Reset

Standard Insurance Company
Medical Underwriting, 900 SW Fifth Avenue Portland OR 97204

P.E.C.G.
Medical History Statement
California

DIRECTIONS FOR APPLYING FOR COVERAGE

Read the Information Practices Notice(s) on page 4. A separate form must be submitted for each applicant (Member, Spouse) when Evidence Of Insurability or Proof of Good Health is required to apply for coverage. Complete all items, date and sign in the space at the bottom of page 5. Keep a copy for your records, and send the original to Standard Insurance Company at the address given above.

MEMBER INFORMATION

Name of Group	Group Number	Type of Application	Date of Employment with the State of California	Date of Membership in P.E.C.G.
P.E.C.G.	**608009 or 641094**	☐ Initial ☐ Increase in Coverage		

Member's Name	Birthdate	Social Security No.	Occupation	Check Who is Applying (One Per Form)
				☐ Member ☐ Spouse

APPLICANT INFORMATION

Applicant's Name (Person to be Insured)	Applicant's Address (Street, City, State, ZIP)	Work Phone ( ) Home Phone ( )

Sex ☐ M ☐ F	Birthdate	Birthplace	Social Security No.	Base Monthly Earnings from the State of California

Please check option desired:

☐ 1. Supplemental Plan *(Member Only)* $26,000
The Medical History Statement must always be completed if you have been employed by the State of California more than 90 days.
Please complete the Beneficiary Designation below and then, if applicable, answer the medical questions on page two.

☐ 2. Basic Dependents Life *(Spouse)* $5,000
If you do not apply for Basic Dependents Life within 31 days of your approval for Supplemental Life, your dependents will need to complete the Medical Questions on page two. Your Dependents may become insured for Basic Dependents Life only if you are insured under the Supplemental Plan (option 1 above). **Please have each Dependent complete a separate medical history statement, if applicable.**

☐ 3. Supplemental Plus *(Member Only)* Any Multiple of $15,000, up to $495,000. (E.g. $15,000, $30,000, $45,000, $60,000, etc.)
Amount Requested $ _____
The Medical History Statement must always be completed. A physical examination and/or medical records may be required for evaluation. You may become insured under the Supplemental Plus plan only if you are insured under the Supplemental Plan (option 1 above). **Please complete the Beneficiary Designation below and then answer medical questions on page two.**

☐ 4. Supplemental Plus Dependents Life *(Spouse Only)* Any Multiple of $15,000, up to $255,000. (E.g. $15,000, $30,000, $45,000, $60,000, etc.)
Amount Requested $ _____
Amount requested must not exceed 50% of the Member's total Life Insurance Amount. The Medical History Statement must always be completed. A physical examination and/or medical records may be required for evaluation. Your spouse may become insured for Supplemental Plus Dependents Life only if you are insured under the Supplemental Plus Plan (option 3 above). **Please have your Spouse answer the medical questions on page two.**

☐ 5. Life Only *(Excludes Accidental Death Benefits)*
Do not check if you want Accidental Death Benefits included with options 1 and 3 above.

☐ 6. Long Term Disability *(Member Only)* ☐ 60 days ☐ 90 days ☐ 180 days
Premium rates are based on whether or not you use tobacco. Check one of the following:
☐ I use tobacco ☐ I do not use tobacco
The Medical questions on page two must always be completed. A physical examination and/or medical records may be required for evaluation.

You must be insured under the Supplemental Plan (option 1) to be eligible for the "Supplemental Plus" plan (option 3) and "Basic Dependents Life" plan (option 2). You must be insured under the "Supplemental Plus" plan (option 3) to be eligible for the "Supplemental Plus Dependents Life" plan (option 4).

Applicant Name	Social Security Number

PHYSICIAN INFORMATION *(Physician name or medical facility with Applicant's complete medical records—provide name and full mailing address)*

Doctor First Name	Doctor Last Name		
Clinic Name		Doctor Phone	
Doctor Address	City	State/Province	ZIP/Postal Code
Date Last Consulted			
Reason Last Consulted			

MEDICAL HISTORY STATEMENT QUESTIONS

Check yes or no for each of these questions, and give details for any "yes" answers. Attach a separate sheet if necessary.

1. Have you been absent from work for a period of 5 or more consecutive days during the last 2 years due to any sickness, surgery, injury, mental or emotional condition? ☐ Yes ☐ No
2. In the last 5 years, has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
   - A. Disease of:
     - Liver (including but not limited to hepatitis, cirrhosis, fatty liver)? ☐ Yes ☐ No
     - Pancreas (including but not limited to pancreatitis)? ☐ Yes ☐ No
     - Kidney (including but not limited to kidney failure, nephritis)? ☐ Yes ☐ No
     - Ulcers? ☐ Yes ☐ No
     - Stomach (including but not limited to gastritis, gastroparesis, stomach surgery)? ☐ Yes ☐ No
     - Intestines (including but not limited to Crohn's disease, ulcerative colitis, irritable bowel syndrome)? ☐ Yes ☐ No
     - Digestive system (including but not limited to acid reflux, Barrett's esophagus, rectal bleeding)? ☐ Yes ☐ No
   - B. Multiple sclerosis, epilepsy, stroke, paralysis, blindness, deafness? ☐ Yes ☐ No
     - Other neurological disease (including but not limited to dementia, narcolepsy, congenital spine)? ☐ Yes ☐ No
     - Muscle disease (including but not limited to muscular dystrophy, fibromyalgia, congenital muscle condition)? ☐ Yes ☐ No
   - C. Cancer (malignancy or growth), leukemia, lymphoma, chronic anemia, or blood clotting (thrombophlebitis, pulmonary embolism)? ☐ Yes ☐ No
   - D. Cardiovascular disease (including but not limited to coronary artery disease, stroke, angina)? ☐ Yes ☐ No
     - Heart ailment (including but not limited to congenital heart condition, abnormal heart rhythm, heart failure, valve disorder)? ☐ Yes ☐ No
     - Arteriosclerosis, chest pain, high blood pressure, heart murmur, valve? ☐ Yes ☐ No
     - Circulatory (including but not limited to aneurysm, fainting)? ☐ Yes ☐ No
     - Vascular disease (including but not limited to peripheral vascular disease, blocked artery)? ☐ Yes ☐ No
   - E. Emphysema, asthma, chronic bronchitis, sleep apnea? ☐ Yes ☐ No
     - Other lung disease (including but not limited to chronic obstructive pulmonary disease, cystic fibrosis, collapsed lung)? ☐ Yes ☐ No
   - F. Lupus, scleroderma, vasculitis, or other auto-immune disorder not related to Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
   - G. Osteoarthritis, rheumatoid arthritis, osteoporosis, amputations? ☐ Yes ☐ No
     - Other diseases of the bones (including but not limited to injuries, repairs with hardware, congenital bone conditions)? ☐ Yes ☐ No
     - Joints (including but not limited to pain, injuries, repairs with hardware)? ☐ Yes ☐ No
     - Back (including but not limited to injuries, repairs with hardware, disc conditions)? ☐ Yes ☐ No
     - Spine (including but not limited to injuries, repairs with hardware, congenital spine conditions)? ☐ Yes ☐ No
     - Arthritic conditions (including but not limited to psoriatic arthritis, post-traumatic arthritis, seasonal arthritis)? ☐ Yes ☐ No
   - H. Disease of diabetes or endocrine systems (including thyroid, adrenal, pituitary, or reproductive)? ☐ Yes ☐ No
   - I. Drug, alcohol or nicotine use or abuse, or have you used drugs, alcohol or nicotine in a manner that resulted in you having to obtain advice, counseling or treatment? ☐ Yes ☐ No
   - J. Psychiatric or mental condition, depression, adjustment disorder, affective disorder, or obsessive-compulsive disorder? ☐ Yes ☐ No
3. Has a medical professional ever diagnosed you as having or prescribed medication to you for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No

Applicant Name	Social Security Number

4. During the past five years have you been in a hospital or other institution for observation, rest, diagnosis, or treatment of any disease (not related to Human Immunodeficiency Virus (HIV)), condition or injury? ☐ Yes ☐ No
5. Other than as stated above, within the last 3 years, to the best of your recollection, have you:
   A. Been hospitalized or been seen by a physician, chiropractor, counselor, psychiatrist, therapist, or other medical practitioner? ☐ Yes ☐ No
   B. Been advised to have any medical test, surgery or hospitalization that was not completed? ☐ Yes ☐ No
6. Do you currently have any disorder, condition **(including pregnancy)** or disease, or are you currently taking medication prescribed by a medical or other practitioner for any disorder, condition or disease (not related to Human Immunodeficiency Virus (HIV)) other than cold or allergies not disclosed above? ☐ Yes ☐ No

Height_____ **Weight**_____

DETAILS OF ANY "YES" ANSWERS ABOVE

Include diagnosis, start and end dates, duration, type and frequency of treatment, hospitalization, physician visits, cause, location of disorder, residuals, acute or chronic status, work loss, and operations.

Question #	Diagnosis/Description	Month/Year	Details/Current Status	Physicians Consulted, City and State

BENEFICIARY INFORMATION

- Your designation revokes all prior designations.
- Benefits are payable to a contingent Beneficiary only if you are not survived by one or more primary Beneficiaries.
- If you name two or more Beneficiaries in a class (primary or contingent), two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
- If a minor (a person not of legal age) or your estate is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated ."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance and Supplemental Life Insurance on your Spouse, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.
- If you complete the "% of Benefit" box(es), the amounts should add up to 100% for each class (primary or contingent). For example, "Primary - John Q. Doe, 60%; Jane Q. Doe, 40%."

Beneficiary Information section continues on page 4.

Applicant Name	Social Security Number

BENEFICIARY INFORMATION ***(Continued)***

Primary – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. *if known*	Relationship	% of Benefit *Total must equal 100%*

Contingent – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. *if known*	Relationship	% of Benefit *Total must equal 100%*

Signature of Member

Date

INFORMATION PRACTICES NOTICE

- To help us determine your eligibility for group insurance we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or MIB, LLC (MIB), formerly known as Medical Information Bureau. We will use the authorization you signed on this form when we seek this information.
- MIB – Information regarding your insurability will be treated as confidential. Standard Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health (including short and long term disability) insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

  Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a 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.

  Standard Insurance Company may release information in its file to its reinsurers, and Standard Insurance Company, or its reinsurers, may release information in its file to other insurance companies to whom you may apply for life or health (including short and long term disability) insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.
- DISCLOSURE TO OTHERS – The information collected about you is confidential. We will not release any information about you without your authorization, except to the extent necessary to conduct our business, as noted in the Acknowledgment And Authorization For Release Of Information and this notice, or as required or permitted by law.
- YOUR RIGHTS – You have a right to know what information we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices please write to us at Medical Underwriting, Standard Insurance Company, 900 SW Fifth Avenue, Portland, Oregon 97204 or call 1-800-843-7979.

Applicant Name	Social Security Number

ACKNOWLEDGMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION *(Please read carefully.)*

- I represent that the statements contained herein, including those made in response to the Medical History Statement questions and any supplemental information, are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, The Standard's liability is limited to the return of any premium which may have been paid.
- To any health plan, physician, health care provider, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance or reinsurance company, and the MIB, LLC (MIB), I instruct you to disclose my entire medical record and any other protected health information concerning me to The Standard or its reinsurers. This includes information on any disorder of the immune system, including Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes (excluding Human Immunodeficiency Virus (HIV)), and any communicable or sexually transmitted disease or disorder (excluding HIV). This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.
- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any of the above to release and disclose my entire medical records without restriction.
- I understand that The Standard will use information to determine my eligibility for group insurance coverage. I understand The Standard may release information it has about me to its reinsurers and to any person performing business or legal services for The Standard in connection with my application. I authorize The Standard to release information it has about me to MIB for the purpose of reporting to the MIB information exchange and for MIB to audit The Standard's reporting. I understand The Standard may release information it has about me to other insurance companies to which I have applied for insurance coverage or benefits.
- I understand that information disclosed to The Standard pursuant to authorization may be subject to redisclosure with my authorization or as otherwise permitted by law. Life and disability insurance coverages are not subject to the Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA), and therefore release of information to The Standard is not protected under the Act.
- I understand that I am entitled to receive a copy of this authorization. This authorization will remain valid six months from the date of the signature below. A photocopy or facsimile of this authorization shall be as valid as the original.
- I understand that I have the right to refuse to sign this authorization. I further understand that I have a right to revoke this authorization at any time by sending a written statement to The Standard, except to the extent it has been relied upon to disclose requested records. I understand that the revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.
- I understand that if my application is approved, premiums shall be paid in accordance with the provisions of the Group Policy(ies), and my coverage will be subject to all terms and conditions of the Group Policy(ies) and state limitations.
- For Member: If I currently have a Life and/or Trust Life beneficiary designation on file with my plan administrator, I understand the designation(s) on file will also apply to any approved amounts. If I have no beneficiary designation(s) on file or I wish to change the name of the current beneficiary(ies), I will contact my plan administrator.
- I understand that insurance on a Spouse, if any, is payable to the Member, if living, or as provided under the terms of the Group Policy(ies).
- I acknowledge that I have read and received the Information Practices Notice and Fraud Notice (if applicable), and I have made a copy of this Medical History Statement.

Signature of Applicant	**Date**

Note: Declinations do not affect either Guarantee Issue Amounts not subject to Evidence Of Insurability or other coverages already in force with Standard Insurance Company.

Applicant Name	Social Security Number

FRAUD NOTICE

- ARKANSAS, MAINE, OHIO: Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.
- CALIFORNIA: 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.
- COLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who kindly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- LOUISIANA, NEW MEXICO: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- MARYLAND, RHODE ISLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- PUERTO RICO: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or any other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.
- TENNESSEE, VIRGINIA, WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.