Reset

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% ☐ 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?.....	_____

Standard Insurance Company

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

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

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

Disclosure of Benefit Offsets

Benefits payable under the disability policy being applied for may be reduced by other sources of income you may be receiving while disabled under the policy terms.

If your policy is issued with a Residual Disability Rider, work earnings may reduce benefit payments under the rider. If the policy includes a Supplemental Social Insurance Rider, benefit payments under the rider may be reduced by any Legislated Benefits you receive. Legislated Benefits include:

Social Security Disability Benefit. This includes primary or family disability benefits for which You may become eligible. These benefits include benefits payable under:

a. The U.S. Social Security Act;

b. A similar law of any other country; and

c. Optional Social Security Retirement provisions.

Worker's Compensation. This includes compensation benefits under any:

a. Worker's Compensation Act; and

b. Occupational Disease Law;

for which You may become eligible. It also includes insurance benefits provided under any similar law of: (i) any U.S. State; (ii) any U.S. Territory; and (iii) any other country.

Federal, State and Local Retirement And Disability Fund Benefit. This includes disability compensation under any governmental retirement and disability fund for which You may become eligible. Amounts for Your dependents are included. Any payment because of elective retirement will also be considered a Federal, State and Local Retirement And Disability Fund Benefit.

Railroad Retirement Disability Income. This includes these benefits under the federal Railroad Retirement Act:

a. Primary or family disability benefits for which You may become eligible; and

b. Payments under the retirement option.

In addition to the above, if your policy pays a Survivor Benefit at your death, payment of that benefit may be reduced by the amount of any overpayments paid to you in regard to your claim.

If you have any questions or would like more information regarding the above, please contact your Standard Insurance Company representative.

Standard Insurance Company

Individual Disability
1100 SW Sixth Avenue Portland OR 97204-1093

Notice to Applicant Regarding Replacement of Health Insurance

According to your application, you intend to lapse or otherwise terminate existing health 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 that 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. Do not cancel your present policy until you have actually received your new policy and are sure you want to keep it.
4. 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

Standard Insurance Company

Individual Disability
1100 SW Sixth Avenue Portland OR 97204-1093

Notice to Applicant Regarding Replacement of Health Insurance

According to your application, you intend to lapse or otherwise terminate existing health 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 that 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. Do not cancel your present policy until you have actually received your new policy and are sure you want to keep it.
4. 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

STANDARD INSURANCE COMPANY
Home Office: P.O. Box 711, Portland, Oregon 97207
800-247-6888

INSURED: _____

POLICY NUMBER: _____

INDIVIDUAL DISABILITY INCOME INSURANCE OUTLINE OF COVERAGE FOR POLICY ICC17-B180(07/17)

READ YOUR POLICY CAREFULLY

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Standard Insurance Company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

DISABILITY INCOME INSURANCE COVERAGE

Disability income insurance is designed to provide, to persons insured, coverage for disabilities resulting from a covered accidental injury or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

Date _____ Sales Producer _____

Address _____

_____

Telephone _____

POLICY BENEFITS

Disability Benefits are the monthly benefit payment(s) for Total Disability. Benefits begin on the Commencement Date. The Commencement Date is the next day immediately following completion of the the Benefit Waiting Period.

The **Benefit Waiting Period** is the period, measured from the first day of your Disability, throughout which you must be Disabled before Disability Benefits become payable. The Benefit Waiting Period is shown on the Policy Data page.

The **Maximum Benefit Period** is the maximum period of time we will pay benefits for any one Disability.

Commencement Date: The _____ Day of Disability

Basic Monthly Benefit: $ _____

Maximum Benefit Period: _____

BENEFIT FOR TOTAL DISABILITY – You will be eligible for a Disability Benefit during your Total Disability. The Disability Benefit payable each month will equal the Basic Monthly Benefit.

Total Disability/Totally Disabled means that, due to your Injury or Sickness:

- you are unable to perform the Substantial and Material Duties of your Regular Occupation; and
- you are not engaged in any other job or occupation for wage or profit; and
- you are receiving Regular Medical Care from one or more Physician(s) appropriate for the Injury or Sickness. This Regular Medical Care requirement will be waived when we receive written proof, satisfactory to us, that further care would be of no benefit to you.

Regular Occupation means the occupation or occupations which you are regularly engaged in at the time your Disability begins.

If you are a physician or dentist and have limited your Regular Occupation to the performance of the Substantial And Material Duties of a single specialty recognized by the American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS) or American Dental Association (ADA), then that specialty will be deemed your Regular Occupation.

BENEFIT FOR PRESUMPTIVE DISABILITY – We will consider you to be Totally Disabled if, after the Policy Effective Date, your Injury or Sickness first occurs while the policy is in force and causes you to totally and permanently lose one of the following: speech; hearing in both ears not restorable by hearing aids; sight in both eyes; use of both hands; use of both feet; or use of one hand and one foot. There is no Benefit Waiting Period if you become Presumptively Disabled.

REHABILITATION PROGRAM – While you are Disabled, you may participate in a Rehabilitation Program to help you prepare for your return to full time work. Your participation in the program is voluntary. We will pay the reasonable costs of the Program and periodically review your progress. We will continue to pay the agreed upon costs for as long as we determine the Rehabilitation Program is meeting the mutually agreed upon objectives.

PREMIUM WAIVER BENEFIT – We will waive all premiums due under the policy while Disability Benefits {or Recovery Benefits} are payable. After completion of the Benefit Waiting Period, we will refund to the Owner any premium due and paid after the date your Disability began.

FAMILY CARE BENEFIT – We will pay a Family Care Benefit while:

- you are working at least 20% fewer hours in order to care for your Family Member while he or she has a Serious Health Condition; and
- your Monthly Earnings is at least 20% less than your Predisability Earnings due to that reduction in hours worked; and
- you are not Disabled; and
- no other benefit is payable under the policy.

Family Member means your parent, child (including an adopted child and stepchild), spouse, Domestic Partner, and child of your Domestic Partner.

Serious Health Condition means that due to your Family Member's Injury or Sickness, he or she:

- is receiving inpatient care in a hospital, hospice or residential medical care facility;
- requires Substantial Supervision for his or her health or safety due to Severe Cognitive Impairment;
- is unable to safely and completely perform two or more Activities Of Daily Living without assistance; or
- is terminally ill with a condition that is reasonably expected to result in death within 12 months.

For a Family Care Benefit to be payable, the Serious Health Condition must be caused by an Injury or Sickness that first occurs after the Policy Effective Date and before the Termination Date. The Benefit Waiting Period is measured from the day the Serious Health Condition begins. The maximum amount of Family Care Benefit we will pay for all claims and all Family Members is limited to a total amount equal to six times the Basic Monthly Benefit.

The amount of Family Care Benefit we will pay each month will depend on your Monthly Earnings. If your Monthly Earnings is:

- less than 20% of your Predisability Earnings, the benefit amount will equal the Basic Monthly Benefit.
- 20% to 80% of your Predisability Earnings, the benefit amount will equal:

$$\frac{\text{your Predisability Earnings} - \text{your Monthly Earnings}}{\text{your Predisability Earnings}} \times \text{the Basic Monthly Benefit}$$

- more than 80% of your Predisability Earnings, no Family Care Benefit is payable.

If a Family Member dies while the Family Care Benefit is being paid, the Family Care Benefit will end as of the date of death. Premiums will not be waived while the Family Care Benefit is paid.

SURVIVOR BENEFIT – We will pay a benefit to a survivor (Survivor Benefit) if you die while Disability Benefits are payable under this policy. The amount of the Survivor Benefit will equal three times the Basic Monthly Benefit. The Owner may designate a payee, or change a previously named payee, to receive the Survivor Benefit.

EXCLUSIONS AND LIMITATIONS

EXCLUSIONS FROM COVERAGE

We will not pay benefits for:

- disability caused or contributed to by war, declared or undeclared, or any act or incident of war, or which resulted from military training, military action or military conflict while you are on active duty in the military service;
- the first 90 days of your Disability due to pregnancy or childbirth, except for Complications Of Pregnancy;
- disability caused or contributed to by your: (a) committing or attempting to commit a felony; (b) being engaged in an illegal occupation; or (c) actively participating in a violent disorder or riot;
- disability while you are confined for any reason to a penal or correctional institution for a period of more than 7 days; or
- intentionally self-inflicted injury.

PRE-EXISTING CONDITIONS – We will pay Disability Benefits for a Disability caused or contributed to by a Pre-existing Condition, or by a medical or surgical treatment of a Pre-existing Condition, only if:

- it is fully disclosed on your application; and
- it is not specifically excluded from coverage by amendment or endorsement.

A Pre-existing Condition is any mental or physical condition for which, during the 365 days immediately prior to the Policy Effective Date:

- you have consulted a physician or licensed medical professional, or received medical treatment or services;
- you have undergone diagnostic procedures;
- you have taken prescription drugs or medications; or
- a reasonably prudent person would have sought medical advice, care or treatment.

If during the first two years the policy is in force, we find that any answer in your application is misstated, incorrect or incomplete: we may rescind the policy or deny a claim for Disability starting within the two-year period.

SUSPENSION DURING MILITARY SERVICE – If you enter active military service of any nation or international authority, or a reserve component of the armed forces of the United States for a period of at least 90 days, you may suspend the policy by providing us with a written request. While the policy is suspended, no premiums are due and you have no coverage under the policy.

POLICY RENEWABILITY

GUARANTEED RENEWABLE – If all required premiums are paid, the policy is guaranteed renewable to the Termination Date. We cannot change any part of the policy, except its premium, until the Termination Date. We can change the premium rates only: (1) after the policy has been in force for three years; and (2) if the change applies to all policies with like benefits insuring the same Risk Class. The policy ends on the Termination Date, except as provided by the Renewal Option (below).

The Termination Date is shown on the Policy Data page. If you are under age 65 when we issue the policy, the Termination Date will be the Policy Anniversary on or next following your [65th or 67th] birthday. If you are age 65 or older when we issue the policy, the Termination Date first Policy Anniversary.

RENEWAL OPTION – If you are not Disabled, Disability coverage may be continued beyond the Termination Date. Coverage will be for Total Disability only. There will be a limited benefit period. You must be actively and regularly employed for at least 30 hours per week. We may change premium rates.

PREMIUMS – Premiums may be paid under any of these modes: annual, semi-annual, or quarterly. We may allow for payment under a special monthly mode. The special mode premium is paid through your bank. There is a 31-day grace period for all premiums due except the first.

The annual premium for the policy is $ _____ . If premiums are payable under a different mode, the premium for that mode is:

☐ Special Monthly ☐ Quarterly ☐ Semi-Annual $_____

Also included, if checked, are the following riders:

TITLE	PREMIUM	THIS RIDER:
☐ Indexed Cost Of Living Benefit Rider	$_____	Provides a Cost of Living Adjustment to the Basic Monthly Benefit, compounded each year for a Disability continuing more than one year.
☐ Own Occupation Rider	$_____	Allows you to be considered Totally Disabled if, due to injury or sickness, you are unable to perform the duties of your Regular Occupation, even though you may be working in another gainful occupation.

☐ Enhanced Residual Disability Benefit Rider	$_____	Provides that you are Residually Disabled if, during the Benefit Waiting Period, you are not Totally Disabled and are working, but you have a Loss Of Duties, or a Loss Of Time, or a Loss Of Income, as defined in the rider. After the Benefit Waiting Period, a monthly Disability Benefit for Residual Disability is payable if you are not Totally Disabled and are working, and you have a Loss Of Income.
☐ Basic Residual Disability Rider	$_____	Provides a Disability Benefit for Residual Disability if you are not Totally Disabled and are working and you have a Loss Of Income as defined in the rider.
☐ Short Term Residual Disability Benefit Rider	$_____	Provides a Disability Benefit for Residual Disability for up to 6 months if you are not Totally Disabled and are working, but you are not able to do all of the duties of your Regular Occupation, or you are able to do all the duties but for no more than half the time. A Loss Of Income is also required.
☐ Noncancelable Policy Rider	Premium included in base policy premium.	Changes the policy to noncancelable and guaranteed renewable. Premium rates cannot change.
☐ Catastrophic Disability Benefit Rider	$_____	Pays an additional monthly benefit if you become Catastrophically Disabled, as defined in the rider.
☐ Benefit Increase Rider	$ 0	Provides the option to purchase additional coverage at three-year intervals without having to provide medical information. Application is required and is subject to financial underwriting.
☐ Automatic Increase Benefit Rider	$ 0	Provides Automatic Increases to the policy's Basic Monthly Benefit each year during a 6-year Increase Period, without evidence of insurability.

☐ Student Loan Rider	$_____	Provides monthly reimbursement, up to a stated maximum amount, for student loan payments you make while you are Totally Disabled during the term of the rider.

DEFINITIONS

These definitions apply to both the policy and this outline of coverage. Other terms are defined in the policy.

Disability/Disabled means that you are Totally Disabled.

Injury means an accidental bodily injury which is sustained after the Policy Effective Date and while the policy is in force.

Owner means the owner of the policy.

Policy Anniversary means the anniversary of the Policy Effective Date occurring each year the policy remains in force.

Predisability Earnings means the greater of (1) your highest average Monthly Earnings for any consecutive 12 months in the last 24 months before the date your Disability or your Family Member's Serious Health Condition began; or (2) your Annual Earnings for any two full tax years within the three full tax years preceding the date your Disability or your Family Member's Serious Health Condition began, divided by 24.

Regular Medical Care means the appropriate medical treatment for your Injury or Sickness, based on prevailing medical standards. Regular Medical Care includes compliance with appropriate medical treatments recommended by the Physician(s) providing care for your Injury or Sickness.

Sickness means an illness or disease which first manifests itself after the Policy Effective Date and while the policy is in force. Sickness includes Complications of Pregnancy as diagnosed by a Physician.

Substantial And Material Duties means the usual and customary duties that are generally performed and essential to your Regular Occupation.

Termination Date means the date the policy ends, unless it ended earlier. This date is shown on the Policy Data page.

we/us/our mean Standard Insurance Company.

you/your mean the Insured.

THIS OUTLINE OF COVERAGE IS ONLY A SUMMARY OF THE COVERAGE PROVIDED BY THE POLICY. THIS OUTLINE IS NOT THE CONTRACT AND IS NOT PART OF IT. SEE THE POLICY FOR THE ACTUAL CONTRACT PROVISIONS.

STANDARD INSURANCE COMPANY
Home Office: 1100 SW Sixth Avenue, Portland, Oregon 97204
800-247-6888

ACKNOWLEDGMENT OF RECEIPT

Disability Insurance, Outline Of Coverage

I have received a copy of Standard Insurance Company's Disability Insurance Outline Of Coverage in connection with my application for Disability Insurance.

_____
Name of Applicant

_____ _____
Signature Of Applicant Date Signed

TO SALES REPRESENTATIVE: You must send this signed Acknowledgment Of Receipt to the home office with all Disability Insurance applications.

Print