



TheStandard®

Group Additional Life Insurance

FOR EMPLOYEES OF JEFFERSON COUNTY PUBLIC SCHOOLS

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 Additional Life insurance coverage being offered by Jefferson County Public Schools to eligible employees. It is not intended to provide a detailed description of the coverage.

If coverage becomes effective and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage including the definitions, exclusions, limitations, reductions 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 Jefferson County Public Schools benefits representative.

Please note that defined terms and provisions from the *group policy* are italicized in this booklet. Features of the group Additional Life coverage may vary by state.



Group Additional Life Insurance

It's not easy to think about, but what if you suddenly died? Your family could be faced with house payments, unpaid bills, childcare and other expenses just to maintain their current lifestyle. Could your family live without your income? Would your family be able to cover the medical expenses associated with a terminal illness or with burial and funeral expenses?

You make a great investment in your family. You spend time with them. You care for them. You work for them. And if you're not there for them, you want them protected. Jefferson County Public Schools provides you with a basic amount of Group Life insurance to help protect your loved ones in the event of your death. Since every employee's needs are different, Jefferson County Public Schools also provides you with the opportunity to apply for Additional Life insurance from The Standard.

The advantages to you and your loved ones include:

- **Choice.** You decide how much coverage you need from the range of amounts available.
- **Flexibility.** If your needs change, you can request to change the amount of coverage. Increases in coverage require *evidence of insurability*.
- **Convenience.** With premiums deducted directly from your paycheck, you don't have to worry about mailing monthly payments.
- **Peace of Mind.** You can take comfort and satisfaction in knowing that you have done something positive for your family's future.

Commonly Asked Questions

The following information provides details to give you a better understanding of group Additional Life insurance available from The Standard.

Am I eligible for this coverage?

To be eligible for this plan:

- You must be an active employee of Jefferson County Public Schools, excluding temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors.
- You must be regularly working at least 20 hours each week.
- For dependent coverage, your *spouse* or *children* must not be full-time members of the armed forces of any country.

When does my insurance go into effect?

The effective date of your coverage depends on whether you are required to provide *evidence of insurability*.

If you are not required to provide *evidence of insurability*, if you apply and agree to pay premiums, your Additional Life 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*, if you apply and agree to pay premiums, your Additional Life coverage becomes effective on the date The Standard approves your *evidence of insurability*.

In every case, you must 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 (including Dependents Life insurance) will not become effective until the day after you complete one day of *active work* as an eligible employee.

How much coverage may I get for myself?

Eligible employees may elect Additional Life coverage in units of \$10,000, to a maximum of \$300,000.

If you want to become insured for an amount of Additional Life in excess of the *guarantee issue amount* of one times your base annual earnings, rounded to the next higher multiple of \$10,000, the excess will be subject to medical underwriting approval. All late applications and requests for coverage increases are also subject to medical underwriting approval.

If you were previously declined for Additional Life coverage by The Standard, you will not be eligible to apply.

How much coverage may I get for my spouse and children?

This plan also includes Dependents Life insurance from The Standard.

Eligible employees may elect Additional Life coverage for a *spouse* in units of \$10,000 to a maximum of \$150,000, but not to exceed 50 percent of the employee's Additional Life coverage.

If you elect an amount for your *spouse* greater than the *guarantee issue amount* of one times your base annual earnings, rounded to the next higher multiple of \$10,000, the excess will be subject to medical underwriting approval. All late applications and requests for coverage increases will also require medical underwriting approval.

If your *spouse* was previously declined for Additional Life coverage by The Standard, they will not be eligible to apply.

You may elect either \$2,500 or \$5,000 of Dependents Life insurance for your eligible *child(ren)*. This amount may not exceed 50 percent of your Additional Life coverage. Dependent Child(ren) means your unmarried *child* from live birth through age 19 (through age 25 if a registered student in full-time attendance at an accredited educational institution); or if your *child* is continuously incapable of self-sustaining employment because of mental retardation or physical handicap and is chiefly dependent upon you for support and maintenance.

How much coverage do I need?

It can be difficult to determine the amount of insurance you need. Each family has its own unique set of circumstances, combined with needs that may arise with the unexpected loss of life. Use the worksheet below in calculating the amount of life insurance coverage you may need. The final total is the amount of Additional Life insurance you might want to consider applying for to meet your obligations.

Immediate Needs	You	Your Spouse
Medical and hospital expenses	\$ _____	\$ _____
Funeral/Burial expenses	_____	_____
Loans/Debts requiring payment upon death	_____	_____
Taxes:		
Federal and state income taxes	_____	_____
Property taxes	_____	_____
Federal and state estate taxes	_____	_____
Long Term Needs		
Mortgage	\$ _____	\$ _____
Debts (credit cards, car and student loans, etc.)	_____	_____
Educational/Vocational fund	_____	_____
Childcare expenses	_____	_____
Emergency fund for unforeseen expenses	_____	_____
Income Replacement		
<i>Consider the income needed to support your family and the number of years they will need that support.</i>	\$ _____	\$ _____
Total Income Needs		
<i>Add together all of the above.</i>	\$ _____	\$ _____
Available Resources		
Existing life insurance coverage	\$ _____	\$ _____
Other assets such as 401(k), stocks, bonds, etc.	_____	_____
Total Additional Life Insurance Needed		
<i>Subtract the amount of your available resources from your total income needs.</i>	\$ _____	\$ _____

How much will the Additional Life coverage cost me?

Use the following rates to determine the premium for Additional Life coverage. The rate charts are based on 24 payroll deductions per year and are the same for both employee and *spouse*. To determine your premium per employee or *spouse*, select age and amount of coverage you are electing.

PREMIUMS BASED ON 24 PAYROLL DEDUCTIONS PER YEAR

Employee/Spouse Age as of January 1	Amount of Coverage					
	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000
29 and under	\$0.30	\$0.60	\$0.90	\$1.20	\$1.50	\$1.80
30-34	\$0.40	\$0.80	\$1.20	\$1.60	\$2.00	\$2.40
35-39	\$0.45	\$0.90	\$1.35	\$1.80	\$2.25	\$2.70
40-44	\$0.60	\$1.20	\$1.80	\$2.40	\$3.00	\$3.60
45-49	\$0.80	\$1.60	\$2.40	\$3.20	\$4.00	\$4.80
50-54	\$1.55	\$3.10	\$4.65	\$6.20	\$7.75	\$9.30
55-59	\$3.25	\$6.50	\$9.75	\$13.00	\$16.25	\$19.50
60-64	\$3.60	\$7.20	\$10.80	\$14.40	\$18.00	\$21.60
65-69	\$6.45	\$12.90	\$19.35	\$25.80	\$32.25	\$38.70
70-74	\$14.85	\$29.70	\$44.55	\$59.40	\$74.25	\$89.10
75 and over	\$17.55	\$35.10	\$52.65	\$70.20	\$87.75	\$105.30

Employee/Spouse Age as of January 1	Amount of Coverage					
	\$70,000	\$80,000	\$90,000	\$100,000	\$200,000	\$300,000
29 and under	\$2.10	\$2.40	\$2.70	\$3.00	\$6.00	\$9.00
30-34	\$2.80	\$3.20	\$3.60	\$4.00	\$8.00	\$12.00
35-39	\$3.15	\$3.60	\$4.05	\$4.50	\$9.00	\$13.50
40-44	\$4.20	\$4.80	\$5.40	\$6.00	\$12.00	\$18.00
45-49	\$5.60	\$6.40	\$7.20	\$8.00	\$16.00	\$24.00
50-54	\$10.85	\$12.40	\$13.95	\$15.50	\$31.00	\$46.50
55-59	\$22.75	\$26.00	\$29.25	\$32.50	\$65.00	\$97.50
60-64	\$25.20	\$28.80	\$32.40	\$36.00	\$72.00	\$108.00
65-69	\$45.15	\$51.60	\$58.05	\$64.50	\$129.00	\$193.50
70-74	\$103.95	\$118.80	\$133.65	\$148.50	\$297.00	\$445.50
75 and over	\$122.85	\$140.40	\$157.95	\$175.50	\$351.00	\$526.50

The employee maximum benefit is \$300,000. The *spouse* maximum is \$150,000, not to exceed 50% of the employee's Additional Life amount.

Dependents Life insurance for children is shown below. You will pay one cost regardless of the number of eligible *children* you have.

24 Deductions Per Year

- Option 1: \$2,500\$0.25
- Option 2: \$5,000\$0.50

Will I have to provide information regarding my medical history?

If you apply for Additional Life insurance within 31 days of becoming eligible, you will automatically qualify for up to a set amount of insurance coverage called the *guarantee issue amount*. This means that you will not have to answer medical questions to purchase coverage up to one times your annual earnings, rounded to the next higher multiple of \$10,000.

If you apply after the eligibility period or if you determine that you need more insurance than the *guarantee issue amount* (one times annual earnings, rounded to the next higher multiple of \$10,000), satisfactory *evidence of insurability* is required. You will need to complete and submit a Medical History Statement. In some cases, we may request additional medical information or a physical exam.

Evidence of insurability is also required for reinstatement of terminated coverage and for *members* eligible but declined under prior life insurance plans provided by Jefferson County Public Schools.

How do I apply for Additional Life insurance coverage?

To apply for Additional Life insurance, complete the enrollment worksheet, enrollment form, and Medical History Statement* (if required). Return the enrollment worksheet and enrollment form, which are included in this booklet, to your Jefferson County Public Schools benefits representative and mail the Medical History Statement (if required) to The Standard. You can apply at any time, but remember **if you apply after 31 days of becoming eligible, then satisfactory evidence of insurability will be required**. Coverage subject to *evidence of insurability* is not effective until approved by The Standard.

How are benefits paid?

For amounts of less than \$25,000, The Standard issues a check to each designated *beneficiary*. The Standard pays amounts of \$25,000 or more to each designated *beneficiary* by depositing funds into Standard Secure Access — a convenient, no fee, interest-bearing draft account.

With Standard Secure Access, each *beneficiary* receives a personalized checkbook and has complete control of the account. *Beneficiaries* can write checks as needed or for the full amount. This arrangement allows *beneficiaries* to earn competitive interest rates on their benefits while they take the necessary time to consider financial decisions and evaluate their choices.

Will insurance benefits be reduced as I grow older?

Under this plan, coverage reduces 35 percent at age 70, 58 percent at age 75, 72 percent at age 80 and 85 percent at age 85. If you or your *spouse* are age 70 or over, ask your benefits representative for the amount of coverage available.

*If you need a Medical History Statement, you will find one in the back of this booklet. If you are a resident of the state of Indiana or if additional copies are needed, you may obtain them from your Jefferson County Public Schools benefits representative, Jefferson County's Employee Web Site or online at http://www.standard.com/mybenefits/mhs_sp.html.

What happens if I become totally disabled and can't work?

The Standard will continue your Additional Life insurance without premium payments if you:

- Become *totally disabled* while insured under the *group policy*
- Are under the age of 60
- Complete the *waiting period* of 180 days
- Provide The Standard with satisfactory proof of *total disability*

What happens if I become terminally ill?

Under the *Accelerated Benefit* provision, you may be eligible to receive up to 75 percent of your Additional Life insurance coverage if you become terminally ill, have a life expectancy of less than 12 months and meet other eligibility requirements.

This benefit allows you to use the proceeds as you desire — whether to cover medical expenses or to maintain your quality of life. The amount of Additional Life insurance payable upon your death is reduced by the *Accelerated Benefit* paid and an interest charge. However, to help protect your *beneficiaries*, The Standard will pay at least 10 percent of the original Additional Life coverage amount at that time even if interest charges on the accelerated amount would have exhausted the remaining benefits over time.

What are the exclusions?

Additional Life includes an exclusion for death resulting from suicide or other intentionally self-inflicted injury while sane or insane. The amount payable will exclude amounts that have not been continuously in effect for at least two years on the date of death.

When does coverage end?

Additional Life coverage ends automatically on the earliest of the following:

- The date the last period ends for which a premium was paid for your Additional Life insurance (except if premiums are waived while *totally disabled*, if applicable)
- The end of the month following the date your employment terminates
- The date your Group Life insurance ends
- The date the *group policy* terminates
- The date Additional Life insurance terminates under the *group policy*
- The date you cease to be a *member*; however, insurance may continue for limited periods under certain circumstances
- If applicable, the date your *employer* ceases to participate under the *group policy*

Dependents Life coverage for your *spouse* and *children* ends automatically on the earliest of the following:

- Five months after the date you die
- The date your Group Life insurance ends

- The date the Dependents Life insurance terminates under the *group policy*
- The date the last period ends for which a premium was paid for your Dependents Life insurance
- When the *dependent* ceases to be an eligible *dependent*
- For your *spouse*, the date of your divorce or legal separation
- For a *child* who is *disabled*, 90 days after we mail you a request for proof of *disability*, if proof is not given

If my Additional Life insurance ends or is reduced, may I convert to an individual policy?

If your Additional Life insurance from The Standard ends or is reduced for any reason other than failure to pay premiums, you may be able to convert the terminated coverage to certain types of individual life insurance policies without providing *evidence of insurability*. You must apply for conversion and pay the required premium within 31 days after group coverage ends or is reduced.

May I buy group life coverage after I leave my employer?

If your insurance ends because your employment terminates, you may be eligible to buy group life insurance from The Standard through the *Portability* provision, assuming you meet the eligibility requirements. Please see your benefits representative for additional information. This option is not available in all states and is subject to state variations.

What if I have additional questions?

If you have any additional questions, please contact your Jefferson County Public Schools benefits representative.



The Standard[®]
Positively different.

**JEFFERSON COUNTY PUBLIC SCHOOLS
ADDITIONAL LIFE ENROLLMENT
POLICY NUMBER 645818**

Additional Life Insurance for You

Additional Life coverage from Standard Insurance Company is available to you in increments of \$10,000 to a maximum of \$300,000.

Employee Requested Amount

Deduction Amount (see page 4).

Evidence of Insurability requirements: If you elect an amount for yourself that is in excess of one times your base annual earnings, rounded to the next higher multiple of \$10,000, the excess will be subject to medical underwriting approval. You will need to complete a Medical History Statement*.

Dependents Life Insurance for your Spouse

If you elect coverage for yourself, you can also elect Dependents Life coverage for your *spouse*. This coverage is available to you in increments of \$10,000 to a maximum of \$150,000, but not to exceed 50% of your Additional Life coverage.

Please note that if your *spouse* is also an employee of Jefferson County Public Schools *and* is electing coverage for himself/herself, you may **not** elect Life Insurance for them.

Spouse Requested Amount

Deduction Amount (see page 4).

Evidence of Insurability requirements: If you elect an amount for your spouse that is greater than one times your base annual earnings, rounded to the next higher multiple of \$10,000, the excess will be subject to medical underwriting approval. Your spouse will need to complete and submit the Medical History Statement.

Dependents Child(ren) Life Insurance

You may elect either \$2,500 or \$5,000 of Dependents Life Insurance for your eligible dependent *child(ren)*.

Please note that if both parents are employees of Jefferson County Public Schools, only one parent may enroll the *child(ren)*. You will pay one cost regardless of the number of eligible children you have.

Please circle the insurance amount below that represents the coverage level you are choosing and enter the correct deduction amount shown on page 4.

Option No.	1	2
Child(ren) Amount	\$5,000	\$2,500
Deduction Amount		

Dependent Child means your unmarried *child* from live birth through age 19 (through age 25 if a registered student in full-time attendance at an accredited educational institution); or if your *child* is continuously incapable of self-sustaining employment because of mental retardation or physical handicap and is chiefly dependent upon you for support and maintenance.

Please return this form along with your enrollment form to your Jefferson County Public Schools benefits representative.

*If you need a Medical History Statement, you will find one in the back of this booklet. If you are a resident of the state of Indiana or if additional copies are needed, you may obtain them from your Jefferson County Public Schools benefits representative, Jefferson County's Employee Web Site or online at http://www.standard.com/mybenefits/mhs_sp.html.

To Be Completed By Human Resources

Group Number 645818	Employee ID No.	Billing Category	Date of Employment
-------------------------------	-----------------	------------------	--------------------

To Be Completed By Applicant Apply for Coverage Beneficiary Change *Complete Beneficiary Section below.* Name Change
 Add or Delete Dependent Date of add/delete _____

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Your Address		City	State	ZIP
Former Name (Last, First, Middle) <i>Complete only if name change</i>			Phone Number	
Employer Name Jefferson County Public Schools			Job Title/Occupation	
Hours Worked Per Week		Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		

Coverage *Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.*

Life Insurance

Additional/Optional Life Your requested amount \$ _____

Dependents Life Insurance

Spouse requested amount \$ _____ Spouse Name _____ Date of Birth _____
 Children requested amount \$ _____

Beneficiary *This designation applies to Additional Life Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.*

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

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) _____

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
 1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
 2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
 3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, “Dorothy Q. Smith, Trustee under the trust agreement dated _____.”
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer’s coverage under the Group Policy.

DIRECTIONS FOR APPLYING FOR COVERAGE

Read the Information Practices Notice(s) on page 3. 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. Complete all items, date and sign in the space at the bottom of page 2. Keep a copy for your records, and send the original to Standard Insurance Company at the address given above.

MEMBER/EMPLOYEE INFORMATION

Name of Group Jefferson County Public Schools		Group Number 645818	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"/> Life	_____ + _____ = _____	Current Amount In Force, if any	Additional 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 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.

About Standard Insurance Company

Standard Insurance Company has earned a solid reputation for its quality products, expert resources, superior service, steady growth, innovation and strong financial performance. Founded in 1906, The Standard is a leader in the group disability and life insurance market, while also offering individual disability, group dental and retirement plans for groups and individuals.



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

A subsidiary of StanCorp Financial Group, Inc.