

**DIRECTIONS FOR APPLYING FOR COVERAGE**

*This form must be completed when Evidence Of Insurability is required. To apply for coverage (as a Member/Employee, Spouse or Child), read the Information Practices Notice(s). Then complete all items, date, and sign as instructed. Send the original to Standard Insurance Company, at the address above. Please keep a copy for your records.*

**MEMBER/EMPLOYEE INFORMATION**

Name of Group		Group Number	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 (*check one*)  Initial  Increase in coverage  Late Application

**Check the insurance coverage you are requesting.**

Short Term Disability

Long Term Disability

Life

Dependents Life

Current Amount In Force, if any	+	Additional Amount Requested	=	Total Amount Requested
Current Amount In Force, if any	+	Additional Amount Requested	=	Total Amount Requested
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.**

1. Have you had any physical, mental or emotional condition, injury, sickness, or surgery in the past 5 years?  Yes  No
2. Have you consulted or been attended by a physician or practitioner for any cause in the past 5 years?  Yes  No
3. Are you now unable to work full-time because of any physical, mental or emotional condition, injury, or sickness?  Yes  No
4. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
  - A. High blood pressure, cardiovascular disease, heart ailment, arteriosclerosis, or stroke?  Yes  No
  - B. Mental condition, depression, epilepsy, or nervous system disorder?  Yes  No
  - C. Cancer, diabetes, or nephritis?  Yes  No
  - D. Arthritis, strained or injured back, slipped disc, or any bone, joint, or muscle disorder?  Yes  No
  - E. Lung, kidney, stomach, genital, urinary, liver, pancreas, or intestinal ailment?  Yes  No
  - F. Blindness or deafness?  Yes  No
  - G. An immune system disorder not related to Human Immunodeficiency Virus (HIV)?  Yes  No
5. Has a medical professional ever diagnosed you as having or prescribed medication to you for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or HIV infection?  Yes  No
6. Have you sought or received advice or treatment for the use of alcohol or drugs in the past 10 years?  Yes  No
7. In the past 10 years have you had a persistent cough, unintentional weight loss of 10 pounds or more, persistent fatigue, persistent lymph node enlargement, prolonged night sweats, pneumonia, lesions, or growths?  Yes  No
8. Do you take medication for any physical, mental or emotional condition, injury, or sickness?  Yes  No
9. Do you plan any operation or visit to a doctor or practitioner for an existing physical, mental or emotional condition, injury, or sickness?  Yes  No
10. Have you ever been declined for insurance or offered a rated or restricted policy, either as a new policy or reinstatement?  Yes  No
11. Are you now pregnant?  Yes  No

Height	Weight	Physician or Medical Facility with Applicant's Complete Medical Records
		Name and Full Mailing Address