

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"/> Reinstatement in accordance with policy provisions	<input type="checkbox"/> Decrease waiting 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 Have you ever applied for life or disability insurance and later withdrawn your application; or have you had it cancelled, declined, postponed, rated, modified or approved other than as applied for?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 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 been treated for or been diagnosed 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:
- 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 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.

Signature of Insured

Signed at _____ on _____
City, State Date

Signature of Owner (if other than insured)

Signed at _____ on _____
City, State Date

Signature of Producer (if present)

Signed at _____ on _____
City, State Date

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 and security of your personal information. To help clarify the sources and uses of information necessary to process your application for insurance, reinstatement, or change in insurance benefits, and to help you understand how we protect your personal information, this notice describes our current privacy policy and practices.

Collection of Information

In order to properly underwrite your application for insurance and to administer your insurance coverage, we must obtain and review a certain amount and type of personal information about you. The types of information we collect may vary, depending on the amount and kind of insurance applied for or purchased. In general, we may seek information about your age, occupation, health and medical history, personal characteristics and activities, avocations, income and finances.

You and your application for insurance are our primary source 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 your application. In addition, with your written authorization, we may 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 collect personal information from these sources by telephone, in writing or electronically, and from any medical exam or test that we may require.

In some cases 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. If you would like a copy of the investigative consumer report from the consumer reporting agency, please contact us and we will give you the name and address of the consumer reporting agency. The information contained in the report may be retained by the consumer reporting agency and later disclosed to other persons or organizations to the extent permitted by the federal Fair Credit Reporting Act.

We, or our reinsurers, may make a brief report to 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.

Disclosure of Information

Standard regards all your personal information as confidential. However, in the course of conducting our business, there are circumstances in which we may disclose to other persons or organizations information we have about you. Such disclosures are made only with appropriate authorization from you or as permitted or required by law. The authorization that you signed with your application allows us to disclose information to our reinsurers, MIB, LLC and other insurance companies to whom you have applied or may apply for insurance. It also permits us to disclose information to persons or organizations who provide business services for us in regard to your application or insurance coverage.

As permitted by law, Standard may disclose personal information to other persons or organizations without your authorization. This may include the following:

- We may disclose personal information to your Standard sales representative in order to administer your business and provide you with quality service regarding your insurance needs.
- We may disclose personal information to a physician, medical professional or facility in order to inform you of medical information of which you may not be aware or to verify insurance coverage or benefits.

- We may disclose personal information to law enforcement officials and agencies, at their request, to help prevent or prosecute the perpetration of fraud or to investigate illegal activities.
- We may disclose personal information to respond to judicial process or government regulatory authorities having jurisdiction over us for examination, compliance or other purposes authorized by law.
- We may disclose personal information, in de-identified format, to professional organizations conducting actuarial or scientific research studies for the insurance industry or the medical profession.
- We may disclose personal information to comply with a properly authorized civil, criminal or regulatory investigation, or subpoena or summons by federal, state or local authorities.

While often times it is necessary for us to engage the services of other persons or organization to assist us conduct our business, please be assured that we expect them to maintain the confidentiality of your personal information and to abide by all applicable federal and state privacy laws. Furthermore, we do not authorize any person or organization to use or disclose your personal information for any purpose other than performing insurance functions on our behalf or as required by law.

If your relationship with Standard should end, we will continue to limit disclosures of your personal information in accordance with our stated privacy policy and practices, just as we do for those with a continuing relationship with us.

Access to Information

We want to make sure that we have accurate information about you. Generally, upon written request and after proper identification, you may learn the nature and substance of personal information about you recorded in our files and review or obtain a copy of that information, with limited restrictions. To obtain the nature of such information, please send us your full name, address, the policy number(s) under which you are insured and a brief description of the kind of information you wish to review.

Within 30 business days of receipt of your request, we will inform you in writing of the nature and substance of recorded personal information about you in our files and identify any institutional source of that information. We will permit you to review and copy, in person, the recorded personal information pertaining to you or to obtain a copy of the recorded personal information by mail, whichever you prefer. We may charge you for copies of records you request. We will also identify the persons or organizations to whom we disclosed the information within two years (three years with respect to disclosures of medical information) prior to the request.

In addition, upon receiving a written request to do so, we will include the name, address, and institutional affiliation of those receiving or examining your medical information during the preceding three years. We will also include the date of receipt or examination and, to the extent practicable, a description of the information disclosed. We have the right to disclose medical record information, supplied by a medical professional or medical care facility, only to a licensed medical professional designated by you so that it may be properly explained. If we elect to disclose the medical record information to a medical professional designated by you, we will notify you, at the time of disclosure, that we have provided the information to the medical professional.

Some types of personal information will not be disclosed to you. These include information collected during a claim evaluation process and information involving a civil or criminal proceeding. We will also not disclose psychotherapy records. Information obtained from MIB, LLC or a consumer reporting agency will be processed in accordance with the procedures outlined above.

Correction, Amendment or Deletion of Information

After you have reviewed the personal information in our files, you may request in writing that we correct, amend or delete information which you think is inaccurate. We will provide you with a response to your request within 30 business days. If we agree that certain items of information should be corrected, amended or deleted, we will make the necessary changes and notify you in writing of the changes made. We will then send the change to any person specifically designated by you who may have, within the preceding two years, received recorded personal information about you. We will also notify any insurance support organization, such as MIB, LLC, to whom we systematically disclose information, and any consumer reporting agency that may have originally furnished the information to us.

Standard Insurance Company

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

Disclosure Notice - Information Practices

If we do not agree to make the correction, amendment or deletion, we will inform you of our reason(s) for not changing the information. If you are not satisfied with our explanation, you have the right to file a statement with us, indicating what you think is the correct, relevant or fair information and explaining why you disagree with our determination not to correct, amend or delete the information. Your statement will become part of our file and will be disclosed any time we release the information about which you disagree. In addition, copies of your statement will be sent to any person to whom we have released the original information in the previous two years. If we received the original information from MIB, LLC or a consumer reporting agency, we will provide them with a copy of your statement.

This right to correct, amend or delete information does not apply to personal information maintained by a consumer reporting agency. Correction of this kind of information is regulated by the federal Fair Credit Reporting Act and is the responsibility of the consumer reporting agency that prepared it. We will provide you with the name and address of a consumer reporting agency if you should wish to contact them.

Confidentiality and Security

We have and maintain strict policies and procedures to protect the confidentiality of your personal information during all stages of your relationship with us. We restrict access to information about you to those employees who need to know that information in order to provide products or services to you. We train our employees so that they will understand the importance of maintaining the confidentiality of your personal information. We also maintain physical, electronic and procedural safeguards to protect your personal information from unauthorized access and anticipated threats or hazards.

Information Regarding an Adverse Underwriting Decision

If we have notified you that your requested insurance coverage is declined, in whole or in part, for any reason, your premium is higher than standard rates, or your insurance coverage is terminated for any reason other than failure to pay a premium, you have a right to know the specific reason for the decision. To obtain such information, you must send us a written request within 90 business days after we send you the notice of our decision. Within 21 business days after we receive your request, we will send you written notice of the reason(s) for the decision and provide the information supporting our decision. We will also provide the name and address of any person or organization who supplied us with this information. We reserve the right to disclose specific items of medical record information only directly to a medical professional designated by you.

Where to Write

Please direct any requests regarding our information procedures discussed above to Standard Insurance Company, Individual Disability Insurance Underwriting, P.O. Box 711, Portland, Oregon 97207. Please include, in all correspondence, your name, current address and policy number.

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