

ALPA - Member Insurance Dept.  
535 Herndon Parkway  
Herndon, VA 20170-5226

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| **Please print in ink or type all answers.** | | | | | |
| Policyholder Name  **Air Line Pilots Association, International Pilot Welfare Benefit Plan** | | Group Policy No.  **397109/386506** | | | |
| MEMBER INFORMATION Air Line Pilots Association International Pilot Welfare Benefit Plans Loss of License Annual Step Up Application | | | | | |
| Member Name (Last, First, Middle Initial) | | | Sex  M  F | Date of Birth     /   / | |
| Street Address | | | Home Phone  (     )     - | | |
| City        State       ZIP | | | Work Phone  (     )     - | | |
| Member’s Social Security Number | Member’s Place of Birth (City, State) | | Cell Phone  (     )     - | | |
| E-Mail Address | | | | | |
| **OCCUPATION INFORMATION** | | | | | |
| ALPA Membership #       Airline       Council # | | | | | |
| a. Are you now in one of the following ALPA membership classes?  Yes  No If “Yes”, please check applicable box.  Apprentice Member  Active Member  Executive Member  Reactivated Member   Inactive Participant – Carrier       FAR Part# | | | | | |
| b. Do you hold a Valid Airman Certificate?  Yes  No If “Yes”, Class       If “NO” Complete Medical History for all amounts | | | | | |
| c. What is your occupation?       Main Duties | | | | | |
| d. Have you flown in the past six months?  Yes  No If “No”, indicate date last flown and state reason. Date:   /  /  Reason: | | | | | |
| e. Gross Annual Income from flying as a commercial pilot: $ | | | | | |
| f. Date of last FAA physical exam?    /  /     Name and address of examining physician: | | | | | |
| g. Name and address of regular attending physician: | | | | | |
| h. Has your FAA Airman Medical Certificate ever been denied, suspended or revoked?  Yes  No If “Yes,” please explain. | | | | | |
| i. Have you ever been issued or currently have a Special Issuance or SODA by the FAA?  Yes  No If “YES” Complete Medical History for all amounts  If “Yes,” please explain. | | | | | |
| j. Are you actively at work or physically/psychologically available for work, in the capacity for which you hold an FAA license?  Yes  No If “No”, give details. | | | | | |
| **LOSS OF LICENSE COVERAGE**  **LOSS OF LICENSE COVERAGE** | | | | | |
| This application is:  For an Annual Step Up (to the next benefit level)  If “(b)”, Please state your current ALPA Sum Insured: $  **Lump Sum -** Select desired amount of Lump Sum Loss of License (LOL) coverage\*:  $25,000  $50,000  $75,000  $100,000  $125,000  $150,000  **Monthly -** Select desired amount of Monthly Loss of License (LOL) coverage\*:  $600  $1,200  $1,800  $2,400  $3,000  $3,600  $4,200  $4,800  \*Note – you are not eligible for an insurance amount greater than $1,800.00 if your gross annual airline income is less than $50,000.  **Do you elect the Monthly LOL “Plus” plan?**  **Yes**  **No** (Your monthly insurance amount is reduced by 50% during the “Plus” or extended benefit period.)  **Annual Step Up:** If you are currently enrolled in ALPA’s LOL plan and you wish to take advantage of the Annual Step-Up (to the next benefit level), please answer the following **Conditional Issue Question** to increase coverage: In the last 6 months have you received medical care, including treatment, consultation, services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: Cancer, Heart Disease; any condition related to AIDS or AIDS Related Complex; or any other Chronic Condition?  Yes  No If “**Yes**” to the Conditional Issue Question, or a Step Up of more than one benefit level, complete Medical History below for additional coverage. | | | | | |
| **SIGNATURE**: **Please review and sign**   * You must be legally working in the United States, or working outside of the United States for a United States based employer in a country or region approved by us. * I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) * Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. * Your coverage will not be effective until approved by a Guardian underwriter. * I hereby apply for the benefit(s) that I have chosen above. * I understand that I must meet eligibility requirements for all coverage’s that I have chosen above. * I understand that coverage will become effective on the first day of the month coincident with or immediately following the date my application for coverage is approved; provided I am eligible, actively at work on this date and the initial contribution is paid within 31 days after the date I am billed. * I acknowledge and consent to receiving electronic copies of Guardian insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing Guardian thirty (30) day prior written notice. * I attest that the information provided above is true and correct to the best of my knowledge. * **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.** * **The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.** | | | | | |
| **Applicant’s Signature: X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Please sign and date in ink) | | | | | |
| **MEDICAL HISTORY**  (Please initial any changes you make on this form.) **Complete if you answered ‘YES’ to the Conditional Issue Question or if instructed to when completing page 1 of this application.** | | | | | |
| You are required to state your medical history including disabilities, illnesses and accidents, with dates of any such occurrences, by studying the questions which follow and entering the appropriate details in the spaces provided. It is in your interest to declare all of your medical history and not to omit the details because you think, or because your advisors (professional or otherwise) tell you, that it is irrelevant or immaterial. You should declare all conditions even though you have been declared medically fit. | | | | | |
| 1) State your height       Present weight       Weight 12 months ago | | | | | |
| 2) Do you currently smoke? | | | | | Yes  No |
| **Please answer the following questions. For any “Yes” answers, please provide dates and details at the end of this section.** | | | | | |
| 3) Are you receiving any disability or workers’ compensation benefits or are you eligible for waiver of premium for life or health insurance? | | | | | Yes  No |
| 4) Are you now ill, receiving or contemplating any medical attention or surgical treatment? | | | | | Yes  No |
| 5) Are you now taking any prescribed medications? | | | | | Yes  No |
| 6) Have you consulted any medical practitioner during the last 10 years other than for the purpose of renewing your license? | | | | | Yes  No |
| 7) In the last 10 years have you suffered from any condition which necessitated hospital attendance or admission or diagnosis or treatment? | | | | | Yes  No |
| 8) In the last 10 years, have you been investigated, diagnosed or treated for: | | | | | |
| a) any psychiatric or nervous disorder (including migraine), epilepsy or any other form of convulsion or any loss of consciousness? | | | | | Yes  No |
| b) any heart, blood pressure, stroke, circulatory or a respiratory disorder? | | | | | Yes  No |
| c) any condition involving eyes, ears, nose or throat, alimentary tract or genitourinary system? | | | | | Yes  No |
| d) any disorder of the blood or lymphatic system? | | | | | Yes  No |
| e) any musculoskeletal condition? | | | | | Yes  No |
| f) any disorder of the skin? | | | | | Yes  No |
| g) diabetes or albumin, blood or sugar in urine? | | | | | Yes  No |
| h) neurological disorder? | | | | | Yes  No |
| i) alcohol or drug abuse? | | | | | Yes  No |
| j) liver or kidney disorder? | | | | | Yes  No |
| k) cancer or tumor? | | | | | Yes  No |
| l) HIV, AIDS or AIDS Related Complex? | | | | | Yes  No |
| 9) Are you aware of any deterioration in your health including hearing, eyesight and blood pressure? | | | | | Yes  No |
| 10) Have you ever been required to take additional tests at or after a medical examination, been referred for specialist investigation, had the issue or renewal of your medical certificate deferred, had to return for examination at less than the normal interval of time, or been ordered to take drugs or follow any special diet or treatment? | | | | | Yes  No |
| 11) Give the date of your last electrocardiogram taken as required by the license issuing authority (if applicable)    /   /      Were you advised of any abnormality in, or revealed by, the examination? | | | | | Yes  No |
| 12) Have you had any other medical condition, illness or injury which has been diagnosed and for which you have had treatment (including  accidents involving injury)? | | | | | Yes  No |

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| **If any answer to items 3-12 is “Yes”, give dates, names and full details here.**  (If you need more space, use a signed and dated separate sheet. Please avoid the use of terms such as “etc.”, “various” or miscellaneous.”) | | | |
| Ques. No. | Date | Names and addresses of physicians and hospitals (if any) | Include all information as to nature of illness or injury, symptoms, number of attacks, duration, treatment and results |
|  | /  / |  |  |
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**I request the group coverage indicated.** To the best of my knowledge and belief: (a) I am eligible for such coverage, and (b) the statements I have made are true and complete. I understand that Guardian reserves the right to require additional information and, if necessary, an examination by a physician. I ask Guardian to rely on all statements made on this form, and any supplements to it, while considering this request.

**I understand** that coverage will become effective on the first day of the month coincident with or immediately following the date my application for coverage is approved; provided I am actively at work on this date and the initial contribution is paid within 31 days after the date I am billed. If I am not actively at work on the scheduled effective date, coverage will begin on the first day of the month coincident with or immediately following the date I have been actively at work for 10 consecutive working days, within three months following the original scheduled effective date. For the Loss of License, I understand that benefits will not be payable for losses occurring during the first 24 months of coverage that are due to a disease or condition for which I have received medical care, treatment, or advice during the 12 months prior to my effective date of coverage unless disclosed on my application and accepted by underwriting. I understand that coverage may be invalidated if it is determined that I am not eligible or have not answered any of the above questions truthfully and completely.

**I authorize** any physician, medical practitioner, hospital, clinic, other health facility, MIB, Inc., insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding my medical history, mental or physical condition, or treatment.

**I agree** that this authorization will be valid for two and one half years from the date shown below, and I have read, understand, and accept the statements and provisions below.

**MEDICAL REQUIREMENTS:** Some, not all, applicants may need a physical exam, blood test or EKG, depending on their age and the benefit level requested.

**Applicant’s Signature: X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please sign and date in ink)

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| **ENDORSEMENT (GUARDIAN USE ONLY)** | | | |
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| **Member**:  Approved  Declined Step Up Monthly Loss of License Insurance Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rider:  Yes  No  Approved  Declined Step Up Lump Sum Loss of License Insurance Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rider:  Yes  No | | | |
| Effective Date: | By: | Date: | SecrtarySecretary |

I hereby represent that the statements and answers to the questions on this document are, to the best of my knowledge and belief, full, complete and true. I understand that they will form the basis of any coverage under the Group Plan for which Evidence of Insurability is required.

Also, it is mutually understood and agreed that (1) the Company reserves the right to request, at its expense, that I be examined by an accredited medical examiner selected by the Company; (2) no Group Insurance will be binding or in force until satisfactory evidence of insurability is submitted and approved by the Insurance Company at the Home Office as shown in the Endorsement; and (a) I am actively at work as defined in the Group Plan on the date my Group Insurance becomes effective; otherwise, (b) I will become insured on the first of the month coincident with or immediately following the date I have been actively at work for 10 consecutive working days, within three months following the original scheduled effective date; (3) no person, except the President, a Vice-President or a Secretary of the Company, has authority to: (a) determine whether any contract(s) of insurance shall be issued on the basis of the application; (b) waive or modify any of the provisions of the application or any of the Company's requirements; (c) bind the Company by any statement or promise pertaining to any insurance contract(s) issued or to be issued on the basis of the application; or (d) accept any information or representation not contained in the written application; (4) the policyholder is hereby named the Proposed Insured's representative for the purpose of receiving premiums and remitting them to the Company.

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.

**I understand** The Guardian Life Insurance Company of America will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. Guardian will not release any information obtained to any person or organization except to reinsurance companies, MIB, Inc., or other persons or organizations performing business or legal services in connection with my application, claim or as may be lawfully permitted or required, or as I may further authorize.

**I know** that I may request and receive a copy of this authorization.

**I agree** that a photocopy of this authorization will be as valid as the original.

**I acknowledge** receipt of Guardian’s notice regarding its insurance information practices, and medical records.

Read and Detach for your records

Thank you for choosing Guardian insurance. This notice is given to you at the time you apply for insurance to tell you about the kinds of information we may obtain in connection with your application. We will treat all personal information about you as confidential. You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please send your written request to Corporate Secretary, The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004-2616.

**MIB, Inc. Pre-notice:** MIB, Inc. is a nonprofit membership organization of life insurance companies. MIB, Inc. provides an information exchange for its members. On the request of any of its member companies to which you apply for insurance, or to which you make a claim for benefits, MIB, Inc. will supply the inquiring company with the information in its files.

Guardian or our reinsurers may make a brief report of objective findings about you to MIB, Inc. We will not report what action we have taken on your application.

If you so request of MIB, Inc., it will arrange to disclose the information it may have in your file. If you question the accuracy of the information in MIB, Inc.’s file, you may contact MIB, Inc. and seek to correct the information according to procedures set forth in the Federal Fair Credit Reporting Act. MIB, Inc.’s address is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866-692-6901 (TTY 866-346-3642).

**Medical Records:** We may request information from health care providers or others who have records of your medical history, mental or physical condition, or treatment. Only qualified members of Guardian’s staff will have access to your medical file to evaluate your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our request for information and any later disclosure of that information.

I hereby represent that the statements and answers to the questions on the attached form are, to the best of my knowledge and belief, full, complete and true. I understand that they shall form the basis upon which I may be included for insurance.

Also, it is mutually understood and agreed that (1) the Company reserves the right to request, at its expense, that I be examined by an accredited medical examiner selected by the Company; (2) no Group Insurance will be binding or in force until satisfactory evidence of insurability is submitted and approved by the Insurance Company at the Home Office as shown in the Endorsement; and (a) I am actively at work as defined in the Group Plan on the date my Group Insurance becomes effective; otherwise, (b) I will become insured on the first of the month coincident with or immediately following the date I have been actively at work for 10 consecutive working days,within three months following the original scheduled effective date; (3) no person, except the President, a Vice-President or a Secretary of the Company, has authority to: (a) determine whether any contract(s) of insurance shall be issued on the basis of the application; (b) waive or modify any of the provisions of the application or any of the Company's requirements; (c) bind the Company by any statement or promise pertaining to any insurance contract(s) issued or to be issued on the basis of the application; or (d) accept any information or representation not contained in the written application; (4) the policyholder is hereby named the Proposed Insured's representative for the purpose of receiving premiums and remitting them to the Company.

**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.

**I authorize** any physician, medical practitioner, hospital, clinic, other health facility, MIB, Inc., insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding my medical history, mental or physical condition, or treatment.

**I understand** The Guardian Life Insurance Company of America will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. Guardian will not release any information obtained to any person or organization except to reinsurance companies, MIB, Inc., or other persons or organizations performing business or legal services in connection with my application, claim or as may be lawfully permitted or required, or as I may further authorize.

**I know** that I may request and receive a copy of this authorization.

**I agree** that a photocopy of this authorization shall be as valid as the original.

**I acknowledge** receipt of Guardian’s notice regarding its insurance information practices, and medical records.

**I agree** that this authorization shall be valid for two and one half years from the date signed.

Please retain a photocopy for your records and submit this form to ALPA.

GG-016522

To be completed by ALPA: PKG     /    /

EML     /    /

**Fraud Warning Statements**

**The laws of several states require the following statements to appear on the enrollment form. These statements apply only to residents of the noted States.**

**Arizona:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**California:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**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.

**Connecticut, Iowa, Kansas, Nebraska, Oregon, and Vermont:** Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

**Delaware, Indiana and Oklahoma:** WARNING: Any person who knowingly, and with the 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.

**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.

**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.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

**Louisiana and Texas:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

**New Mexico**: Any person who knowingly presents a false or fraudulent claim for payment or 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 or denial of insurance benefits.

**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 may include imprisonment, fines or a denial of insurance benefit.

**Maryland and Rhode Island:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20.

**Ohio:** Any person who with intent to defraud or knowing that he/she 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.

**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.