE YOU HAD AND BEEN TREATED FOR: (Circle specific disorders experienced.)	YES	NO
a. Heart trouble or murmur, chest pain, rheumatic fever, elevated blood pressure, stroke?	<input type="checkbox"/>	<input type="checkbox"/>
b. Injury, pain or disorder of neck or back? Sciatica? Any disabling injury?	<input type="checkbox"/>	<input type="checkbox"/>
c. Arthritis, gout, bursitis or rheumatism?	<input type="checkbox"/>	<input type="checkbox"/>
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears?	<input type="checkbox"/>	<input type="checkbox"/>
e. Disease or disorder of rectum or anus? Varicose veins or other vascular disorder?	<input type="checkbox"/>	<input type="checkbox"/>
f. Diabetes? Sugar, albumin or pus in urine? Thyroid or other glandular disorder?	<input type="checkbox"/>	<input type="checkbox"/>
g. Duodenal or stomach ulcer, or other disorder of stomach, liver, gall bladder? Colitis, diverticulitis, or other disorder of small or large intestine?	<input type="checkbox"/>	<input type="checkbox"/>
h. Prostate disorder? Kidney stone or colic, nephritis, nephrosis or other kidney disorder? Urinary infection?	<input type="checkbox"/>	<input type="checkbox"/>
i. Menstrual, uterine or ovarian disorder? Disorder of the breast?	<input type="checkbox"/>	<input type="checkbox"/>
j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting or other disorder of lung or nose?	<input type="checkbox"/>	<input type="checkbox"/>
k. Cancer or other tumor? Deformity or loss of limb? Congenital defect?	<input type="checkbox"/>	<input type="checkbox"/>
l. Mental or emotional problem requiring help of a physician or psychologist?	<input type="checkbox"/>	<input type="checkbox"/>
m. A surgical operation? A surgical operation advised but not performed?	<input type="checkbox"/>	<input type="checkbox"/>

7. Have you had treatment by, or consultation with, any hospital, institution, physician or practitioner within the past 7 years?  Yes  No

GIVE DETAILS BELOW IF: (A) "Yes" to any part of question 6, or (B) "Yes" to question 7 for a condition not specified in question 6.

Question No.	Name of Person	Condition	Date Occurred	Duration	Degree of Recovery	Names & Addresses of Physicians Hospitals or Clinics Consulted



# 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 \_\_\_\_\_

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**These Notices must be detached and retained by the applicant****MIB DISCLOSURE NOTICE**

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

**NOTICE AS REQUIRED UNDER THE FAIR CREDIT REPORTING ACT(S)**

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be requested for the preparation of a report whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted or who may have knowledge of any such items of information. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request to be informed as to whether or not such consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. You may receive a copy of this report by contacting such agency.

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**Important Notice**

**For residents of Arkansas, Louisiana, Rhode Island and 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.

**For residents of 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.

**For residents of the 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.

**For residents of 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.

**For residents of Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

**For residents of Maine, Tennessee, Virginia and 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 include imprisonment, fines and denial of insurance benefits.

**For residents of Maryland:**

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

**For residents of New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**For residents of 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.

**The following statement does not apply to an application for life insurance in New York:**

**For residents of New York:** 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.

**For residents of Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**For residents of 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.

**For residents of 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.