

Proposed Insured *(In this application, "you" and "your" mean the proposed insured unless otherwise specified.)*

Full Name (First, Middle, Last)		Gender	Social Security Number	
Home Address		City	State	ZIP
Birth Date	Email Address			
Are you a U.S. citizen or permanent resident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, Country of Citizenship	Visa Type and No.		Expiration Date

Disability Income Coverage Applied For

Basic Monthly Benefit \$ _____ Benefit Period _____ Waiting Period _____ days
 Occupation Class _____ Premium Mode: EFT: Monthly Quarterly Semi-Annual Annual
 Direct Bill: Quarterly Semi-Annual Annual

Pre-existing Conditions Limitation: 3/12
 Mental Disorder/Substance Abuse Limitation

Additional Benefits
 Residual Disability (select one): Enhanced Residual Basic Residual
 Indexed Cost of Living: 3% 6% Catastrophic Disability* \$ _____
 Own Occupation Noncancelable
 Benefit Increase
 Student Loan Benefit: Maximum Monthly Benefit \$ _____ Rider Period: 10 Years 15 Years
 (If selected please answer questions 8 – 10 below.)

*Include the appropriate Application Supplement.

General Information About Your GME Program

Program Name		Expected Completion Date of Current Program		
Program Address		City	State	ZIP
Current Specialty or Sub-specialty (Include professional designation, or degree)			Current Post Graduate Year (PGY)	

Please answer Yes or No to questions 1 – 4

	Yes/No
1. Have you been declined or postponed for individual disability insurance coverage in the last 7 years?..... If Yes, please explain: _____	_____
2. Have you filed a claim for or received any disability insurance benefits or Workers' Compensation benefits in the last 12 months?..... If Yes, please explain: _____	_____
3. For the period of time starting 180 days prior to and including the date of this application: Have you been continuously at work on a full-time basis; and during that time have you been performing all the duties of your occupation without limitation due to an injury or sickness? (Full-time means at least 30 hours per week.) If No, please explain: _____	_____
4. Within the last 12 months, have you used tobacco or nicotine in any form, including: cigarettes, cigar, pipe, vapor, smokeless, gum, or the patch?.....	_____

Other Coverage: Explain all Yes answers in the table below.

Do not include the disability insurance you are applying for with this application.

Yes/No

- | | |
|--|-------|
| 5. Is there any other individual disability insurance currently in force or pending on you? | _____ |
| 6. Is there any Group Long Term Disability (LTD) insurance currently in force or pending on you? | _____ |
| 7. Have you applied for any disability insurance in the last 12 months?..... | _____ |

Company or Source	Type of coverage*	Monthly amount	Benefit Period	Waiting Period	Will this coverage be replaced or reduced? Yes or No

***Use type codes:** I - individual; G - group; X - association; OE - overhead expense; O - other

If the Student Loan Benefit was selected: please answer questions 8 - 10 below:

Yes/No

- | | |
|---|-------|
| 8. Total student loan obligation outstanding: \$ _____ | |
| 9. Is your student loan(s) a legally binding loan agreement(s) that: | |
| a. Establishes your personal obligation to repay the loan(s) in monthly installments over a period of time? | _____ |
| b. Is secured from a bank or lending institution in the United States, or from a U.S. federal, state, or local program? | _____ |
| c. Was obtained for the sole purpose of paying education expenses?..... | _____ |
| d. Is separate and distinct from any other loans or obligations you may have with the same or any other lender? | _____ |
| 10. Is there any other disability insurance for your student loan(s) currently in force or pending on you? | _____ |
| If yes, please provide details below. | |

Company Name	Status - Inforce or Pending	Monthly Benefit Amount	Will this coverage be replaced or reduced? Yes or No

Agreement, Representations, Authorizations and Signatures

I agree with the following:

1. This application includes pages 1-3 and all attached application supplements and amendments.
2. Standard Insurance Company (Standard) will rely on the information I have provided in this application in considering the proposed insured's eligibility for insurance and for various premium rates.
3. This application will not be effective unless it is signed and dated by the proposed insured and owner, if different. **No insurance will be in force until: (a) the date a policy has been issued, delivered to and accepted by the owner; and (b) the first full premium is paid while all answers in this application remain true and complete.**
4. No sales representative is authorized to judge insurability or change any of Standard's requirements. No changes to this application may be made without the owner's written consent.
5. I have read this application. I understand that if any answers are false, incorrect or untrue, Standard may have the right to deny benefits or rescind my policy.

I Represent That: all answers in this application are true and complete to the best of my knowledge and belief; and they are correctly recorded; and any and all answers I have provided to any Standard representative are recorded in this application.

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.

I authorize any: insurance or reinsurance company; insurance sales representative or employer; MIB, LLC or 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;

For the purposes of: determining eligibility for insurance and reinsurance; determining appropriate premium rates; evaluating claims for insurance benefits; and conducting other activities that relate to my application and insurance coverage, as allowed by law.

I understand that personal information may include: information about my age and occupation; income and finances; and other insurance.

I further authorize Standard to disclose any personal information about me to: its 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, who perform 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 allowed or required by law.

This Authorization will expire automatically 24 months after 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, at the address above. 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. Revocation of this Authorization will not affect any use or disclosure of information prior to Standard's receipt of my revocation.

I acknowledge that I have received and read a copy of the Disclosure Notice-Information Practices. A copy of this Authorization is as valid as the original. Any alteration made to this Authorization will render it invalid and unacceptable by Standard.

	Signed at _____	on _____
Signature of Owner (Proposed Insured)	City, State	Date
	Signed at _____	on _____
Soliciting Producer	City, State	Date

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, income and finances. This personal information is obtained and disclosed by us in order to evaluate your insurability and determine appropriate premium rates; to support our normal business practices; and to 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 insurance 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: insurance producers, insurance or reinsurance companies, and the MIB, LLC. (see below); employers, and personal and business associates.

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 that perform services or functions on our behalf or to serve you, and to regulatory, law enforcement and governmental authorities. Standard or its reinsurers may also release information in its file 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 the address at the top 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.

MIB, LLC.

Standard, or its 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.