



# Group Accidental Death & Dismemberment (AD&D) Insurance

Additional coverage for you and your family

**Administered by:**

SERVING PILOTS SINCE 1951



# No one plans to have a serious accident, so when one happens the financial consequences can be devastating.

Accidental Death & Dismemberment (AD&D) provides a lump sum benefit that can help you or your family deal with expenses and financial obligations that arise in the event of a covered disabling accident or unintentional death.

## How can AD&D insurance help?

As a member of the Aviation Health Association (AHA), you can help safeguard your assets with broad accident coverage that pays in addition to other insurance you might already have. You're covered 24 hours a day, worldwide – at home, at work, on vacation, for practically every activity.

Think about how a disabling accident or death resulting in a covered accident could impact your personal financial goals.

### Here are some items consider:



**Your Family:** Evaluate your family's needs and current finances: savings, debt/medical bills, emergency cushion.



**Your Household:** You may need to replace a portion of your income to maintain your family's standard of living.



**Your Final Expenses:** Peace of mind that you've protected your family against the burden of final expenses.

## Who is eligible for coverage?



**You**

Members who are under age 60 and actively at work may enroll for up to \$500,000 of guaranteed coverage, in units of \$50,000.



**Your Family**

Your spouse and dependent children (under 19 years of age, or 25 if dependent student) are also guaranteed coverage, if elected.

Your spouse's benefit amount will be 40% of your benefit amount or 50% of your benefit amount if you have no dependent children.

Each of your children's benefit amount will be 10% of your benefit amount or 15% of your benefit amount if you have no eligible spouse.

## What is covered?

Loss of	% of Full Amount
Life	100%
Both hands, both feet or sight of both eyes	100%
One hand and one foot	100%
Paralysis of three limbs	75%
Hemiplegia	50%
Loss of speech	50%
Thumb and index finger of same hand	25%

Loss of	% of Full Amount
Speech and hearing in both ears	100%
One hand or one foot and sight of one eye	100%
Quadriplegia	100%
Paraplegia	50%
One hand or one foot or sight of one eye	50%
Hearing in both ears	50%
Paralysis of one limb	25%

Unless otherwise indicated, only one full amount for all losses and benefits will be paid while the group policy is in effect. For example, if you have a loss for which the insurer paid "50% of the Full Amount", the insurer will pay no more than "50% of the Full Amount" for the next loss.

## Pays additional accident-related benefits

Benefit:	Additional payment:
<b>Safe Driver</b>	+ 10% up to \$10,000 with seatbelt use only or an additional 15% up to \$13,000 for seatbelt and airbag use during a covered fatal accident.
<b>Coma</b>	+ 1% of full amount of AD&D benefit per month for up to 11 months; balance of full amount payable after 12 months.
<b>Education</b>	+ 3% up to \$5,000/year for 4 years for your children to continue their education.
<b>Child Care</b>	+ 3% up to \$3,000/year for up to 4 years.
<b>Elder Care</b>	+ 5% up to \$5,000 for elderly relative dependent on you for support and maintenance.
<b>Training</b>	+ 3% to \$3,000 for your spouse, if enrolled in a professional or trade training program.
<b>Common Disaster</b>	+ Increases your insured spouse's benefit up to 100% of your benefit if you and your spouse die within one year as a result of the same covered accident, or separate accidents occurring within a 24-hour period.
<b>Transportation</b>	+ 2% up to \$2,000 if death is due to a covered accident that occurs at least 75 miles from your primary residence.
<b>Common Carrier</b>	+ 100% up to \$100,000 if loss occurs while traveling as a fare-paying passenger of boarding or debarking a licensed common carrier.
<b>Burn Disfigurement</b>	+ 10% up to \$30,000 if you suffer disfigurement due to burns covering at least 5% of your body.
<b>Rehabilitation</b>	+ 2% up to \$5,000 for rehabilitation services received due to a covered loss.
<b>Total &amp; Permanent Disability</b>	+ 5% up to \$10,000 if you are totally and permanently disabled, as defined in the certificate, due to a covered accident.
<b>Exposure and Disappearance</b>	+ Pays amount of benefit otherwise payable for the loss.

## How much does it cost?

The monthly cost varies depending on the benefit and coverage option you select – but group coverage is typically lower than an individual policy. Use the table below to calculate the monthly premium.

<b>Monthly Rates for Accidental Death &amp; Dismemberment Insurance</b>		
<i>Rates shown are guaranteed until October 31, 2022</i>		
<b>Amount</b>	<b>Member Only</b>	<b>Member + Family</b>
<b>\$500,000</b>	\$25.00	\$32.50
<b>\$450,000</b>	\$22.50	\$29.25
<b>\$400,000</b>	\$20.00	\$26.00
<b>\$350,000</b>	\$17.50	\$22.75
<b>\$300,000</b>	\$15.00	\$19.50
<b>\$250,000</b>	\$12.50	\$16.25
<b>\$200,000</b>	\$10.00	\$13.00
<b>\$150,000</b>	\$7.50	\$9.75
<b>\$100,000</b>	\$5.00	\$6.50
<b>\$50,000</b>	\$2.50	\$3.25

When the member reaches age 70, benefits will be reduced to 50% of the benefit amount selected. Coverage terminates when the members reaches age 75.

## Guaranteed Acceptance

As an AHA Member under age 60, you're guaranteed this coverage. No health questions asked. No physical exam is required.

Coverage will be effective on the first of the month following receipt of your enrollment form and first premium payment.

## Additional Plan Information

### Termination

Your insurance stops on the earliest of the following dates: the last day of the month during which you are no longer eligible for insurance under the group policy, the date the group policy stops, the end of the period for which you paid premiums if you do not make the next required premium contribution when due, the premium due date on or after your 75<sup>th</sup> birthday.

Family coverage terminates when the member's coverage ends, you stop paying premiums or they are no longer eligible due to age, dependency or marital status – whichever occurs first.

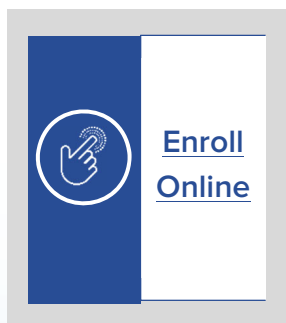
### Exclusions

Benefits are not payable for loss directly or indirectly caused by any of the following:

- An accident occurring before the Effective Date of the Group Policy
- Suicide or intentionally self-inflicted injury, while sane or insane
- Physical or mental illness
- Bacterial infection or bacterial poisoning. **Exception:** Infection from a cut or wound caused by an accident
- Any armed conflict, whether declared as war or not, involving any country or government
- An accident which occurs while in the military service for any country or government
- An accident which occurs when you commit or attempt to commit a crime
- Flight in, boarding or alighting from an aircraft or any craft designed to fly above the earth's surface being used for crop dusting, spraying or seeding, giving or receiving flying instruction, firefighting, sky writing, sky diving or hang-gliding, racing, endurance tests, stunt or acrobatic flying, or parachuting or skydiving, by any operation that requires a special permit from the FAA, by or for any military authority, except aircraft used by the AMC, or designed for flight above and beyond the earth's atmosphere
- Use of any drug, narcotic or hallucinogenic agent, unless prescribed by a doctor or taken as directed by a doctor or the manufacturer
- Your intoxication. Intoxication means your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.

## How do I enroll?

Enrolling is easy... no medical exams required! Complete the attached enrollment form and return it to the plan administrator:



For questions and coverage details, please contact the plan administrator:



Call **(800) 241-6103** or email [pilot@harveywatt.com](mailto:pilot@harveywatt.com)

PO Box 20787, Atlanta, GA 30320

[www.harveywatt.com](http://www.harveywatt.com)

Visit: <http://harveywatt.co/harveywatt/accidental-death-and-dismemberment>

Group AD&D Insurance is underwritten by ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies. This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of coverage. All coverage is subject to the terms of the group policy and may not be available in all states. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. Policy Form HP010GP.



# Accidental Death & Dismemberment Insurance Enrollment

The member should use this form to enroll for **Accidental Death & Dismemberment Insurance**. Please return this form by mail to **Harvey W. Watt & Co., P.O. Box 20787, Atlanta, GA 30320** or by email to [pilot@harveywatt.com](mailto:pilot@harveywatt.com) or by fax to **(404) 761-8326**.

**Questions?** Contact the plan administrator by phone **(800) 241-6103** or email [pilot@harveywatt.com](mailto:pilot@harveywatt.com).

AVIATION HEALTH ASSOCIATION

Group Policy No. 65009-9-3

## 1. TELL US ABOUT YOURSELF

Your Name (Last, First, M.I.)				<input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth (MM/DD/YYYY)	Place of Birth		Social Security Number		
Address		City	State	Zip	
Home/Cell Phone #	Work Phone #	E-mail Address			

**AMOUNT OF COVERAGE:**       \$100,000     \$200,000     Other \_\_\_\_\_ (*\$50,000 to \$500,000, in \$50,000 increments*)

**DEPENDENT AD&D INSURANCE:**     Spouse Only (*Amount equal to 50% of member's coverage*)

Spouse & Child(ren) (*Spouse amount equal to 40% of member's coverage; child(ren) equal to 10%*)

Child(ren) Only (*Amount equal to 15% of member's coverage*)

## 2. BENEFICIARY INFORMATION

Include Name, Address, Date of Birth, and Social Security Number for each beneficiary you list below. List the percent each will receive. The total must equal 100 percent. Beneficiary for dependent family coverage (if elected) will be the insured under the certificate to which the dependent family coverage is attached. Attach additional sheets if necessary.

Name (Last, First, M.I.)					
Date of Birth (MM/DD/YYYY)	Social Security Number		Relationship		Percent
Address		City	State	Zip	Home/Cell Phone #

Name (Last, First, M.I.)					
Date of Birth (MM/DD/YYYY)	Social Security Number		Relationship		Percent
Address		City	State	Zip	Home/Cell Phone #

## 3. 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 Insurance Company.

**Include a check for your first annual premium unless you prefer the monthly bank draft option which requires a minimum monthly premium of \$10.00 and a completed Authorization for Premium Payments form (included).**

**Any person who, knowingly 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, and may subject such person to criminal and civil penalties, and denial of insurance benefits.**

<b>Your Signature</b>	<b>Date</b>
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# Attach Voided Check

## AUTHORIZATION FOR PREMIUM PAYMENTS

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

Complete and sign the Membership Premium Payment Authorization form.

**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.

DEPOSITORY (BANK) NAME \_\_\_\_\_

ROUTING # \_\_\_\_\_ 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 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 account has been charged, I have the right to have the amount of the erroneous debit immediately credited to my account by DEPOSITORY, provide 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 \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_