



P.O. Box 14536
Des Moines, IA 50306

Dear AOPA Member,

This is your official notice concerning the high-benefit, relatively low-cost AOPA Group Accidental Death & Dismemberment (AD&D) Insurance Plan.

Act now for up to \$300,000.00 in benefits, payable for a covered fatal accident. Under this plan you can also cover your family. With the AOPA AD&D Insurance Plan, you're covered anywhere, 24/7.

As an AOPA member under age 75, you are guaranteed acceptance into the plan with group rates, which are generally unavailable to the general public.

To enroll:

- Fill out the Enrollment Form enclosed. Indicate family coverage, if desired.
- Mail the form back in the enclosed reply envelope.
- **No need to send money now.** You will be billed when coverage is approved by the insurer.
- If you are an AOPA Member under age 75, you can request coverage at the current rates by returning your Enrollment Form today.

Act now. Please review the product brochure for more information about the coverage.

Group AD&D Insurance underwritten by Metropolitan Life Insurance Company New York, NY 10166.

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. If no coverage is selected on the enclosed application, you will be issued the lowest benefit amount you are eligible for.

Sincerely,

Stephen Miller, Senior Vice President
Association Member Benefits Advisors, LLC
AOPA Insurance Administrator
License #1936106

P.S. This urgent message is your OFFICIAL NOTICE that your response is requested. Fill out the form and mail it back today.

DON'T SEND MONEY NOW!



5 Reasons Why AOPA Members Should Enroll in the AOPA Group Accidental Death & Dismemberment (AD&D) Insurance Plan

Accident coverage is becoming a more popular way to supplement other insurance coverage you already have. And AOPA Members are choosing the AOPA AD&D Plan for these important reasons:

1. With your AOPA AD&D Insurance Plan, you're covered anywhere, 24/7.

The bottom line is the AOPA AD&D Plan offers affordable and valuable benefits to you and your family — without worrying about whether you'll be covered if something were to happen while you're flying. There are some exclusions that would apply while you're flying. Refer to "Exclusion" section on next page.

2. It's Easy to Get – You're Guaranteed Acceptance

As an AOPA Member you're guaranteed coverage under age 75. No health questions asked. No physical exam is required. This makes it much easier to get than some life and health insurance plans.

3. Pays the Lump Sum Accidental Death Benefit

If you die from a covered accident, your loved ones can receive the benefit in one lump sum. No monthly or partial payments. Just one payment.

4. Family Coverage

Because accidents can happen to anyone, AOPA suggests you get maximum coverage for your loved ones. Your spouse and dependent children under age 25 are also guaranteed coverage. Your spouse's benefits are 50% of the benefit amount you choose and dependent child(ren)'s benefits are 10% of your benefit.

If you are unmarried, each dependent child's coverage will be 15% of your benefit. If you have no children, your spouse's benefits are 60% of your coverage.

Annual Rates per \$1,000

	Under age 70	Age 70 through 84
Under \$150,000	\$2.01 Member only \$3.39 Member+Family	\$4.03 Member only \$5.41 Member+Family
\$150,000-\$300,000	\$3.02 Member only \$4.40 Member+Family	\$6.04 Member only (\$150,000 only*) \$8.11 Member+Family (\$150,000 only*)

*Applies only to an Insured who had a \$300,000 at age 70 and reduced 50% to \$150,000

- Under age 70, member may enroll for up to \$300,000.
- 70-74, member may enroll for up to 50,000.

Under age 70 coverage reduces by 50% at Age 70, 75% at Age 85; for 70-74: Coverage reduces by: 50% at Age 85.

	Age 85+
Under \$150,000	\$8.06 Member only \$9.43 Member+Family

- At age 85, coverage reduces to 25% of the original amount.

If no coverage is selected on the enclosed application, you will be issued the lowest benefit amount you are eligible for.

ADDITIONAL Benefits Included

Seat Belt Benefit

If an insured person is involved in an automobile accident in which he/she was properly wearing a seatbelt, and dies within 365 days as a result of that accident, the beneficiary can receive an additional amount which is the lesser of \$25,000 or 10% of the Principal Sum payable. Please refer to the Certificate of Insurance for certain limitations and conditions on this benefit.

Common Disaster

If both the insured member and spouse die within one year of same or separate accidents that occurred within the same 24-hour period, in addition to the benefit payable for loss of life for each, the insured spouse benefit amount for loss of life will be increased to 100% of the member's Principal Sum if the member and spouse are survived by one or more eligible children and the combined member and spouse Principal Sums do not exceed \$300,000.

Air Bag Benefit

If the Seat Belt Benefit is payable, MetLife will pay an additional benefit if the insured person was positioned in a seat protected by properly functioning, original, factory-installed airbag system that inflates on impact when the accident occurred. The benefit amount is the lesser of the amount of the Principal Sum or \$15,000.

BENEFITS FOR ACCIDENTS

The Accidental Death & Dismemberment loss must occur within 365 days after the date of the accident and be a direct result of bodily injury sustained from that accident, independent of other causes.

Life.....	100% of Full Amount
Hand.....	50% of Full Amount
Foot.....	50% of Full Amount
Arm.....	75% of Full Amount
Leg.....	75% of Full Amount
Sight of One Eye.....	50% of Full Amount
Combination of a Hand, Foot, and/or Eye.....	100% of Full Amount
Thumb & Index Finger on the Same Hand.....	25% of Full Amount
Speech and Hearing.....	100% of Full Amount
Speech.....	50% of Full Amount
Hearing.....	25% of Full Amount
Paralysis of Both Arms and Both Legs.....	100% of Full Amount
Paralysis of Both Legs.....	75% of Full Amount
Paralysis of the Arm & Leg on Either Side of the Body.....	50% of Full Amount
Paralysis of One Arm or Leg.....	25% of Full Amount
Brain Damage.....	100% of Full Amount
Coma.....	1% monthly up to 60 months of Full Amount

NOTE: This is only a sample of the covered losses. See Certificate of Insurance for all benefits and conditions on coverage.

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.

MetLife stops providing a specific benefit to you on the date that benefit is no longer provided under the Group Policy.

EXCLUSIONS

MetLife does not pay benefits for loss directly or indirectly caused by any of the following:

- physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
- infection, other than infection occurring in an external accidental wound;
- suicide or attempted suicide; (In Missouri, such exclusion only applies while the person is sane);
- intentionally self-inflicted injury;
- service in the armed forces of any country or international authority. However, service in reserve forces does not constitute service in the armed forces, unless in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. For purposes of this provision reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the national guard of any other country;
- any incident related to: 1) travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight; 2) parachuting or otherwise exiting from an aircraft while such aircraft is in flight except for self preservation; 3) travel in an aircraft or device used for testing or experimental purposes; by or for any military authority; or for travel or designed for travel beyond the earth's atmosphere;
- committing or attempting to commit a felony;
- the voluntary intake or use by any means of: 1) any drug, medication or sedative, unless it is: taken or used as prescribed by a Physician, or an "over the counter" drug, medication or sedative, taken as directed; 2) alcohol in combination with any drug, medication, or sedative; or 3) poison, gas, or fumes;
- war, whether declared or undeclared; or act of war, insurrection, rebellion, riot;
- driving a vehicle or operating another device while intoxicated as defined by the laws of the jurisdiction in which the vehicle or other device was being operated.

Do Not Delay!

IMPORTANT

Complete, date, and sign the Enrollment Form.
Check family coverage, if desired.

Don't send money now!

Licensed insurance agents are ready to answer any questions you have about this plan. We're eager to help you.

FREE LOOK RIGHT TO EXAMINE POLICY

If you change your mind within the first 30 days of your coverage, just tell us and we'll refund your money in full, provided no claims have been submitted or paid.

Administered by:



Association Member Benefits Advisors, LLC
P.O. Box 14536
Des Moines, IA 50306

QUESTIONS?

Call: 844.304.AOPA (2672)

E-Mail: aopa.service@getamba.com

Visit: aopainsurance.org/add

AR Insurance License #100114462
CA Insurance License #0196562
In CA d/b/a Association Member Benefits &
Insurance Agency

Group AD&D Insurance Underwritten by:



Metropolitan Life Insurance
Company New York, NY 10166

About This Plan Information

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.

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Policyholder Aircraft Owners and Pilots Association (AOPA)	Sponsoring/Participating Association (if different from Policyholder)	Group Customer # 229348
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YOUR ENROLLMENT INFORMATION (To be Completed by the Member)

Name (First, Middle, Last)	Social Security # - -	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, City, State, Zip Code)	Phone #	Date of Birth (MM/DD/YYYY)
Email Address	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change in Enrollment	Date of Membership (MM/DD/YYYY)

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below.

Accidental Death & Dismemberment (AD&D) Insurance

Voluntary AD&D
First select your option
 Member Only
 Member + Spouse/Civil Union Partner ¹ /Domestic Partner ² + Child(ren)
Then select your level of coverage
Member Under Age 70:
 \$50,000 (00B1 / 00B3) \$100,000 (00D1 / 00D3) \$150,000 (00F1 / 00F3)
 \$200,000 (00H1 / 00H3) \$250,000 (00K1 / 00K3) \$300,000 (00M1 / 00M3)
Member Age 70 to 74:
 \$25,000 (X251 / X253) \$50,000 (X501 / X503)

Dependent Information

If you are applying for coverage for your Spouse/Civil Union Partner/Domestic Partner and/or Child(ren), please provide the information requested below:

Name of your Spouse/Civil Union Partner/Domestic Partner (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Name(s) of your Child(ren) (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female

Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

¹ Civil Union Partners registered pursuant to the New Jersey Civil Union Act or to similar laws of other jurisdictions which provide substantially all the rights and benefits of marriage.
² Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner in whom you have an insurable interest. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to your insurable interest.

**GEF02-1
ADM**

(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana;

GEF02-1
ADM applies to residents of Connecticut, North Dakota;
GEF20-AOPA-VADD-UT applies to residents of Utah;
GEF20-AOPA-VADD-WA-2 applies to residents of Washington)

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, 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.

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 to the extent required by applicable law.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

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.

Maine, Tennessee 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 benefits.

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

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York (only applies to Accident and Health Insurance): 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.

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.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the 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 may have violated the state law.

Pennsylvania and all other states: 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.

GEF09-1

FW

(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana;

GEF09-1

FW applies to residents of Connecticut, North Dakota;

GEF20-AOPA-VADD-UT applies to residents of Utah;

GEF20-AOPA-VADD-WA-2 applies to residents of Washington)

BENEFICIARY DESIGNATION FOR MEMBER INSURANCE

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.

I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Member.

Check if you need more space for additional beneficiaries including contingent beneficiary information, attach a separate page. Include all beneficiary information, and sign/date the page. If you are adding contingent beneficiaries, please indicate which beneficiaries are to be considered contingent.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.				TOTAL: 100%

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
3. I have read the applicable Fraud Warning(s) provided in this enrollment form.



_____ Signature of Member	_____ Print Name	_____ Date Signed (MM/DD/YYYY)
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**GEF09-1
DEC**

(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana;

GEF09-1

DEC applies to residents of Connecticut, North Dakota;

GEF20-AOPA-VADD-UT applies to residents of Utah;

GEF20-AOPA-VADD-WA-2 applies to residents of Washington)



Delaware American Life Insurance Company
MetLife Legal Plans, Inc.
MetLife Legal Plans of Florida, Inc.
MetLife Health Plans, Inc.

Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance Company

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

SECTION 1: Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

SECTION 2: Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

SECTION 3: Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

SECTION 4: How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB, Inc. ("MIB"). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of 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. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at www.mib.com.

SECTION 5: Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

SECTION 6: Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

SECTION 7: HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act ("HIPAA") protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

SECTION 8: Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. We will provide it as long as it is reasonably locatable and retrievable. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

SECTION 9: Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. A detailed notice shall be furnished to you upon request. When you write, include your name, address, and policy or account number.

Send privacy questions to: MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.