Standard Insurance Company

Individual Client Services
PO Box 711 Portland OR 97207

Policy Change Form and Application Supplement A

NAME OF INSURED	POLICY NUMBER

PLEASE MAKE THE FOLLOWING MARKED CHANGE(S) ON THE POLICY SHOWN ABOVE:

☐ 1. ADDITIONS

Add the following benefits/riders effective _____.

Benefits – Regular Life

- ☐ Waiver of Premium
- ☐ Payor Waiver – Payor birthdate _____
- ☐ Guaranteed Insurability amount $_____
- ☐ Accidental Death* amount $_____

Benefits – Universal Life

- ☐ Waiver of Monthly Charges
- ☐ Monthly Disability – amount $_____ (ULII & ULIII only)
- ☐ Guaranteed Insurability amount $_____
- ☐ Accidental Death* amount $_____

Riders

- ☐ Family Insurance Benefit – units _____
- ☐ Decreasing Term Insurance – amount $_____ Term _____ years (Reg. Life only)
- ☐ 5 Year Convertable/Renewable Term – amount $_____ (Reg. Life only)
- ☐ Term Insurance Benefit – amount $_____ (ULII, ULIII only)

*Total amount of Accidental Death now in force with all companies: $_____

☐ **Other:** _____

☐ 2. PLAN

Change Plan to: _____ Dividend Option _____.
(Use Rate Book Description)

☐ 3. UL ONLY

☐ Change Death Benefit Option to:
- ☐ Face Amount (Option B or Level)
- ☐ Face Amount plus Cash Value (Option A or Variable)

☐ Increase Face Amount to: $_____ Effective Next MAV.

☐ 4. REINSTATE

- ☐ In Accordance with Policy Provisions.
- ☐ By Redating (Policy Required).

☐ 5. POLICY RATING

- ☐ Request Elimination or Reduction of Rating.
- ☐ Change Risk Class to: ☐ Non-Smoker ☐ Preferred

☐ 6. PAID UP ADDITIONS

Use all Accumulated Dividends and Interest on this Policy to purchase Paid Up Additions.

☐ 7. DISABILITY INCOME

- ☐ Change elimination period to: _____ ☐ Change benefit period to: _____
- ☐ Add Benefit/Rider: _____
- ☐ Other: _____

☐ 8. REISSUE FROM START

☐ Reissue Policy to Increase Coverage. Describe Increase: _____

(Evidence Required if Requested More Than 90 Days After Original Issue Date.)

☐ 9. OTHER

HOME OFFICE ONLY

EFFECTIVE DATE	MODE	MODE PREMIUM	AUTHORIZED REPRESENTATIVE

UNDERWRITING ACTION

BY _____ DATE _____

IMPORTANT: Signature required on reverse side. All changes on this form require evidence of insurability. A separate AUTHORIZATION TO OBTAIN INFORMATION (3519NB) must be signed and attached to this form. Also a DISCLOSURE NOTICE must be handed to the proposed insured.

NOTICE TO OHIO POLICYOWNERS/INSUREDS ONLY: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud under Ohio law.

PLEASE COMPLETE AND SIGN THE OTHER SIDE.

APPLICATION SUPPLEMENT: EVIDENCE OF INSURABILITY

You or your means any person insured under this policy, including payor, Other Insured and children, if applicable.

		Yes	No
1.	Have you ever applied for life, disability or health insurance which was declined, postponed or withdrawn; or has any such policy issued on you been modified, rated up, cancelled or renewal refused?	☐	☐
2.	In the last 10 years have you been treated for or been diagnosed as having:		
	a. High blood pressure, chest pain, heart attack or any other disorder of heart or blood vessels?	☐	☐
	b. Stroke, fainting, mental or nervous disorder?	☐	☐
	c. Asthma, bronchitis, emphysema or other lung or respiratory disorder?	☐	☐
	d. Colitis, ulcer or other disorder of stomach, liver or intestines?	☐	☐
	e. Diabetes; or a growth, tumor, or cancer?	☐	☐
	f. Arthritis, or any disorder of joint, muscle, nerve, spine, neck or back, including sprain, strain or disc disorder?	☐	☐
	g. Any sexually transmitted disease, AIDS, AIDS Related Complex or immune system disorder? (**NV** and **MI** insureds, disregard this question. Instead, answer h or i, below, as applicable.)	☐	☐
	h. For **Nevada** insureds only: Any sexually transmitted disease or immune system disorder?	☐	☐
	i. For **Michigan** insureds only, answer a. and b. below:		
	a. Acquired immune deficiency syndrome (AIDS)?	☐	☐
	b. Any sexually transmitted disease?	☐	☐
3.	In the last 10 years have you had a positive (unfavorable) AIDS test? (**CA, HI, AZ, MI** and **NV** insureds, disregard this question.) For **CA** insureds only, answer a. below:	☐	☐
	a. In the last 10 years have you had a positive (unfavorable) AIDS test which was taken in connection with an application for insurance?	☐	☐
4.	Other than as stated in the above answers, and within the past 5 years, have you:		
	a. Been hospitalized or had a checkup, consultation, illness, injury or surgery?	☐	☐
	b. Had an electrocardiogram, blood test or other medical test or study?	☐	☐
	c. Been advised to have any medical test, hospitalization or surgery that was not completed?	☐	☐
	d. Had recommended any treatment, received treatment, or been arrested for the use of alcohol, drugs or any controlled or illegal substance?	☐	☐
	e. Used tobacco? If yes, circle type(s) and give month and year last used: cigarettes _____ ; cigars _____ ; pipe _____ ; chewing or snuff _____	☐	☐
5.	Do you take any prescription medication?	☐	☐
6.	Are you now aware of any current physical or mental condition or symptom that has not previously been diagnosed or treated?	☐	☐

7. What is your: Height _____ Weight _____ Occupation _____
8. Explain any "yes" answers below:

Question Number	Dates	Give full details, including: name of proposed insured, names and addresses of physicians, diagnosis, duration, severity, treatment and results. (Use a separate sheet if additional space is required.)

AGREEMENT

1. All changes or requests are subject to the policy's terms and to Standard's rules and procedures.
2. To make a change, Standard may require one or more of the following: a. Payment of any premium, cost or interest as determined by Standard; b. Standard's receipt of the policy for endorsement or cancellation; c. Any other information which Standard believes is necessary.
3. All changes made will take effect only when all of Standard's requirements are met and when Standard enters its approval on the other side. The effective date of all changes made is that shown above "Effective Date" on the other side.
4. This application supplement and all changes made will become a part of the policy.
5. Standard cannot contest any changes, insurance benefits or reinstatement as a result of this application supplement after two years from the effective date shown on the other side.
6. If the policy is reinstated, suicide by the insured, while sane or insane, within two years after the effective date on the other side is not covered. If this happens, the only amount due is the total premium paid since the date of reinstatement, less any loan, loan interest and partial surrenders.
7. If the death benefit of a universal life policy is increased, the increase is not covered if the insured commits suicide, while sane or insane, within two years after the effective date of the increase. If this happens, the only amount due is the total premium paid for the increase since the effective date on the other side, less any loan, loan interest and partial surrenders.
8. If a policy is issued, reinstated, or changed on the basis of this application supplement, any corrections or additions under HOME OFFICE ONLY will be ratified when the policy is accepted. However, changes made as to amount, classification, plan or benefit requested may not be made without written owner approval.
9. I understand that: a. Standard will rely on this information in considering my eligibility for insurance and my eligibility for various premium rates; b. any false statements or misrepresentations may result in loss of coverage. I declare that all answers to the above questions are correctly recorded and are complete and true to the best of my knowledge and belief.

DATE _____ _____

Signature(s) of Insured(s)

_____ _____

Signature of Agent | Signature of Owner (If Other than Insured)

Standard Insurance Company

Individual Disability Insurance Underwriting
1100 SW Sixth Avenue Portland OR 97204-1093

Disclosure Notice - Information Practices

Standard Insurance Company (Standard) is committed to keeping your personal information confidential. In order to offer and service our insurance products, Standard must obtain and review a certain amount and type of personal information about you. In general, we may seek information about your:

- Age
- Occupation
- Health
- Medical history
- Personal characteristics
- Activities
- Avocations
- Income
- Finances

This personal information is obtained and disclosed by us in order for us to: evaluate your insurability; determine the appropriate premium rates; support our normal business practices; and provide quality policy service to you.

SOURCES OF INFORMATION: You and your application for insurance are our primary sources of personal information. We, or our representative, may call you for a personal history interview (PHI). The purpose of the PHI is to obtain supplementary information or to confirm the information you give on your application. With your written authorization, we may also collect or verify personal information by contacting:

- Physicians
- Medical professionals
- Health care providers
- Hospitals
- Clinics
- Pharmacies
- Other medical or medically-related facilities
- Consumer reporting agencies
- Insurance sales representatives
- Insurance support organizations
- Insurance or reinsurance companies
- MIB, Inc. (see below)
- Employers
- Personal and business associates

We may also request that you have medical exams and tests.

DISCLOSURE OF INFORMATION: In the course of conducting our business, there are circumstances in which we may disclose to others the information we collect about you. These disclosures are only made with your authorization, or as permitted or required by law. Such disclosures may be to:

- MIB, Inc.
- Regulatory, law enforcement and governmental authorities
- Reinsurers
- Organizations that perform services or functions on your or our behalf

We, or our reinsurers, may also release information to other insurance companies to whom you have applied or may apply for life or health insurance, or to whom a claim for benefits may be submitted.

When information is disclosed to another party to perform services or functions on our behalf, we expect them to: (a) Adhere to procedures and practices to keep your personal information confidential; (b) Use the information only for the limited purpose for which it was shared; and to (c) Abide by all applicable federal and state privacy laws.

REVIEW AND CORRECTION OF INFORMATION: In general, you have a right to learn the nature and substance of the personal information about you in our files. You also have a right to obtain a copy of that information, subject to limited restrictions. To access the information about you, send a signed, written request to us at the address at the bottom of this page. If you believe that any information about you is inaccurate, you may notify us in writing of any correction, amendment, or deletion that you believe should be made. We will review your request and, where appropriate, make the necessary change.

Individual Disability Insurance Underwriting
1100 SW Sixth Avenue Portland OR 97204-1093

INVESTIGATIVE CONSUMER REPORTS: We may ask that an investigative consumer report be prepared by an independent source called a consumer reporting agency. The report is for insurance purposes only. It may include information about your: character and general reputation; personal characteristics and activities; and mode of living. The consumer reporting agency may obtain information for the report through personal interviews with: (a) your family members; (b) your friends or neighbors; or (c) others with whom you are acquainted.

If we request a report and you wish to be interviewed, please let us know in writing; we will notify the consumer reporting agency. When we receive your written request, we will: (a) tell you whether or not such a report was done; and (b) give you a more detailed description of the nature and scope of the report. You have a right to receive a copy of the investigative consumer report from the consumer reporting agency. If you would like a copy of the report, please contact us; we will give you the name and address of the consumer reporting agency.

MIB, INC.: We, or our reinsurers, may make a brief report to the MIB, Inc. MIB, Inc. is a not-for-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply the company with the information in its file. At your request, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek 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. The telephone number is 866-692-6901 (TTY 866-346-3642). Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

ADDITIONAL INFORMATION: We hope this Notice helps you understand how and why we obtain information about you. For a more detailed explanation of your rights and our information practices, please contact: Standard Insurance Company, Individual Disability Insurance Underwriting, 1100 SW Sixth Ave., Portland, OR 97204-1093.

This Disclosure Notice-Information Practices is being given to you in accordance with the law in California. All rights granted to you are in no way limited by Standard's Insurance Company's Privacy Policy Notice, which will be provided to you if you become a customer of Standard.

Standard Insurance Company

Individual Disability Insurance Underwriting
1100 SW Sixth Avenue Portland OR 97204-1093

Authorization to Obtain and Disclose Information

Types of Personal Information Collected
I understand that it is necessary for Standard Insurance Company (Standard) to collect and review personal information about me in order to offer and administer insurance products. I understand this personal information may include information about my age, occupation, avocations, driving record, travel, aviation, character, general reputation, personal characteristics and activities, mode of living, income and finances and other insurance. I also understand that personal information may include health information related to medical history, examinations, diagnoses, prognoses, test results, prescriptions and treatments of any physical or mental conditions.

Authorization to Obtain Personal Information
I authorize MIB, Inc., and any licensed physician, medical professional, health care provider, hospital, medical or medically-related facility, clinic, pharmacy, alcohol or drug treatment facility, insurance or reinsurance company, insurance sales representative, consumer reporting agency, government department or agency, employer, and any other person, organization or institution having records or knowledge of me, to release personal information about me, as described above, to Standard, its reinsurers, and any insurance support organization acting on behalf of Standard. I further authorize Standard to request and obtain an investigative consumer report about me from a consumer reporting agency, as described in the Disclosure Notice-Information Practices.

Authorization to Use Personal Information
I authorize Standard to use personal information obtained about me for the purposes of evaluating eligibility for insurance and reinsurance, determining appropriate premium rates, evaluating claims for insurance benefits and conducting other legally permissible activities that relate to my application and insurance coverage.

Authorization to Disclose Personal Information
I authorize Standard to disclose personal information about me to Standard's reinsurers, MIB, Inc., other insurance companies to whom I have applied or may apply for insurance, and to organizations or persons, including insurance sales representatives, performing business services for Standard related to my application and policy administration. No other disclosure may be made without my further authorization, except to the extent necessary for the conduct of Standard's business or as permitted or required by law. I understand that any health information that is disclosed pursuant to this Authorization may be subject to redisclosure as permitted or required by law and may no longer be protected by federal laws governing privacy and confidentiality of health information.

Certain Types of Health Information
I understand that certain health information cannot be released without my specific consent, in accordance with federal and state laws. I hereby expressly consent to the release of information related to my use of alcohol, drugs and tobacco; diagnosis or treatment of Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and sexually transmitted diseases; and diagnosis and treatment of psychological or mental illness (excluding psychotherapy notes). I also understand that blood, urine, saliva or other medical tests or examinations may be required to determine my insurability.

Expiration and Revocation
This Authorization will expire automatically twenty-four (24) months following the date of my signature below. I understand that I have the right to revoke this Authorization at any time by sending a written request for revocation to Standard Insurance Company, Attention: Individual Disability Insurance Underwriting, 1100 SW Sixth Avenue, Portland, Oregon 97204-1093. Revocation of this Authorization, or failure to sign this Authorization, will impair Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage. I realize that if I do revoke this Authorization it will not affect any use or disclosure of information prior to the receipt of my revocation and that any action taken before Standard receives my written revocation will be valid.

I acknowledge that I have read and received a copy of the Disclosure Notice-Information Practices. A copy of this Authorization will be provided to me upon request. A photocopy or facsimile of this Authorization is as valid as the original. Any alteration made to this Authorization will render it invalid and unacceptable by Standard.

Signature of (Proposed) Insured	Date of Signature
Name (*please print*)	Date of Birth