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. ☐ 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 Have you ever applied for life or disability insurance and later withdrawn your application; or have you had it cancelled, declined, postponed, rated, modified or approved other than as applied for?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. In the last 5 years, have you 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 5 years, have you had your driver's license suspended or revoked; or have you been convicted of 3 or more moving violations; or have you been 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 except as prescribed by a medical professional? ☐ Yes ☐ No
   If Yes, please provide details, including substance(s) used and dates.

   b. Received, or been advised by a 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 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. Provide details including dates, durations, test results (except tests related to HIV), diagnoses and treatments. Also provide names and addresses of all medical professionals and facilities.

13. In the last 10 years have you been diagnosed as having, or been treated or tested positive for, or been given medical advice by a medical professional for:
   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 been treated for or been diagnosed by a medical professional as having human immunodeficiency virus (HIV) 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

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 taken any prescription or non-prescription medicine or supplement?........ ☐ Yes ☐ No

____
____

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

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____
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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 producer or other Standard representative have also been recorded in this application.

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

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 Insured — City, State — Date

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

____________________ Signed at ________________ on __________
Signature of Producer (if present) — City, State — Date

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

Disclosure Notice - Information Practices

In this Disclosure Notice, “we,” “us” and “our” mean Standard Insurance Company. “You” and “your” mean the Proposed Insured.

Sources of Information: In order to offer and service insurance, we rely mainly on the information you provide in your application. We may also request that you have medical exams and tests; and we, or our representative, may call you for a personal history interview (PHI) to obtain additional information or to confirm information you gave us. We may also collect personal information about you from others such as: medical professionals, consumer reporting agencies and other insurance companies; and/or we may obtain an investigative consumer report. Your signed Authorization allows us to obtain personal information from such sources and to share some items of information when necessary.

Disclosure of Information: Your personal information will be treated as confidential by us. We will not release your personal information unless it is necessary to conduct our business or required by law. In some circumstances, as allowed by law, we may release some items of information to third parties, without your authorization. When we do this, we expect the parties to: (a) keep your information confidential; (b) use it only for the purpose for which it was shared; and (c) abide by all applicable federal and state privacy laws.

Your Right to Access and Correction of Information: In general, you have a right to know the personal information about you that we have in our files. This includes information contained in an investigative consumer report if one was conducted. You have a right to obtain a copy of the information we have about you, subject to some restrictions. You also have the right to seek correction of information you believe is not accurate.

Additional Information: The above is a general description of our information practices. If you wish to receive a more detailed explanation of these practices and your rights, please send your request to us at: Standard Insurance Company, Individual Disability Insurance Underwriting, 1100 SW Sixth Ave., Portland, OR 97204-1093.

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Disclosure Notice – MIB, LLC Pre-Notice and Investigative Consumer Reports Notice

MIB, LLC PRE-NOTICE: We, or our reinsurers, may make a brief report to the MIB, LLC, formerly known as Medical Information Bureau. 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.

INVESTIGATIVE CONSUMER REPORTS NOTICE: We may ask that an investigative consumer report be prepared about you. If we do, this report will be done by an independent source. This source is 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: your family members; your friends or neighbors; and 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.

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Authorization to Obtain and Disclose Information

Types of Personal Information Collected
I understand that: Standard Insurance Company (Standard) must collect and review personal information about me in order to offer and service its products. This personal information about me may include information about: my age, my occupation and my avocations; my driving record; my travel and aviation; my character and my general reputation; my personal characteristics and activities; my mode of living; and my income and finances, and other insurance.

My personal information may also include health information such as: my medical history; exams, diagnoses, and prognoses; test results and prescriptions; and treatments of physical or mental conditions.

Authorization to Obtain Personal Information
I authorize: MIB, LLC; any licensed medical professional or health care provider; hospital or medical or medically related facility; clinic or pharmacy; alcohol or drug treatment facility; insurance or reinsurance company, or insurance sales representative; consumer reporting agency or government office; employer, or any other person or organization that has records or knowledge of me;

To give my personal information: to Standard and its reinsurers; and to any insurance support organization acting on behalf of Standard.

I authorize Standard to request and obtain an investigative consumer report about me. If this is done, it will be as described in the Disclosure Notice - Information Practices.

Authorization to Use Personal Information
I authorize Standard to use my personal information: to evaluate my eligibility for insurance and reinsurance; and to determine appropriate premium rates; and to carry out other activities allowed by law that relate to my application or to my coverage.

Authorization to Disclose Personal Information
I authorize Standard to disclose personal information about me: to Standard's reinsurers and to MIB, LLC; and to other companies to whom I have applied or may apply for insurance; and to persons or entities that perform business services for Standard that relate to my application or my policy. No other disclosure may be made unless I authorize it, except to the extent necessary for Standard to conduct its business, or as allowed by law, or as required by law. I understand: that any health information that is disclosed pursuant to this Authorization may be redisclosed as allowed by law or as required by law; and that such redisclosed information may not be protected by the federal laws that govern the privacy and confidentiality of health information.

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

Expiration and Revocation
This Authorization will expire twenty-four (24) months following the date I sign it below. I understand that I have the right to revoke this Authorization at any time. If I want to revoke this Authorization I must send a written request for revocation to Standard at its home office. Revoking this Authorization, or failing sign it, or refusing to sign it, will impair Standard's ability to evaluate or process my application. It may also be a basis for denying the coverage I apply for. I realize: that if I do revoke this Authorization, any use or release of information that occurred prior to Standard's receipt of my revocation will not be affected; and that any action taken before Standard receives my written revocation will be valid.

I acknowledge that I have read and I have received a copy of the Disclosure-Notice Information Practices. A copy of this Authorization form will be given to me, or to my authorized representative, upon request. A photocopy or facsimile of this Authorization form is as valid as the original. If this Authorization form is altered in any way, it will be invalid and Standard will not accept it.

______________________________ ______________________________

Signature of (Proposed) Insured | Date of Signature

______________________________ ______________________________

Name (*please print*) | Date of Birth

Standard Insurance Company

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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 ______________________