The Standard Life Insurance Company of New York
Medical Underwriting, 900 SW Fifth Avenue Portland OR 97204-1282

Medical History Statement
For applicants not residing in New York

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. K ven above.

Due to state regulatory requirements,
this Medical History Statement form is now out of date.

Use the link below
to access the correct form for your state.

Please update your link or bookmark.
http://www.standard.com/ny2/mhsforms.html

If you have questions, please contact your employer
or call The Standard at 888.456.3505.
Thank you

MEMBER

Name of G ne per form)
use ☐ Child

Member/Er ar)

Occupation tification No.

APPLICA

Applicant's

Street Add o

Sex
☐ M ☐ F

APPLICAT

Type of App

Check the

☐ Short Te

☐ Long Te

	Current Amount In Force, if any		Additional Amount Requested		Total Amount Requested
☐ Life	_____	+	_____	=	_____
☐ Dependents Life	_____	+	_____	=	_____

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. Are you now unable to work full-time because of any physical or mental condition, or injury? ☐ Yes ☐ No
2. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
   - A. Disease of the liver, pancreas, kidney, ulcers, stomach, intestinal ailment, or digestive system disorder? ☐ Yes ☐ No
   - B. Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, blindness, deafness, or any other neurological or muscle disorder? ☐ Yes ☐ No
   - C. Cancer, tumor, lesions, leukemia, lymphoma, blood clotting or other malignancy or growth? ☐ Yes ☐ No
   - D. Cardiovascular disease, heart ailment, arteriosclerosis, abnormal pulse, high blood pressure, heart murmur, valve, circulatory, or vascular disorders? ☐ Yes ☐ No
   - E. Emphysema, asthma, bronchitis, sleep apnea, or other respiratory or lung disease? ☐ Yes ☐ No
   - F. Lupus, scleroderma, vasculitis, connective tissue disease, or other immune system disorder not related to Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
   - G. 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
   - H. Diabetes, thyroid, gland, spleen, or nephritis? ☐ Yes ☐ No
   - I. Drug or alcohol abuse, or have you used alcohol, drugs or nicotine in a manner that has resulted in medical treatment? ☐ Yes ☐ No
   - J. Psychiatric or mental condition, depression, adjustment disorder, affective disorder, anxiety disorder, or obsessive-compulsive disorder? ☐ Yes ☐ No
3. 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
4. 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
5. Do you plan any operation or visit to a doctor or practitioner for an existing physical or mental condition, or injury? ☐ Yes ☐ No
6. 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)