Reset

Standard Insurance Company

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

Producer Instructions and Information Report on a Policy Increase Option Application

Note: Any policy and riders issued will be those most comparable to the base policy and riders available at the time of the increase and will be subject to underwriting rules and income limits in effect as of the applicable option date.

1. Prior to completing this application, give the Disclosure Notice - Information Practices (Nonmedical) to the policyowner.
2. Complete all questions and obtain required income documentation. See **Understanding Income Documentation** for documentation requirements. If applying for an increase option on a Business Overhead Protector or Business Equity Protector policy, include the appropriate Application Supplement.
3. Complete the Producer Information Report below. Use Remarks to note special instructions or requests.
4. Submit to your master general agent (MGA) or Securian managing partner (SMP). Include a copy of the sales illustration used as the basis for the sale.

Producer Information Report

Producer Name (Please Print)	Producer No.	Agency
Telephone Nos. Primary ( ) Secondary ( )	Email Address	

1. Other producer(s) to receive credit for this application:
   Name (Print) _____ Producer No. _____ Percent_____
   Name (Print) _____ Producer No. _____ Percent_____
   Name (Print) _____ Producer No. _____ Percent_____
2. To the best of your knowledge, is replacement involved or intended to be involved with this application?.....☐ Yes ☐ No
3. Give billing instructions (if other than bill to policyowner):_____
   _____
4. **Remarks.** Note anything not disclosed on the application that might affect the insured's eligibility for an increase.
   _____
   _____
   _____
   _____
   _____

Standard Insurance Company

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

Application for Policy Increase

Proposed Insured

Full Name (First, Middle, Last)			Gender	Social Security No.	
Home Address		City		State	ZIP
Birth Date	State of Birth	Primary Phone No.	Email Address		
Policy No.	Current Primary Occupation (include professional designation, specialty or degree)				
Current Employer					
Employer Address		City		State	ZIP

Insurance Applied For

Disability Income
☐ Purchase/Renew Increase Option:
Increase in Basic Monthly Benefit: $ _____
☐ Accelerated Option - Check reason(s) and provide date(s):
☐ Loss of LTD coverage: Date of loss_____
☐ Increase in income: Date of increase _____
☐ Renew Automatic Increase Benefit

Business Buy-Out Expense*
Increase in Aggregate Benefit Limit: $ _____

Business Overhead Expense*
Increase in Base Amount: $ _____

Other (specify) _____
**Include the appropriate Application Supplement.*

General Information

1. Other than the policy shown above: Is there any individual or group disability insurance currently in force, applied for and pending on you; or for which you are or will become eligible?..... ☐ Yes ☐ No
If yes, please explain in the table below. Use status and type codes. List all individual and group disability policies with any company, including Standard Insurance Company; but do not list the policy number referenced above.

Status Codes: **N** - now in force with any company; **P** - applied for and pending; **F** - will become eligible in the next 24 months
Type Codes: **I** - individual; **G** - group; **X** - association; **OE** - overhead expense; **L** - loan repayment; **O** - other

Company	Status	Type	Who pays premium?	Benefit amount or % of income	If group: Benefit maximum	If group: Bonus covered?	Benefit period	Waiting period	Will coverage be replaced or reduced?
						☐ Yes ☐ No			☐ Yes ☐ No
						☐ Yes ☐ No			☐ Yes ☐ No
						☐ Yes ☐ No			☐ Yes ☐ No

2. Are you currently receiving or entitled to receive disability benefits from Workers' Compensation, Social Security, or any other source? ..... ☐ Yes ☐ No
If Yes, please explain:
_____

3. How many hours a week do you work in your primary occupation? _____

4. How much of the premium for this increase will be paid by your employer? ☐ None ☐ 100% ☐ Other _____%
If premium paid by employer, will the employer's contribution be added to your taxable income? ..... ☐ Yes ☐ No

5. Do you own any part of or are you an independent contractor for the business where you work? ..... ☐ Yes ☐ No
If Yes, please answer a, b and c.
a. Business entity: ☐ C Corp ☐ S Corp ☐ LLC ☐ LLP ☐ Sole Proprietor ☐ Partnership
☐ Other _____
b. Number of employees: Full-time _____ Part-time _____
c. Percent of business entity owned _____% Years owned _____

6. Your annual earned income from your primary occupation: Current year $ _____ Last year $ _____
   If you are self-employed, earned income is after business expenses. Do not include investment or other passive income. Please explain any significant fluctuations between years.

   _____

   _____

   _____

Agreement and Signatures

I, the undersigned, understand and agree to the following:

This application includes pages 1 and 2 and all attached application supplements and amendments. In this application, "you" and "your" mean the proposed insured unless otherwise specified.

Standard Insurance Company (Standard) will rely on the information given in this application in considering the Insured's eligibility for insurance and for various premium rates. This application will become part of any policy issued by Standard based on this application. If an increase to an existing policy is issued, this application will become part of that existing policy.

This application will not be effective unless it is signed and dated by the Insured and Owner, if different. **No insurance will be in force unless: (a) a policy, or an increase in coverage to an existing policy, is issued, delivered to and accepted by the Owner; and (b) the first full premium is paid, while all answers in this application remain true and complete.**

No sales representative is authorized: (a) to determine insurability; (b) to change any of Standard's requirements; or (c) to waive any rights Standard may have. No corrections or amendments to this application may be made without the Owner's written consent.

Standard may require that any disability policy(s) listed in answer to Question 1 be permanently terminated or reduced as a condition of issuing the insurance applied for. If such insurance is not terminated or reduced as required by Standard, any policy, or increase in coverage to any existing policy, issued and accepted pursuant to this application may be rescinded. This means it would be considered void from the beginning and all premiums would be returned. Standard will rely on the information given in answer to Question 1 in determining the amount, if any, of disability insurance it will issue. If any insurance applied for is intended to replace other insurance in force with, or administered by, Standard, the policy(s) being replaced will end the moment the insurance applied for becomes effective.

I have read this application. I understand that if any answers are false, incorrect, or untrue, Standard may have the right to deny benefits or rescind my policy and/or any increase in coverage under an existing policy. **I Represent That:** All answers in this application are correctly recorded, true and complete to the best of my knowledge and belief; and any and all answers I have provided verbally to a Standard producer or other Standard representative have also been correctly recorded. No knowledge of any fact on the part of any sales representative shall be considered to be knowledge of Standard unless such fact is stated in this application. I signed this application in the city and state and on the date shown below.

NOTE: **A person who knowingly presents false information or conceals material information in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.**

_____ Signed at _____ on _____
Signature of Proposed Insured City, State Date

_____ Signed at _____ on _____
Signature of Policyowner (If other than Proposed Insured) City, State Date
If a company is policyowner, signature of authorized representative.

_____ _____
Print Name of Policyowner Owner's Tax ID Number (If other than Proposed Insured)
If a company is policyowner, also print title of authorized representative and company name.

_____ _____
Owner's Address City, State ZIP Email Address

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

Disclosure Notice - Information Practices (Nonmedical)

Standard Insurance Company (Standard) is committed to maintaining the confidentiality of your personal information. In order to offer and administer 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, income and finances. This personal information is obtained and disclosed by us in order to evaluate your insurability and determine appropriate premium rates; to support our normal business practices; and to provide quality service in administering policies.

Sources of Information
You and your application for insurance are our primary sources of personal information. We, or our insurance representative, may call you for a personal history interview (PHI) to obtain supplementary information or to confirm information you provide on the application. With your written authorization, we may also collect or verify personal information by contacting: insurance producers, insurance or reinsurance companies, and the MIB, LLC. (see below); employers, and personal and business associates.

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 the MIB, LLC., reinsurers; organizations that perform services or functions on our behalf or to serve you, and to regulatory, law enforcement and governmental authorities. Standard or its reinsurers may also release information in its file 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 adhere to procedures and practices that maintain the confidentiality of your personal information, to use the information only for the limited purpose for which it was shared, and to 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 any 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 information about you, send a signed, written request to the address at the top 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 carefully review your request and, where appropriate, make the necessary change.

MIB, LLC.
Standard, or its reinsurers, may make a brief report to the MIB, LLC. MIB, LLC. 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. Information for consumers about MIB, LLC. may be obtained on its website at www.mib.com.

Additional Information
We hope this information helps you understand how and why we obtain information about you. To obtain 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.

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

Authorization to Obtain and Disclose Personal (Nonmedical) 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 that personal information may include information about my age, occupation, other insurance, income and finances. I also understand that personal information does not include any information related to my physical or mental condition, medical history or medical treatment.

Authorization to Obtain Personal Information

I authorize any insurance or reinsurance company, insurance sales representative, employer, MIB, LLC. 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.

Authorization to Use Personal Information

I authorize Standard to use personal information obtained about me for the purposes of determining eligibility for insurance and reinsurance and 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 any personal information about me to Standard's reinsurers, MIB, LLC., 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.

Expiration and Revocation

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. 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.

This Authorization will expire automatically twenty-four (24) months following the date of my signature below.

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, or my authorized representative, 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)*

Print