



TheStandard®

Voluntary Short Term Disability Insurance

FOR EMPLOYEES OF EMPLOYERS PARTICIPATING IN THE
WASHINGTON COUNTIES INSURANCE FUND

Answers to your questions about coverage from Standard Insurance Company



STANDARD INSURANCE COMPANY

About This Booklet

This booklet is designed to answer some common questions about the group Voluntary Short Term Disability (STD) insurance coverage being offered by Washington Counties Insurance Fund to participating *employers* with eligible employees. It is not intended to provide a detailed description of the coverage.

If you become insured, you will receive a web link to a group insurance certificate containing a detailed description of the insurance coverage including the definitions, exclusions, limitations and terminating events. The controlling provisions will be in the *group policy* issued by Standard Insurance Company. Neither the certificate nor the information presented in this booklet modifies the *group policy* or the insurance coverage in any way. If you have additional questions, please contact your human resources representative.

Please note that defined terms and provisions from the *group policy* are italicized in this booklet.



Voluntary Short Term Disability Insurance Features

Chances are you already purchase home, auto and life insurance to protect yourself against the threat of loss. And you probably have health insurance to guard against costly medical bills.

So, what steps have you taken to help shield yourself, your lifestyle and those who count on you from an unexpected loss of income? Would you be able to meet your financial obligations if you became *disabled* and unable to work?

STD insurance is designed to pay a weekly benefit to you in the event you cannot work because of a covered illness or *injury*. This benefit replaces a portion of your income, thus helping you to meet your financial commitments in a time of need.

By sponsoring group Voluntary STD insurance from Standard Insurance Company, your *employer* offers you an excellent opportunity to help protect yourself and your lifestyle. The advantages to you include:

- **Convenience.** With premiums deducted directly from your paycheck, you don't have to worry about mailing monthly payments.
- **Savings.** Typically, group insurance rates are lower than the rates of individual insurance plans, generally providing you with coverage at a lower cost.
- **Peace of Mind.** You can take comfort and satisfaction in knowing that you have taken a step toward securing your income during a period of *disability*.

Commonly Asked Questions

The following information provides details to give you a better understanding of group Voluntary STD insurance available from The Standard. Written in non-technical language, this is not intended as a complete description of the coverage.

Do I need STD insurance?

If you are not certain that you need STD coverage, consider if you would be able to meet your financial obligations if you became *disabled* and unable to work for an extended period of time. The risk of *disability* may be greater than you think. Recent statistics show:

- A disabling injury occurs every 1.3 seconds - on and off the job. That's over 63,000 every day, more than 23 million every year. (Source: National Safety Council, *2005-2006 Injury Facts*)
- Three in 10 workers entering the workforce today will become disabled before retiring. (Source: Social Security Administration, *Fact Sheet 2007*)
- Over 6.8 million workers are receiving Social Security disability benefits; almost half are under age 50. (Source: Social Security Administration, *Fact Sheet 2007*)

If you depend on your regular paycheck to pay your bills, what would happen if you became sick and couldn't work? Voluntary STD insurance from The Standard may be part of the solution.

Am I eligible for this coverage?

To be a *member* and eligible for the Voluntary STD insurance coverage, you must be:

- An active elected official or regular employee of an *employer* participating in the Washington Counties Insurance Fund, excluding temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors
- *Actively at work* at least 20 hours each week or 80 hours per month whichever is less (does not apply to elected officials)
- A citizen or resident of the United States or Canada

When does my insurance go into effect?

The effective date of your coverage depends on when you become an eligible *member*, when you apply and whether you are required to provide *evidence of insurability*.

If you are **not** required to provide *evidence of insurability*, your Voluntary STD coverage becomes effective on:

- The date you become eligible if you apply on or before that date; or
- The date you apply if you apply within 31 days after you become eligible.

If you are required to provide *evidence of insurability*, your Voluntary STD coverage becomes effective on the date The Standard approves your *evidence of insurability*.

In every case, you must apply, agree to pay premiums, and meet the active work requirement before your insurance becomes effective.

What is the active work requirement?

Active work means performing with reasonable continuity the *material duties* of your *own occupation* at your *employer's* usual place of business. You must be capable of *active work* on the day before the scheduled effective date of your insurance or your insurance will not become effective as scheduled. If you are not *actively at work* on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete 1 full day of *active work* as an eligible employee.

Will I have to provide information regarding my medical history?

The Standard may require you to provide information regarding your medical history, referred to as *evidence of insurability*, if you:

- Apply more than 31 days after you become eligible for insurance
- Terminate your STD coverage for any reason but later apply to become insured again
- Apply for the 180 day *maximum benefit period* option if you are currently insured for the 90-day MBP option.

Contact your human resources department for a Medical History Statement when *evidence of insurability* is required. In some cases, we may request additional medical information or a physical exam.

When am I considered disabled?

During the *benefit waiting period* and to the end of the *maximum benefit period*, you are considered *disabled* if, as a result of *physical disease, injury, pregnancy or mental disorder*:

- You are unable to perform with reasonable continuity the *material duties* of your *own occupation*, and
- You suffer a loss of at least 20 percent of your *indexed predisability earnings* when working in your *own occupation*.

You are not *disabled* merely because your right to perform your *own occupation* is restricted, including a restriction or loss of license. You may work in another occupation while you are *disabled* from your *own occupation*, however, you will not be considered *disabled* when your *work earnings* from another occupation exceed 80 percent of your *predisability earnings*.

When do STD benefits become payable?

If you become *disabled* and your claim for *STD benefits* is approved by The Standard, *STD benefits* become payable after the *benefit waiting period*. This is a specified number of days during which you must remain continuously *disabled*. *STD benefits* are not payable during the *benefit waiting period*. The *benefit waiting period* is shown below.

| Cause of Disability | Benefit Waiting Period |
|---|-------------------------------|
| Accidental <i>injury</i> | 30 days |
| <i>Physical disease, pregnancy or mental disorder</i> | 30 days |

How much is the STD benefit amount?

Your weekly *STD benefit* is 60 percent of your insured *predisability earnings* reduced by *deductible income*. The plan minimum and maximum *STD benefit* amounts are shown below.

| Plan maximum weekly STD benefit | Plan minimum weekly STD benefit |
|--|--|
| \$ 1,000 | \$15 |

How is the STD benefit amount calculated?

The *STD benefit* amount is determined by multiplying your insured *predisability earnings* by the specified benefit percentage. This amount is then reduced by other income you receive or are eligible to receive while *STD benefits* are payable. This other income is referred to as *deductible income*.

In the example below, the *STD benefit* amount is 60 percent of your insured *predisability earnings*. If your weekly earnings (*predisability earnings*) before becoming *disabled* were \$500 and you now receive a weekly state disability benefit of \$50, your weekly *STD benefit* would be calculated as follows:

| | |
|---|--------|
| Insured <i>predisability earnings</i> | \$500 |
| <i>STD benefit</i> percentage | x 60% |
| | \$300 |
| Less state disability income benefit | - \$50 |
| Amount of <i>STD benefit</i> | \$250 |

What are predisability earnings?

Predisability earnings means your weekly rate of earnings from your *employer* and typically includes:

- Salary
- Shift differential pay
- Contributions you make through a salary reduction agreement with your *employer* to an IRC Section 401(k), 403(b), 408(k), 408(p) or 457 deferred compensation arrangement, or an executive nonqualified deferred compensation arrangement
- Amounts contributed to fringe benefits according to salary reduction agreements under an IRC Section 125 plan

Predisability earnings generally exclude bonuses, commissions, overtime pay, your *employer's* contributions on your behalf to a deferred compensation arrangement or pension plan and any other extra compensation. They are based on your earnings in effect on your last full day of *active work*. Please contact your human resources representative for additional information regarding what is included in *predisability earnings*.

What is deductible income?

Deductible income is income you receive or are eligible to receive while *STD benefits* are payable. It may reduce the amount of your *STD benefit*. It includes, but is not limited to, the following:

- Amounts under any unemployment compensation law, state disability income benefit law or similar law
- Any amount you receive or are eligible to receive because of your disability under another group insurance coverage
- Disability or retirement benefits under your *employer's* retirement plan
- Earnings from work activity while you are *disabled*, plus the earnings you could receive, if you worked as much as you are able considering your *disability*
- Earnings or compensation included in your *predisability earnings* that you receive or are eligible to receive while *STD benefits* are payable
- Amounts you receive or are eligible to receive from or on behalf of a third party because of your *disability*
- Any amount you receive by compromise, judgment, settlement or other method as a result of a claim for any of the above, whether disputed or undisputed

What is the maximum benefit period (MBP)?

The maximum benefit period is the maximum period for which *STD benefits* are payable for any one period of continuous *disability*. If you become *disabled*, *STD benefits* may continue during *disability* for up to 90 days or 180 days. If you are insured for the Buy-up LTD plan with The Standard through your *employer*, you will be eligible for the 90 day maximum benefit period option*. If you do not have the Buy-up LTD plan, you may choose 90 or 180 days for your STD maximum benefit period.

* If you receive benefits under any long term disability plan, your *STD benefits* will end, even if this occurs before the end of the *maximum benefit period* for *STD benefits*.

When do STD benefits end?

STD benefits end automatically on the earliest of:

- The date you are no longer *disabled*
- The date your *maximum benefit period* ends
- The date you die
- The date benefits become payable under any other disability plan under which you become insured through employment during a period of *temporary recovery*
- The date long term disability (LTD) benefits become payable to you under a group plan provided by your *employer*
- The date you fail to provide proof of continued *disability* and entitlement to STD benefits

What are some of the other features of this coverage?

This STD coverage has the following features:

- Your premium payments are made with “after-tax” dollars, so *STD benefits* are federally tax-free under current federal tax law.
- If your employer makes an approved work-site modification that enables you to return to work while *disabled*, The Standard will reimburse your *employer* up to a pre-approved amount for some or all of the cost of the modification.
- If the *group policy* terminates, *STD benefits* will continue as long as you are eligible to receive them.

What exclusions apply to this coverage?

You are not covered for a *disability* caused or contributed to by any of the following:

- Your involvement in any employment for wage or profit
- Your committing or attempting to commit an assault or felony, or your active participation in a violent disorder or riot
- An intentionally self-inflicted *injury*, while sane or insane
- *War* or any act of *war* (declared or undeclared, and any substantial armed conflict between organized forces of a military nature)
- The loss of your professional or occupational license or certification

What limitations apply to this coverage?

STD benefits are not payable for any period when you are:

- Not under the ongoing care of a *physician* in the appropriate specialty as determined by The Standard
- Not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by The Standard, unless your *disability* prevents you from participating
- Confined for any reason in a penal or correctional institution
- Able to work and earn at least 20 percent of your *indexed predisability earnings* in your *own occupation*, but you elect not to work
- Receiving sick leave pay, annual or personal leave pay or other salary continuation, including donated amounts from your *employer*

When does my Voluntary STD insurance coverage end?

The Voluntary STD insurance ends automatically on the earliest of the following:

- The date the last period ends for which you make a premium contribution
- The date your employment terminates
- The date the *group policy* terminates
- The date you cease to be a *member*, however, insurance may continue for limited periods under certain circumstances as described in the *group policy*
- The date your *employer* ceases to participate under the *group policy*

How much will the Voluntary STD coverage cost?

The monthly premium rates for the group Voluntary STD coverage are shown below.

| Monthly Earnings* | Option 1 (90 day MBP) | Option 2 (180 day MBP) |
|-------------------------|-----------------------|------------------------|
| Under \$1,000 | \$9.30 | \$10.80 |
| \$1,000 through \$1,499 | \$10.30 | \$12.30 |
| \$1,500 through \$1,999 | \$11.30 | \$14.80 |
| \$2,000 through \$2,499 | \$12.80 | \$16.80 |
| \$2,500 through \$2,999 | \$14.30 | \$19.30 |
| \$3,000 through \$3,499 | \$15.30 | \$20.80 |
| \$3,500 through \$3,999 | \$16.30 | \$23.30 |
| \$4,000 through \$4,499 | \$17.80 | \$25.30 |
| \$4,500 through \$4,999 | \$18.80 | \$26.80 |
| \$5,000 through \$5,499 | \$19.80 | \$28.80 |
| \$5,500 through \$5,999 | \$21.30 | \$30.80 |
| \$6,000 through \$6,499 | \$22.30 | \$32.80 |
| \$6,500 through \$6,999 | \$23.80 | \$34.80 |
| \$7,000 or over | \$24.80 | \$37.30 |

* Monthly Earnings means 4.333 times your *predisability earnings*, calculated as of the preceding December 31, or the date you become insured, whichever is later.

Premiums for the Voluntary STD coverage will be deducted directly from your paycheck. If you have questions regarding how to determine your monthly earnings, please contact your human resources representative.

How do I apply for Voluntary STD insurance coverage?

You may apply for Voluntary STD insurance during open enrollment, but remember if you apply more than 31 days after becoming eligible, satisfactory *evidence of insurability* is required. Coverage subject to *evidence of insurability* is not effective until approved by The Standard.

What if I have additional questions?

If you have any additional questions, please contact your human resources representative.

DIRECTIONS FOR APPLYING FOR COVERAGE

Read the Information Practices Notice(s) on page 3. Complete all items, date and sign in the space at the bottom of page 2. A separate form must be submitted for each applicant (Employee/Member, Spouse and/or Child) when Evidence Of Insurability or Proof of Good Health is required to apply for coverage. Please keep a copy for your records.

MEMBER/EMPLOYEE INFORMATION

| | | | | | |
|---|--|----------------------------|-------------------------|---|------------------------------------|
| Name of Group and Group Number Washington Counties Insurance Fund/Pool – 645273 | | Employer Name and Location | | Check who is Applying (One per form) <input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child | |
| Member/Employee Name | | | Birthdate (Mo/Day/Year) | | Date Hired (Mo/Day/Year) |
| Occupation | | Salary | Social Security Number | | Member/Employee Identification No. |

APPLICANT INFORMATION

| | | | | | |
|--|-------------------------|------------|------|------------------------|----------------------------------|
| Applicant's Name (Person to be insured) | | | | | |
| Street Address | | | City | State | Zip |
| Sex <input type="checkbox"/> M <input type="checkbox"/> F | Birthdate (Mo/Day/Year) | Birthplace | | Social Security Number | Work Phone () Home Phone () |

APPLICATION INFORMATION

| | | | | | |
|---|---------------------------------|---|-----------------------------|---|------------------------|
| Type of Application (<i>check one</i>) <input type="checkbox"/> Initial <input type="checkbox"/> Increase in Coverage <input type="checkbox"/> Late Application | | | | | |
| Check the type and provide details on the amount of coverage you are requesting. | | | | | |
| <input type="checkbox"/> Short Term Disability | | | | | |
| <input type="checkbox"/> Long Term Disability | | | | | |
| | Current Amount In Force, if any | + | Additional Amount Requested | = | Total Amount Requested |
| <input type="checkbox"/> Life | Current Amount In Force, if any | + | Additional Amount Requested | = | Total Amount Requested |
| <input type="checkbox"/> Dependents Life | Current Amount In Force, if any | + | Additional Amount Requested | = | Total Amount Requested |

MEDICAL HISTORY STATEMENT QUESTIONS

- Check yes or no for each of these questions, and give details for any "yes" answers. Attach a separate sheet if necessary.**
- Are you now unable to work full-time because of any physical or mental condition, or injury? Yes No
 - Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
 - Disease of the liver, pancreas, kidney, ulcers, stomach, intestinal ailment, or digestive system disorder? Yes No
 - Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, blindness, deafness, or any other neurological or muscle disorder? Yes No
 - Cancer, tumor, lesions, leukemia, lymphoma, blood clotting or other malignancy or growth? Yes No
 - Cardiovascular disease, heart ailment, arteriosclerosis, abnormal pulse, high blood pressure, heart murmur, valve, circulatory, or vascular disorders? Yes No
 - Emphysema, asthma, bronchitis, sleep apnea, or other respiratory or lung disease? Yes No
 - Lupus, scleroderma, vasculitis, connective tissue disease, or other immune system disorder not related to Human Immunodeficiency Virus (HIV)? Yes No
 - Osteoarthritis, rheumatoid arthritis, osteoporosis, pain in the joints, amputations, or other disease or disorder of the bones, joints, back, or spine, arthritic or disc conditions? Yes No
 - Diabetes, thyroid, gland, spleen, or nephritis? Yes No
 - Drug or alcohol abuse, or have you used alcohol, drugs or nicotine in a manner that has resulted in medical treatment? Yes No
 - Psychiatric or mental condition, depression, adjustment disorder, affective disorder, anxiety disorder, or obsessive-compulsive disorder? Yes No
 - In the past 7 years have you had any illness or injury not listed above which resulted in the use of prescribed medication or physician visits? Yes No
 - Has a medical professional ever diagnosed you as having or prescribed medication to you for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
 - Do you plan any operation or visit to a doctor or practitioner for an existing physical or mental condition, or injury? Yes No
 - Are you currently pregnant? Yes No

| | | |
|--------|--------|--|
| Height | Weight | Physician Name or Medical Facility with Applicant's Complete Medical Records (provide name and full mailing address) |
| | | |

| | |
|----------------|------------------------|
| Applicant Name | Social Security Number |
|----------------|------------------------|

Describe any "yes" answers below. (Please provide the entire question number.)

| Question Number | Description of Injuries, Disorders and Operations | Month/Year | Duration | Final Result | Physicians Consulted, City & State |
|-----------------|---|------------|----------|--------------|------------------------------------|
| | | | | | |
| | | | | | |
| | | | | | |

ACKNOWLEDGMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION (Please read carefully.)

- I represent that the statements contained herein, including those made in response to the Medical History Statement questions and any attachments, are true and complete, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, The Standard's liability is limited to the return of any premium which may have been paid.
- To any health plan, physician, health care provider, hospital, clinic, laboratory, pharmacy, medical facility, insurance or reinsurance company, and the MIB, Inc. (MIB), I instruct you to disclose my entire medical record and any other protected health information concerning me to The Standard or its reinsurers. This includes information on any disorder of the immune system, including Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, and any communicable or sexually transmitted disease or disorder. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.
- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any of the above to release and disclose my entire medical records without restriction.
- I understand that The Standard will use information to determine my eligibility for group insurance coverage. I understand The Standard may release information it has about me to its reinsurers and to any person performing business or legal services for The Standard in connection with my application. I understand The Standard may release information it has about me to MIB for the purpose of reporting to the MIB information exchange and for MIB to audit The Standard's reporting. I understand The Standard may release information it has about me to other insurance companies to which I have applied for insurance coverage or benefits.
- I understand that information disclosed to The Standard pursuant to authorization may be subject to redisclosure with my authorization or as otherwise permitted by law. Life and disability insurance coverages are not subject to the Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA), and therefore release of information to The Standard is not protected under the Act.
- I understand that I am entitled to receive a copy of this authorization. This authorization will remain valid six months from the date of the signature below. A photocopy or facsimile of this authorization shall be as valid as the original.
- I understand that I have the right to refuse to sign this authorization. I further understand that I have a right to revoke this authorization at any time by sending a written statement to The Standard, except to the extent it has been relied upon to disclose requested records. I understand that the revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.
- I understand that if my application is approved, premiums shall be paid in accordance with the provisions of the Group Policy(ies), and my coverage will be subject to all terms and conditions of the Group Policy(ies) and state limitations.
- For Member/Employee: If I currently have a Life and/or Trust Life beneficiary designation on file with my plan administrator, I understand the designation(s) on file will also apply to any approved amounts. If I have no beneficiary designation(s) on file or I wish to change the name of the current beneficiary(ies), I will contact my plan administrator.
- I understand that insurance on a Spouse or other Dependent, if any, is payable to the Member/Employee, if living, or as provided under the terms of the Group Policy(ies).
- I acknowledge that I have read and received the Information Practices Notice and I have kept a copy of this Medical History Statement.

| | |
|--|-------------|
| Signature of Applicant (or Member/Employee for Dependent Child) | Date |
|--|-------------|

Note: Declinations do not affect either Guarantee Issue Amounts not subject to Evidence Of Insurability or other coverages already in force with Standard Insurance Company.

| | |
|----------------|------------------------|
| Applicant Name | Social Security Number |
|----------------|------------------------|

INFORMATION PRACTICES NOTICE

- To help us determine your eligibility for group insurance we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or MIB, Inc. (MIB), formerly known as Medical Information Bureau. We will use the authorization you signed on this form when we seek this information.
- MIB – Information regarding your insurability will be treated as confidential. Standard Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health (including short and long term disability) insurance coverage, or a claim for benefits is submitted to such a company, 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 (TTY 866-346-3642). 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. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.
 Standard Insurance Company may release information in its file to its reinsurers, and Standard Insurance Company, or its reinsurers, may release information in its file to other insurance companies to whom you may apply for life or health (including short and long term disability) insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.
- DISCLOSURE TO OTHERS – The information collected about you is confidential. We will not release any information about you without your authorization, except to the extent necessary to conduct our business or as required or permitted by law.
- YOUR RIGHTS – You have a right to know what information we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices please write to us at Medical Underwriting, Standard Insurance Company, 900 SW Fifth Avenue, Portland, Oregon 97204 or call 1-800-843-7979.

FRAUD NOTICE

- FOR RESIDENTS OF ARKANSAS, LOUISIANA, OHIO, WASHINGTON: Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.
- FOR RESIDENTS OF COLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- FOR RESIDENTS OF DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- FOR RESIDENTS OF NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- FOR RESIDENTS OF 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.

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

| | | | | | | |
|--|--|---------------------|--|--|----------------------------------|-----|
| APPLICANT | Your Name (Last, First, Middle) | | Group Name Washington Counties Insurance Fund (WCIF) | | Group Number(s) 645273 | |
| | Your Address | | City | | State | ZIP |
| | Your Soc. Sec. No. | Date of Birth | | <input type="checkbox"/> Male <input type="checkbox"/> Female | | |
| | Employer | | | Job Title/Occupation | | |
| DISABILITY | Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements. | | | | | |
| | Voluntary Short Term Disability <input type="checkbox"/> Option 1, 90 days <input type="checkbox"/> Option 2, 180 days | | | | | |
| CHANGE | Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply. | | | | | |
| | <input type="checkbox"/> Name Change Former name _____ <input type="checkbox"/> Other _____ | | | | | |
| SIGNATURE | I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change. | | | | | |
| | Member/Employee Signature Required | | | | Date (Mo/Day/Yr) | |
| Human Resources Department - Complete this section. Retain form for your records. | | | | | | |
| Dvsn ID 0001 | Billing Cat. 0100 | Date of Hire/Rehire | Hrs. Worked Per Wk. | Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr | | |

About Standard Insurance Company

Your *employer* has chosen Standard Insurance Company to provide group Voluntary STD coverage to eligible employees. The Standard has earned a solid reputation for its quality products, superior customer service, expert resources, steady growth, innovation and strong financial performance. Founded in 1906, The Standard has developed a national presence in the employee benefits industry, providing customers with group and individual disability insurance and retirement plans, and group life and dental insurance.

Just as others count on you, you can count on The Standard for Voluntary STD insurance in a time of need. Talk with your *employer's* human resources representative for more information about group Voluntary STD insurance from The Standard.



Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204
www.standard.com

A subsidiary of StanCorp Financial Group, Inc.