Standard Insurance Company
The Standard Life Insurance Company of New York

Individual Disability Insurance
Administrative Office: 1100 SW Sixth Avenue Portland OR 97204-1093

Producer Information Report
Guaranteed Standard Issue
Graduate Medical Education

Residency Program Name	Requested Effective Date (Must be the first of the month)	
Producer Name (Please Print)	Producer No.	Agency
Phone Number	Email Address	

Other producer(s) to receive credit for these applications:

Name (Print) ______________________ Producer No. __________ Percent _____

Name (Print) ______________________ Producer No. __________ Percent _____

Name (Print) ______________________ Producer No. __________ Percent _____

For questions 1 – 4 please answer Yes or No — Yes/No

1. Has all licensing and appointment paperwork, for all states involved, been submitted to Producer Services, on all producers receiving commissions on this applicant? .... _____
   If No, please explain:
   ____
   ____
   ____
   ____
2. Does the proposed insured read, speak and understand English? .... _____
   If No, please explain:
   ____
   ____
   ____
   ____
3. To the best of your knowledge, is replacement involved or intended to be involved with this application? .... _____

I Declare That: The Disclosure Notice-Information Practices was provided to the proposed insured with the application. I understand that the proposed insured completed and signed the application personally, and the application indicates the actual place of signing. I know of nothing affecting the risk that is not recorded on this application or in any accompanying written statement or letter. I understand that any exception to the statements made in this declaration for the proposed insured must be disclosed and explained above, and such an exception may affect The Standard's offer of coverage to the proposed insured.

______________________ ______________________
Producer Signature Date

Standard Insurance Company

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

Application for Individual Disability Income Insurance Graduate Medical Education (GME) Program

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? ☐ Yes ☐ 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% ☐ 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?........ _____

Application for Individual Disability Income Insurance Graduate Medical Education (GME) Program

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

Standard Insurance Company

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

Application for Individual Disability Income Insurance Graduate Medical Education (GME) Program

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

Disclosure Notice - Information Practices (Nonmedical)

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.

Standard Insurance Company

PO Box 711
Portland Oregon 97207

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Standard Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the insurer to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

____________________	____
DATE	APPLICANT'S SIGNATURE

ONE COPY TO APPLICANT • ONE COPY TO HOME OFFICE

Standard Insurance Company

PO Box 711
Portland Oregon 97207

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Standard Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the insurer to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

____________________ DATE

____ APPLICANT'S SIGNATURE

ONE COPY TO APPLICANT • ONE COPY TO HOME OFFICE