Standard Insurance Company

Reset

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. ☐ Work ☐ Residence	Email Address		

The following marked changes are requested on the above policy:

☐ Reinstate in accordance with policy provisions
☐ Reduce or remove rating
☐ Remove policy exclusion
☐ Decrease waiting period to _____
☐ Increase benefit period to _____
☐ 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 Have you ever applied for life or disability insurance and later withdrawn your application; or have you had it cancelled, declined, postponed, rated, modified or approved other than as applied for?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 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.
   _____
   _____

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 marijuana, cocaine, amphetamines, or narcotics; or any other legal or illegal drug? ☐ 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. In the last 10 years have you had, been told you had, been treated or seen by a medical professional or been diagnosed as having:
    a. Disorder of the eye, ear, nose, throat or skin? ☐ Yes ☐ No

       _____

       _____

    b. Anxiety, depression, nervousness, stress or post-traumatic stress disorder (PTSD); or any other mental, emotional, adjustment or psychiatric disorder? ☐ Yes ☐ No

       _____

       _____

    c. Stroke, seizure, paralysis, headaches or migraines; or mental deficiency, dizziness or fainting; or restless leg syndrome; or Attention Deficit Disorder (ADD); or any other disease or disorder of the brain or nervous system? ☐ Yes ☐ No

       _____

       _____

    d. Fibromyalgia, chronic fatigue, rheumatoid arthritis or lupus; or any other disease or disorder of the immune system? ☐ Yes ☐ No

       _____

       _____

    e. Kidney, urinary system or prostate disorder? ☐ Yes ☐ No

       _____

       _____

f. Sleep apnea, asthma or bronchitis; or any other disease or disorder of the lungs or respiratory system? ☐ Yes ☐ No

g. High blood pressure, chest pain, heart murmur, irregular heart beat or anemia; or any other disease or disorder of the heart, blood or blood vessels? ☐ Yes ☐ No

h. Hepatitis, colitis, or ulcer; or any other disease or disorder of the liver, gallbladder, pancreas or digestive tract? ☐ Yes ☐ No

i. Diabetes, pre-diabetes, impaired glucose tolerance or thyroid disorder; or any other disease or disorder of the glandular systems? ☐ Yes ☐ No

j. Complications of pregnancy, C-section or infertility; or any disorder of the breasts, reproductive or genital organs? ☐ Yes ☐ No

k. Cyst, growth, polyp, tumor, leukemia or cancer? ☐ 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? ☐ Yes ☐ No

14. In the last 10 years, have you tested positive for exposure to human immunodeficiency virus (HIV) infection; or have you been diagnosed as having acquired immune deficiency syndrome (AIDS) caused by the HIV infection, or any other sickness or condition derived from such infection? ☐ 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

c. Been advised by a medical professional to have any diagnostic test (except those related to HIV), medical care, surgery or hospitalization that was not completed? ☐ Yes ☐ No

17. Other than as stated in other answers, have you within the last 3 years:
    a. Taken any prescription or non-prescription medicine or supplement?..... ☐ Yes ☐ No

    _____

    _____

    b. Had any physical or mental condition or symptom that has not been treated or diagnosed? ..... ☐ Yes ☐ No

    _____

    _____

18. **Remarks.** (Use this space for any additional information or details regarding any of the above questions.)

    _____

    _____

    _____

    _____

    _____

    _____

Terms and Agreement

1. In this form, "you/your" means the insured named on this application. "We/us/our" and "Standard" mean Standard Insurance Company.
2. Reinstatement and all changes are subject to the policy's provisions and our rules and procedures. This application and all changes made pursuant to it will become part of the policy.
3. To reinstate or make a change, the following may be required: (a) payment of any premium or fee as we determine; and/or (b) any other information we determine is necessary.
4. Reinstatement and/or any change(s) will take effect only when all of our requirements are met and we have given our approval. Once approved, we will notify the owner of the effective date of the reinstatement and/or change(s).
5. If a policy is reinstated or changed on the basis of this application, any corrections or amendments made to this application will be ratified by policy endorsement signed by the owner and made part of the policy.
6. We cannot contest any changes, insurance benefits or reinstatement as a result of this application after two years from the effective date of the reinstatement and/or change, except for fraudulent misrepresentation in this application.
7. I, the undersigned owner and insured, have read this application and **understand** that: (a) Standard will rely on this information in considering my eligibility for reinstatement, change(s), or various premium rates; and (b) Standard may have the right to deny benefits or rescind the policy if any statements are false, incorrect or untrue. I **Represent That** all answers to the above questions are correctly recorded, complete and true to the best of my knowledge and belief; and any and all answers I have provided verbally to a Standard agent have also been recorded in this application.

   I, the undersigned insured, have received a Disclosure Notice-Information Practices.

NOTE: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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

_____ Signed at _____ on _____
Signature of Owner (if other than insured) — City, State — Date

_____ Signed at _____ on _____
Signature of Producer/Agent (if present) — City, State — Date

_____ _____
Name of Producer/Agent (if present – print) — Florida License Identification Number

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

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

Authorization for Release of Personal Psychotherapy Notes to Standard Insurance Company

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 _____

Print