

Standard Insurance Company

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

Application for Reinstatement or Policy Change

Full Name (First, Middle, Last)		Birth Date	Height	Weight
Policy No.	Telephone No.	Email Address		
	<input type="checkbox"/> Work <input type="checkbox"/> Residence			

The following marked changes are requested on the above policy:

<input type="checkbox"/> Reinstate in accordance with policy provisions	<input type="checkbox"/> Decrease elimination period to _____
<input type="checkbox"/> Reduce or remove rating	<input type="checkbox"/> Increase benefit period to _____
<input type="checkbox"/> Remove policy exclusion	<input type="checkbox"/> Other _____

Financial and General Information

1. Is there any other individual or group disability insurance currently in force or pending on you? Yes No
If Yes, please give the company, type of insurance, and monthly amount; also give benefit period and waiting (elimination) period.

2. What is your current primary occupation? _____

3. Your annual earned income from your primary occupation:
If you are self-employed, earned income is after business expenses.
Do not include investment or other passive income. (Passive income includes: capital gains, interest, dividends, net rental income, pensions, annuities, royalties.)
Current year \$ _____ Last year \$ _____

4. 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 and b.
a. Business entity: C Corp S Corp LLC LLP Sole Proprietor Partnership
 Other _____
b. Percent of business entity owned _____ Years owned _____

5. How many hours per week do you work in your primary occupation? _____ hours per week

6. List job duties and percentage of time spent in each duty:

7. Do you have any other part-time or full-time occupation or employment? Yes No
If Yes, please complete a and b.
a. Your annual earned income from this other occupation or employment: _____
b. Name of employer, job duties and percentage of time spent in each duty:

8. Have you ever applied for life or disability insurance and later withdrawn your application; or have you had it cancelled, declined, postponed, rated, modified or approved other than as applied for? Yes No
If Yes, please provide reasons and details.

9. Have you ever filed a claim for, received or been denied disability benefits from:
Worker's Compensation, Social Security or any other disability insurance? Yes No
If Yes, please provide details.

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10. In the last 10 years, have you had your driver's license suspended or revoked; or have you been arrested for or convicted of reckless driving, driving while impaired or driving under the influence of drugs or alcohol? Yes No
If Yes, please provide details, including offense(s) and dates.

11. Within the last 12 months, have you used tobacco or nicotine in any form including cigarettes, cigar, pipe, vapor, smokeless, gum or patch? Yes No
If Yes, please provide type(s) and frequency of use.

12. In the last 10 years, have you:
a. Used legal or illegal drugs, such as marijuana, cocaine, amphetamines, or narcotics? Yes No
If Yes, please provide details, including substance(s) used and dates.

b. Received (or been advised by a counselor or medical professional to seek) treatment, counseling or support for use of alcohol or prescribed or non-prescribed drugs; or have you been advised by a counselor or medical professional to discontinue the use of alcohol or prescribed or non-prescribed drugs? Yes No
If Yes, please provide details including substance(s), treatment (if any), and dates.

Medical Information

For the remaining questions: Explain all Yes answers. Give reasons, diagnoses, dates, durations, severity, treatments and results. Also provide names and addresses of all medical professionals and facilities.

13. To the best of your knowledge, in the last 10 years have you had, been told you had, been treated or advised by a medical professional for, or been diagnosed as having:
a. Disorder of the eye, ear, nose, throat or skin (such as glaucoma, cataracts, iritis, Meniere's disease, eczema or psoriasis)? Yes No

b. Any mental, emotional, adjustment or psychiatric disorder (such as anxiety, depression, nervousness or stress; or post-traumatic stress disorder (PTSD); or panic disorder or bipolar disorder)? Yes No

c. Stroke, headaches or migraines, dizziness, vertigo or restless leg syndrome; or any other disease or disorder of the brain or nervous system (such as seizure, paralysis, mental deficiency, multiple sclerosis, attention deficit disorder (ADD), dementia or Alzheimer's disease)? Yes No

d. Fibromyalgia, chronic fatigue or any other disease or disorder of the immune system or lymph glands (such as reactive or rheumatoid arthritis, lymphedema, Graves's disease or lupus)? Yes No

e. Kidney, urinary system or prostate disorder (such as kidney stones, chronic kidney disease, interstitial cystitis, enlarged prostate or prostatitis)?..... Yes No

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f. Sleep apnea, asthma or bronchitis; or any other disease or disorder of the lungs or respiratory system (such as narcolepsy, chronic insomnia or hypersomnia; or shortness of breath, pleurisy, cystic fibrosis or chronic obstructive pulmonary disease)? Yes No

g. High blood pressure, chest pain, heart murmur or irregular heart beat; or any other disease or disorder of the heart, blood or blood vessels (such as coronary artery disease, aneurysm, atrial fibrillation, anemia, platelet disorder, deep vein thrombosis or peripheral artery disease)? Yes No

h. Hepatitis, colitis, or ulcer; or any other disease or disorder of the liver, gallbladder, pancreas or digestive tract (such as gastrointestinal reflux disease, Barrett's esophagus, esophagitis, intestinal bleeding or diverticulitis)? Yes No

i. Diabetes, pre-diabetes, impaired glucose tolerance or thyroid disorder; or any other disease or disorder of the endocrine system (such as metabolic syndrome, hypoglycemia, hyperglycemia, hypothyroidism, pituitary dysfunction or high cholesterol)?..... Yes No

j. Complications of pregnancy, C-section or infertility; or any disorder of the breasts, reproductive or genital organs (such as fibrocystic breast disease, uterine fibroids, polycystic ovarian syndrome or endometriosis)? Yes No

k. Cyst, growth, polyp, tumor or cancer (such as leukemia, lymphoma, carcinoma, sarcoma or melanoma)?..... Yes No

l. Back or neck pain or disc problems; arthritis or carpal tunnel syndrome; or any other disease, disorder or injury of the bones, joints, nerves or muscles (such as gout, degenerative joint or disc disease, osteoporosis, neuritis or atrophy)? Yes No

14. To the best of your knowledge, in the last 10 years, have you been told you had, been treated for or been diagnosed as having any sexually transmitted disease or acquired immune deficiency syndrome (AIDS)? Yes No

15. Are you currently pregnant? Yes No
If Yes, estimated date of delivery: _____

16. Other than as stated in other answers, have you within the last 5 years:
a. Been hospitalized or been seen by a physician, chiropractor, counselor, psychiatrist, therapist or other medical professional? Yes No

b. Had an EKG, blood test or sleep study; or other medical procedure, study or test (except tests related to HIV)? Yes No

This endorsement is part of the application.

STANDARD INSURANCE COMPANY
1100 SW Sixth Avenue Portland, OR 97204
Individual Disability Insurance
800-247-6888

APPLICATION ENDORSEMENT

Effective January 1, 2023

This Endorsement amends the application, including any application supplements, as follows:

The fraud notice is changed to read:

For your protection California law requires the following to appear on this form:

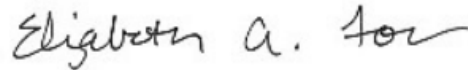
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

STANDARD INSURANCE COMPANY

By



Daniel J. McMillan
President and CEO



Elizabeth A. Fouts
Corporate Secretary

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 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, health and medical history, personal characteristics and activities, avocations, income and finances. This personal information is obtained and disclosed by us in order to evaluate your insurability, determine appropriate premium rates, support our normal business practices and 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 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 physicians, medical professionals, health care providers, hospitals, clinics, pharmacies and other medical or medically-related facilities; consumer reporting agencies, insurance sales representatives, insurance support organizations, insurance or reinsurance companies, and the MIB, LLC (see below); employers, and personal and business associates. We may also request that you have medical examinations 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 the MIB, LLC, reinsurers, organizations or persons, including insurance sales representatives, that perform services or functions on your or our behalf, and to regulatory, law enforcement or governmental authorities. 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 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 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 carefully review your request and, where appropriate, make the necessary change.

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, general reputation, personal characteristics and activities and mode of living. The consumer reporting agency may obtain information for the report through personal interviews with your family members, friends, neighbors 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. On written request, we will disclose to you whether or not such a report was done and provide 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 and we will give you the name and address of the consumer reporting agency.

MIB, LLC: We, or our 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 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 be in paper or electronic format and 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 medical records, in paper or electronic format, containing 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, LLC, 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, 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, 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. 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

Name of (Proposed) Insured/Patient (please print)

Date of Birth

I authorize any licensed physician, medical professional, health care provider, hospital, medical or medically-related facility, laboratory, clinic, pharmacy, alcohol or drug treatment facility that has provided medical treatment, care or services to me to disclose my entire medical record and any other health information **solely relating to psychotherapy notes** to Standard Insurance Company (“Standard”) or an insurance support organization acting on behalf of Standard. Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of my medical record.

By my signature below, I acknowledge that any agreements that I have made to restrict my health information do not apply to this Authorization and I instruct my health care providers to release and disclose my entire medical record relating to psychotherapy notes without restriction.

I understand that the health information to be disclosed to Standard will be used 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. I also 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.

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 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 collection, use or disclosure of information prior to Standard’s receipt of my revocation and any action taken before Standard receives my written revocation will be valid.

I acknowledge that I have read this Authorization and that I have the right to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization is as valid as the original.

Signature of (proposed) Insured/Patient

Date