Plan Highlights:

- Your coverage will go into effect on the first day of the month following approval of your application by the insurer, provided you pay the required premium.
- Dependent child coverage available, insuring all eligible children for $10,000 coverage at a monthly cost of $2.00. Eligible child is your child age 15 days to 21 years who is wholly dependent on you for support, or to age 25 if a full-time student. Just check the box on the application to elect child coverage (member or spouse can elect child coverage, but not both).
- At age 65, member coverage will reduce to the lesser of 50% or $50,000; at age 70 that amount reduces by 50%, and that amount further reduces by 50% at age 80. Spouse coverage will reduce to the lesser of $25,000 or 25% at age 70; spouse coverage terminates at age 75. Coverage will otherwise remain in effect as long as premiums are paid when due and the group policy remains in force.
- Rates will increase per the rate chart as you enter a new age bracket. There is no cancellation for ill health; once your coverage takes effect, your coverage cannot be cancelled due to a change in your health.
- Benefits are paid for death occurring at any time, any place, for any cause, except suicide in the first two years of your coverage or increase in coverage.
- If you later become ineligible for coverage, conversion to an individual whole life policy, without proof of good health, is allowed.
- 30-Day free look – once you receive your certificate, review your plan to discuss 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 of premiums paid, provided no claims have been submitted or paid.

Here is your Monthly Cost												
	Pilot Monthly Cost for $150,000		Pilot Monthly Cost for $100,000		Pilot Monthly Cost for $50,000		Spouse Monthly Cost $150,000		Spouse Monthly Cost $100,000		Spouse Monthly Cost $50,000	
Attained Age	Non-Tobacco	Tobacco	Non-Tabacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
Under 30	$4.20	$8.40	$2.80	$5.60	$1.40	$2.80	$5.50	$8.40	$3.70	$5.60	$1.85	$2.80
30-34	$4.95	$8.40	$3.30	$5.60	$1.65	$2.80	$5.50	$8.40	$3.70	$5.60	$1.85	$2.80
35-39	$6.20	$11.10	$4.20	$7.40	$2.10	$3.70	$7.05	$11.10	$4.70	$7.40	$2.35	$3.70
40-44	$9.75	$18.15	$6.50	$12.10	$3.25	$6.05	$11.10	$18.15	$7.40	$12.10	$3.70	$6.05
45-49	$13.95	$30.75	$9.30	$20.50	$4.65	$10.25	$16.80	$30.75	$11.20	$20.50	$5.60	$10.25
50-54	$25.05	$50.25	$16.70	$33.50	$8.35	$16.75	$36.75	$50.25	$20.50	$33.50	$10.25	$16.75
55-59	$39.00	$78.15	$26.00	$52.10	$13.00	$26.05	$39.00	$78.15	$26.00	$52.10	$13.00	$26.05
60-64	$52.95	$94.80	$35.30	$63.20	$17.65	$31.60	$52.95	$94.80	$35.30	$63.20	$17.65	$31.60

Rates shown are guaranteed until April 30,2021. Rates increase as you enter a new age bracket. Costs shown in the shaded boxes above indicate rates for initial eligibility ages; additional rates are displayed to reflect current rates for all age brackets. (Contact plan administrator for costs after age 64.)

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. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. Policy Form LP00GP. The group policy is sitused in the state of Georgia and is governed by its laws. The product is not available in all states.

Mail, fax, or email your completed application to Harvey Watt & Co to apply during this limited time opportunity.

Administered by:
Harvey Watt & Co,
PO Box 20787
Atlanta, GA 30320
1-800-241-6103
www.harveywatt.com
pilot@harveywatt.com

Group Term Life Insurance Underwritten by:
ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya® family of companies

2 Ways to Apply

Apply by enclosed application (1) or online (2)

1. Print and complete the application. Be sure to sign and date the application. Keep a copy of the application for your records. Complete payment authorization form.

- Write "VOID" across a blank check and attach it to the form.
- Complete, sign and date the form.

Mail your completed application, bank draft authorization form, voided check and this completed form to:

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

Or fax all of the above to: **(404)-761-8326**

Or scan and email all of the above to **pilot@harveywatt.com**

2. Complete the online application:

Pilot: http://harveywatt.co/group-term-life/simplified-issue-application-member
Spouse: http://harveywatt.co/group-term-life/simplified-issue-application-spouse

Please contact us at **(800) 241-6103** or **pilot@harveywatt.com** if you have questions.

If additional information or underwriting is required, you will be notified by Harvey W. Watt & Co. To facilitate that, please provide the following information:

Name: _____ Phone:_____

Address: _____

City: _____ State: _____ Zip Code:_____

Email Address: _____

Want to learn more about our additional life insurance and disability options?

Mark below to receive additional information:

☐ Life ☐ Disability

Note: The results of this confidential Simplified Issue Application will not adversely affect your ability to renew a first class medical certificate. A possible declination only means you have not met the initial eligibility requirements for group insurance. You are not required to report that as it is not a formal and final denial for life or health insurance as stated on the FAA Medical 8500-8 application form.

Group Term Life Simplified Issue Application

Exclusive offer for Aviation Health Association Members. Please use this form to apply for this **Exclusive Simplified Issue** coverage during the specified enrollment period. 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. Or scan and email completed information to pilot@harveywatt.com.***

AVIATION HEALTH ASSOCIATION **Policy No. 65009-9-2**

1. TELL US ABOUT YOURSELF

Member's Information ***(complete this section only if applying for Member coverage on this application)*:**

Name (Last, First, M.I.)			❑Male ❑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	

Spouse's Information ***(complete this section only if applying for Spouse coverage on this application)*:**

Name (Last, First, M.I.)	Name of Member		❑Male ❑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	

Dependent Child(ren)'s Information ***(complete this section only if applying for Dependent Child(ren) on this application)*:**

Number of eligiblechildren:_____ Include Name, Date of Birth (DOB), and Social Security Number (SSN) of each child below

Name_____ DOB_____ SSN_____
Name_____ DOB_____ SSN_____
Name_____ DOB_____ SSN_____
Name_____ DOB_____ SSN_____

Address	City	State	Zip	Home/Cell Phone #

		Member	Spouse
a)	Have you used tobacco or nicotine products of any kind in the last 12 months? …….....	❑Yes ❑No	❑Yes ❑No
b)	Are you currently working less than 30 hours per week at your regular occupation and place of business?.....	❑Yes ❑No	❑Yes ❑No
c)	Will any of the life insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force? …….....	❑Yes ❑No	❑Yes ❑No

If yes, please explain:_____

2. SELECT YOUR COVERAGE

Member Amount

❑$150,000 (Under age 50)
❑$100,000 (Under age 55)
❑$50,000 (Under age 60)

Spouse Amount

❑$150,000 (Under age 50)
❑$100,000 (Under age 55)
❑$50,000 (Under age 60)

Please select if you wish to include additional options with your coverage:

❑$10,000 Dependent Child(ren) Coverage*

* If both Member and Spouse are applying, only one can apply for Dependent Child(ren) Coverage.

PLEASE COMPLETE AND SIGN END OF APPLICATION

3. PROVIDE YOUR HEALTH INFORMATION

Member: Height_____ft. _____in. Weight_____lbs. Spouse: Height_____ft. _____in. Weight_____lbs.

	Member	Spouse
1.) Have you ever been treated for or been diagnosed by a member of the medical profession as having a positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)? ……..	❑Yes ❑No	❑Yes ❑No
2.) Have you ever been diagnosed or treated by a member of the medical profession for: a. stroke, cancer/tumor, diabetes, or a mental condition requiring hospitalization? …….....	❑ Yes ❑ No	❑ Yes ❑ No
b. disease or disorder of the heart, lungs (excluding asthma), liver or kidneys? …….	❑ Yes ❑ No	❑ Yes ❑ No
c. disease or disorder of the blood, or neurological, immune, digestive or intestinal system? ..…….	❑ Yes ❑ No	❑ Yes ❑ No
3.) Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a member of the medical profession to discontinue or reduce the use of such substances? ..……	❑ Yes ❑ No	❑ Yes ❑ No
4.) In the past 5 years, have you been hospitalized or admitted to a medical care facility? …….	❑ Yes ❑ No	❑ Yes ❑ No
5.) In the past 24 months, have medical tests, procedures or treatment been recommended by a member of the medical profession that have not yet been performed? ……..	❑ Yes ❑ No	❑ Yes ❑ No

For every "Yes" answer to questions in the previous section, give details below. Please attach a separate sheet if additional space is needed.

Q#	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Health Practitioner Name, Full Address and Phone
	❑ Member ❑ Spouse				
	❑ Member ❑ Spouse				
	❑ Member ❑ Spouse				

4. DESIGNATE YOUR BENEFICIARY

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 child(ren) coverage (if elected) will be the insured under the certificate to which the dependent child(ren) coverage is attached. Attach additional sheets if necessary.

Beneficiary for Member Coverage ***(complete this section only if applying for Member coverage on this application)***

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 #

Beneficiary for Spouse Coverage ***(complete this section only if applying for Spouse coverage on this application)***

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 #

PLEASE COMPLETE AND SIGN END OF APPLICATION

5. READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW

- To the best of my knowledge and belief, the information I have 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.

Authorization and Acknowledgment – Please read and sign below. For underwriting and claim purposes, I give my permission to: Any physician, or any other member of the medical profession, hospital, clinic, other medical or medically related facility, pharmacy, pharmacy benefit manager, insurance or reinsurance company, MIB, 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, pharmacy prescriptions or prescription records 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, or its reinsurers, to make a brief report of personal health information to MIB about these same persons. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about these 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. This form will be valid for 24 months from the date shown below. I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

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.

Member's Signature (always required)	Date	Spouse's Signature (if applying)	Date

ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York
Consumer Privacy Notice and Insurance Information Practices Notice

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures

For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices

Collecting Information

Your application or claim form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from MIB, Inc., formerly known as the Medical Information Bureau. See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with us. The information may be kept by the consumer reporting agency; it may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc.

We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB's phone number is 866-692-6901 (TTY 866 346-3642). We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

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_____