Standard Insurance Company

Individual Division – Executive Benefits
1100 SW Sixth Avenue Portland OR 97204-1093

Application Packet for Disability Income Insurance
Disclosure Notices

To help Standard Insurance Company (The Standard) determine your eligibility for insurance, we may request information from other persons or organizations such as your doctor or hospital, insurance companies, or the Medical Information Bureau (MIB). We will do this using the authorization which you sign as part of your application.

CONSUMER REPORTS: We may ask a consumer reporting agency to prepare an investigative consumer report. The report may include information regarding such things as your occupation, avocations, aviation activity, finances, and drug and alcohol use. Information for the report may be obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. If we request a report and you wish to be interviewed, please let us know in writing and we will notify the consumer reporting agency.

You have a right to receive a copy of the consumer report from the consumer reporting agency. For information on how to obtain a copy please contact us at the address listed above.

MEDICAL INFORMATION BUREAU (MIB): Information regarding your insurability and/or any past or future claims will be treated as confidential. However, The Standard or its reinsurers may make a brief report to the MIB. The MIB is a nonprofit corporation which operates an information exchange on behalf of member life insurance companies. If you later apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply that company with the information in its file. The Standard or its reinsurers may also release information in their files to additional reinsurers or to other insurance companies to whom you may apply for life or health insurance or submit a claim for benefits.

At your request, the MIB will arrange disclosure of information it has in your file. If you question the accuracy of the MIB's information, you may contact the MIB and seek a correction in accordance with the procedures outlined in the Federal Fair Credit Reporting Act. The address of the MIB information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. The telephone number is 617-426-3660.

DISCLOSURE TO OTHERS: Personal information about you obtained during the underwriting process is confidential. It will not be released to persons or organizations without your authorization except to the extent necessary for the conduct of our business or as permitted or required by law.

DISCLOSURE TO YOU: In general, you have the right to learn the nature and substance of any personal information about you in our file. You also have a right to ask us to correct or amend such information, if necessary. We will carefully review your comments and make requested changes where justified. To obtain further information on these rights and on The Standard's information practices in general, please contact the Executive Benefits Underwriting Department at the address on the top of this page and ask for a copy of our Notice of Information Practices.

FRAUD NOTICE: 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 subjects such person to criminal and civil penalties.

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Application

PROPOSED INSURED *(All references to "you/your" mean the Proposed Insured.)*

Full Name: *(Last, First, Middle)*			Employee Identification Number:		
Home Address:			City:	State:	Zip Code:
Sex: ☐ Male ☐ Female	Date of Birth:	State of Birth:	E-mail Address:		

Have you used tobacco or nicotine in any form (cigarettes, pipe, cigar, gum, patch, other) in the last 12 months? ☐ Yes ☐ No

Are you a U.S. citizen? ☐ Yes ☐ No If No, what country? Type of Visa: ☐ Perm ☐ Temp

INSURANCE APPLIED FOR

Disability Income

Maximum Monthly Amount	Benefit Waiting Period	Maximum Benefit Period
$ _____	**180** Days	☐ 2 yr. ☐ 5 yr. ☑ to age 65 ☐ Other:_____ .

Own Occupation Period: ☐ 2yr. ☐ 5 yr. ☑ to end of Maximum Benefit Period

Maximum Recovery Benefit Period: ☑ None ☐ 6 mo. ☐ 12 mo. ☐ Other:_____ .

Return to Work Incentive Period: ☐ None ☐ 6 mo. ☑ 12 mo. ☐ Other:_____ .

Preexisting Condition: ☐ 3/12 ☐ 6/24 ☑ None

Mental Disorder and Substance Abuse Limitation Period: ☐ 2 yr. ☐ 5 yr. ☑ None

Optional Riders

☑ Noncancelable
☐ Cost of Living *(Choose one.)*: ☐ 1 yr ☐ 3 yr ☐ 5 yr
☐ LTD Insurability Option
☐ Other Limited Conditions *(Choose one.)*: ☐ 2 yr ☐ 5 yr
☐ Catastrophic *(Choose one.)*: ☐ Insured ☐ Insured and Spouse ☐ Insured and Spouse/Domestic Partner
☐ Lifetime Security
☑ Other: **Modified Benefit Waiting Period** .

Occupation Class: ☐ 5A ☐ 4A ☐ 3A ☐ Other:_____ .

OWNER IF OTHER THAN PROPOSED INSURED *(The Owner must sign the application after the Proposed Insured.)*

Name: **NOT APPLICABLE**	Taxpayer I.D.:	Relationship to Proposed Insured:	
Address:	City:	State:	Zip Code:

PREMIUM PAYOR AND METHOD OF PAYMENT

Who will pay for this insurance? ☐ Employer ☐ You and Employer ☑ You

Will the employer contribution be included in your taxable income? ~~☐ Yes ☐ No~~ **NOT APPLICABLE**

List Bill Mode: ☑ Monthly ☐ Other: | List Bill Number *(if existing):*

Requested Policy Effective Date:

OCCUPATION INFORMATION

Employer Name: **University of Pennsylvania**	Primary Occupation:

Employer Address *(City, State, Zip Code)*: **3401 Walnut Street, Philadelphia PA 19104**

Have you been working Actively At Work on a full-time basis (minimum of 30 hours per week) for the last 6 months? ☐ Yes ☐ No

If No, explain:

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PROPOSED INSURED

Full Name: *(Last, First, Middle)*	Employee Identification Number:

OTHER DISABILITY INSURANCE

Explain yes answers in table below. Use status and type codes provided.

a. Have you applied for any disability insurance in the last 12 months? ☐ Yes ☐ No
b. Is there any other disability insurance currently in force or pending on you? ☑ Yes ☐ No
c. Will you become eligible for any disability insurance in the next 12 months? ☐ Yes ☐ No

STATUS Codes: Now In Force (N); Pending (P); Applied for in Last 12 Months (A); Will Become Eligible in the Next 12 Months (F).
TYPE Codes: Individual (I); Group (G); Association (X); Accident/Health/Sickness (H); Other (O).

Company and Policy Number	Status	Type	Year Applied For	Monthly Benefit	Waiting Period	Benefit Period	Will this insurance be reduced or replaced?
University of Penn LTD	**N**	**G**			**180**	**T65**	☐ Yes* ☑ No
							☐ Yes* ☐ No
							☐ Yes* ☐ No

*Please complete and submit state required replacement forms if needed.

FINANCIAL INFORMATION

Current Gross Annual Base Salary:	$	Current Annual Bonus or Incentive:	$ **NOT APPLICABLE**
Prior Year Gross Annual Base Salary:	$ **NOT APPLICABLE**	Prior Year Annual Bonus or Incentive:	$ **NOT APPLICABLE**

MEDICAL INFORMATION FOR CATASTROPHIC BENEFIT AND/OR LIFETIME SECURITY BENEFIT *(Proposed Insured Only.)*

Explain yes answers in REMARKS AREA.

1. Do you currently require hands-on assistance or standby assistance to perform any of the Activities Of Daily Living? Activities Of Daily Living means: bathing; continence; dressing; eating; toileting; or transferring. ☐ Yes ☐ No
2. Are you currently receiving, or have you received in the past 12 months:
   a. Nursing Home Care (in a nursing home or in a nursing home unit of a hospital)? ☐ Yes ☐ No
   b. Home Health Care (nurse, therapist or health aide visits)? ☐ Yes ☐ No
   c. Adult Day Care Services? ☐ Yes ☐ No
3. In the last 5 years, have you had; been medically diagnosed as having; or do you currently have any of the following conditions:
   a. Organic Brain Syndrome; Senility; Dementia; or Alzheimer's Disease? ☐ Yes ☐ No
   b. Parkinson's Disease; Muscular Dystrophy; Multiple Sclerosis; Myasthenia Gravis; Amyotrophic Lateral Sclerosis (ALS); Huntington's Chorea; Multiple Strokes; Multiple Transient Ischemic Attacks (TIAs); Ataxia; or Hydrocephalus? ☐ Yes ☐ No

NOT APPLICABLE

REMARKS AREA:

Write in the number of months you are paid over a 12 month period, if fewer than 12 months. _____

HOME OFFICE USE ONLY – CORRECTIONS AND AMENDMENTS:

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Application Packet for Disability Income Insurance
Application Agreement/Authorization

AGREEMENT TO OBTAIN AND DISCLOSE INFORMATION

AGREEMENT: I, THE UNDERSIGNED, AGREE TO THE FOLLOWING: This application and all signed application supplements and any amendments will be attached to and become part of the Policy, if issued. I understand Standard Insurance Company (The Standard) will rely on this information in considering my eligibility for various levels of insurance and premium rates. This application will not be effective unless signed and dated by the proposed insured and the owner, if different. In this application, "you" or "your" means the proposed insured unless otherwise specified. **No insurance will be in force unless: a policy is issued and delivered to the Owner; and the first full premium is paid while all answers in the application remain true and complete.** The only exceptions are provided in a Disability Income Insurance Conditional Receipt issued at the same time as and in conjunction with this application. No sales person or medical examiner is authorized to judge insurability or change any of The Standard's requirements. Any corrections or amendments under HOME OFFICE USE ONLY will be ratified when the Policy is accepted, in writing, by the Owner. However, any change as to amount, classification, plan, or benefit may not be made without written Owner approval. Any disability income policy(ies) listed under OTHER DISABILITY INSURANCE will be permanently terminated or reduced if listed as such. The Standard will rely on such information in determining the amount of disability income insurance it will issue. If the insurance is not terminated or reduced, any policy issued and accepted may be rescinded and all premiums returned. If any insurance is intended to replace other insurance in force with The Standard, The Standard insurance being replaced will terminate the moment the insurance applied for becomes effective. I have read the application and understand that any false statements or misrepresentations may result in loss of coverage. I REPRESENT that all answers in this application are correctly recorded and are complete and true to the best of my knowledge and belief.

☐ This application is C.O.D. or ☐ I have paid $_____ with this Application for Disability Income Insurance. Payment must equal or exceed one month's premium for the Policy applied for. If money was paid, I have been given the Disability Income Insurance Conditional Receipt. I have read, understand, and agree to its terms, exclusions, and limitations. I also understand and agree that: the Policy Effective Date may be the result of employer negotiations; this date may be the same as that Requested Policy Effective Date shown in this application or as later changed before issue.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health: any physician, medical practitioner, hospital, clinic, the Veteran's Administration, other medical related facility, alcohol or drug treatment facility, insurance (or reinsuring) company, consumer reporting agency, the Medical Information Bureau (MIB) or my insurance agents, family members, friends, neighbors, associates or employers.

TO GIVE THIS INFORMATION: All medical information concerning me, including my medical history, examination, diagnosis, prognosis and treatment of any physical or mental conditions, plus any nonmedical information requested about me. This includes but is not limited to information about occupation, avocations, aviation, finances, tobacco, drug or alcohol use or treatment, and general reputation.

TO THESE PERSONS: The Standard, its reinsurers, and any consumer reporting agency with whom The Standard does business. NOTE: The MIB may not disclose information to any consumer reporting agency.

I UNDERSTAND THAT the information obtained will be used to determine my eligibility for disability income insurance. My medical records, including any alcohol and drug use information, may be protected under Federal or State regulations and I authorize The Standard to get such information. The Standard or its reinsurers may release this information to the MIB, to other insurers with whom I have or had insurance or may apply for insurance, and to any person performing business or legal services for The Standard in connection with my application.

I, or my authorized representative, have received a copy of the "Disability Income Insurance Disclosure Notices," which includes notice required by the Fair Credit Reporting Act. It also describes the MIB, Inc. I agree that this authorization shall be valid for two and one half years from the date this authorization is signed by me. I may revoke my authorization at any time by sending a written notice to The Standard. I understand that my revocation of the authorization, or my 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. Any action taken before The Standard receives my written revocation at its home office will be valid. I agree that a photocopy of this authorization is as valid as the original. I have received a copy of this authorization.

FRAUD NOTICE: 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 subjects such person to criminal and civil penalties.

Signature of Proposed Insured:	Signed at: *(City, State)*	Date Signed:
Signature of Owner: *(If Other than Proposed Insured.)*	Signed at: *(City, State)*	Date Signed:
Signature of Broker:	Signed at: *(City, State)*	Date Signed:
Print Name of Broker:		

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Application Agreement/Authorization
(Proposed Insured's Copy)

PROPOSED INSURED

Full Name: *(Last, First, Middle)*	Employee Identification Number:

AGREEMENT TO OBTAIN AND DISCLOSE INFORMATION

AGREEMENT: I, THE UNDERSIGNED, AGREE TO THE FOLLOWING: This application and all signed application supplements and any amendments will be attached to and become part of the Policy, if issued. I understand Standard Insurance Company (The Standard) will rely on this information in considering my eligibility for various levels of insurance and premium rates. This application will not be effective unless signed and dated by the proposed insured and the owner, if different. In this application, "you" or "your" means the proposed insured unless otherwise specified. **No insurance will be in force unless: a policy is issued and delivered to the Owner; and the first full premium is paid while all answers in the application remain true and complete.** The only exceptions are provided in a Disability Income Insurance Conditional Receipt issued at the same time as and in conjunction with this application. No sales person or medical examiner is authorized to judge insurability or change any of The Standard's requirements. Any corrections or amendments under HOME OFFICE USE ONLY will be ratified when the Policy is accepted, in writing, by the Owner. However, any change as to amount, classification, plan, or benefit may not be made without written Owner approval. Any disability income policy(ies) listed under OTHER DISABILITY INSURANCE will be permanently terminated or reduced if listed as such. The Standard will rely on such information in determining the amount of disability income insurance it will issue. If the insurance is not terminated or reduced, any policy issued and accepted may be rescinded and all premiums returned. If any insurance is intended to replace other insurance in force with The Standard, The Standard insurance being replaced will terminate the moment the insurance applied for becomes effective. I have read the application and understand that any false statements or misrepresentations may result in loss of coverage. I REPRESENT that all answers in this application are correctly recorded and are complete and true to the best of my knowledge and belief.

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TO GIVE THIS INFORMATION: All medical information concerning me, including my medical history, examination, diagnosis, prognosis and treatment of any physical or mental conditions, plus any nonmedical information requested about me. This includes but is not limited to information about occupation, avocations, aviation, finances, tobacco, drug or alcohol use or treatment, and general reputation.

TO THESE PERSONS: The Standard, its reinsurers, and any consumer reporting agency with whom The Standard does business. NOTE: The MIB may not disclose information to any consumer reporting agency.

I UNDERSTAND THAT the information obtained will be used to determine my eligibility for disability income insurance. My medical records, including any alcohol and drug use information, may be protected under Federal or State regulations and I authorize The Standard to get such information. The Standard or its reinsurers may release this information to the MIB, to other insurers with whom I have or had insurance or may apply for insurance, and to any person performing business or legal services for The Standard in connection with my application.

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ANNUAL BENEFIT INCREASE AGREEMENT – CONTRIBUTORY PLAN

I UNDERSTAND AND AGREE TO THE FOLLOWING: By signing this agreement I authorize Standard Insurance Company (The Standard) to increase the amount of my policy's Maximum Monthly Benefit, and any other benefit amount under my policy or any rider attached to it, on any plan anniversary for which The Standard determines my eligibility for such increase is necessary to maintain the plan design agreed upon by The Standard and my employer. My employer must provide verification of earnings to support any such increase. Increases are subject to a minimum qualifying amount and may not exceed the Guaranteed Standard Issue limit approved by The Standard. I may decline an increase or decrease my Maximum Monthly Benefit at any time by submitting a Policy Change Request in writing to The Standard. No further increases will be made after I decline an increase or decrease my Maximum Monthly Benefit, after I cease to be a member of my employer sponsored disability program, or after the annual benefit increase program terminates.

Proposed Insured: (Printed Name)	
Signature of Proposed Insured:	Date Signed:
Signature of Owner: (If other than Proposed Insured)	Date Signed: