

Standard Insurance Company

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

**Application for Individual Disability Insurance**

**Proposed Insured**

Full Name (First, Middle, Last)		Gender	Social Security No.	
Home Address		City	State	ZIP
Birth Date	State of Birth	Driver's License No.	Driver's License Issue State	
Primary Phone No.	Secondary Phone No.	Email Address	<input type="checkbox"/> Check to request electronic policy delivery.	
Current Primary Occupation/Duties				

**Insurance Applied For**

Plan Type & Features:	<p><b>Disability Income</b>                  (Application Supplement required)                  Basic Monthly Benefit \$ _____                  Benefit Waiting Period _____ days                  Benefit Period _____</p> <p><b>Platinum Advantage</b></p> <p><input type="checkbox"/> Residual Disability Benefit Rider                  (Select one):</p> <p><input type="checkbox"/> Enhanced  <input type="checkbox"/> Basic  <input type="checkbox"/> Short Term</p> <p><input type="checkbox"/> Noncancelable  <input type="checkbox"/> Own Occupation  <input type="checkbox"/> Indexed Cost of Living: <input type="checkbox"/> 3% <input type="checkbox"/> 6%  <input type="checkbox"/> Catastrophic Disability \$ _____  <input type="checkbox"/> Benefit Increase  <input type="checkbox"/> Automatic Increase Benefit  <input type="checkbox"/> Mental Disorder/Substance Abuse Limitation  <input type="checkbox"/> Student Loan Benefit                  (Application supplement required)                  Maximum monthly benefit \$ _____                  Rider period: <input type="checkbox"/> 10 Years <input type="checkbox"/> 15 Years</p>	<p><b>Business Overhead Expense</b>                  (Application supplement required)                  Base amount \$ _____                  Waiting Period _____ days                  Benefit multiple _____ months</p> <p><input type="checkbox"/> Residual Disability</p> <p><input type="checkbox"/> Future Purchase Option units \$ _____                  Number of units: _____</p> <p><b>Business Buy-out Expense</b>                  (Application supplement required)                  Waiting period _____ days                  Aggregate Benefit Limit \$ _____</p> <p>Funding method (select and complete one):</p> <p><input type="checkbox"/> Lump sum amount \$ _____  <input type="checkbox"/> Monthly amount \$ _____                  For _____ years</p> <p><input type="checkbox"/> Down payment amount                  \$ _____ Lump sum; and                  \$ _____ Monthly for _____ years</p> <p><input type="checkbox"/> Future Buy-out Expense Rider                  Aggregate Benefit Limit \$ _____                  Funding method (must be same as base)                  (Select and complete one):</p> <p><input type="checkbox"/> Lump sum amount \$ _____  <input type="checkbox"/> Monthly amount \$ _____  <input type="checkbox"/> Down payment amount/mo. \$ _____</p> <p><input type="checkbox"/> Extended Benefit Option</p>
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**Premium Payment**

Premium mode:  EFT (monthly)  List bill (monthly)  Annual  Other \_\_\_\_\_

Payer name and address if other than proposed insured:

\_\_\_\_\_

\_\_\_\_\_

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Other Insurance Coverage

1. Explain Yes answers in the table below. Use **status** and **type** codes provided:
- a. Have you applied for any disability insurance in the last 12 months? .....  Yes  No
  - b. Will you become eligible for any disability insurance in the next 24 months? .....  Yes  No
  - c. Is there any other individual or group disability insurance currently in force or pending on you? ....  Yes  No

**Status** Codes: **N** - now in force with any company; **P** - pending; **A** - applied for in the last 12 months; **F** - will become eligible in the next 24 months  
**Type** Codes: **I** - individual; **G** - group; **X** - association; **OE** - overhead expense; **L** - loan repayment; **O** - other

Company	Status	Type	Who pays premium?	Benefit amount or % of income	If group:		Benefit period	Waiting period	Will coverage be replaced or reduced?
					Benefit cap maximum	Bonus covered?			
						<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No

Financial Information

2. How many hours per week do you work in your primary occupation? \_\_\_\_\_ hours per week
3. What is your annual earned income from your primary occupation?  
 Current year \$ \_\_\_\_\_ Last year \$ \_\_\_\_\_  
 If you are self-employed, earned income is after business expenses.  
 Do not include investment or other passive income.
4. Currently, is your passive income greater than 25% of your earned income or \$50,000? (Passive income includes: capital gains, interest, dividends, net rental income, pensions, annuities, royalties, etc.).....  Yes  No  
 If Yes, please provide sources and amounts:  
 \_\_\_\_\_  
 \_\_\_\_\_
5. Is your net worth, excluding primary residence, greater than \$8,000,000?.....  Yes  No  
 If Yes, please provide sources and amounts:  
 \_\_\_\_\_  
 \_\_\_\_\_
6. Will your employer pay for any part of this requested insurance? .....  Yes  No  
 If Yes, please answer a, b and c.  
 a. What percent of premium will your employer pay?  None  100%  Other \_\_\_\_\_ %  
 b. Will your employer's contribution be included in your taxable income?.....  Yes  No  
 c. Will you reimburse your employer for any premium?.....  Yes  No
7. 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, b and c.  
 a. Business entity:  C Corp  S Corp  LLC  LLP  Sole Proprietor  Partnership  
 Other \_\_\_\_\_  
 b. Number of employees: Full-time \_\_\_\_\_ Part-time \_\_\_\_\_  
 c. Percent of business entity owned \_\_\_\_\_ % Years owned \_\_\_\_\_

If TeleApp complete 8a and 8b.

8. a. Enter your Height \_\_\_\_\_ Weight \_\_\_\_\_  
 b. In the last 5 years have you been treated for, or been diagnosed by a medical professional as having any heart condition, back or neck disorder, anxiety or depression; cancer, diabetes or neurological disorder? .....  Yes  No  
 If Yes, please provide details. Include dates, diagnoses and treatments; also include health care provider name(s) and address(es).  
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 \_\_\_\_\_



***This application supplement is attached to and made part of the application for insurance. In this application supplement, "you" and "your" mean the proposed insured.***

Proposed Insured	Birth Date
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**Employment and General Information**

Current Employer			
Employer Address	City	State	ZIP
Current Primary Occupation	Years in Current Occupation	Years with Current Employer	
Type of Business or Industry	Professional Designation, Specialty or Degree		

1. List job duties and percentage of time spent in each duty:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Do you perform any of your current primary duties at your place of residence?.....  Yes  No  
 If Yes, please provide percentage of time at home and list duties.

\_\_\_\_\_

\_\_\_\_\_

3. Do you intend to change your occupation or employer within the next 180 days? .....  Yes  No  
 If Yes, please provide details, including dates, new occupation and employer, and anticipated annual income.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. 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:

\_\_\_\_\_

\_\_\_\_\_

5. Are you a U.S. citizen? .....  Yes  No  
 If No, please provide country of citizenship, type of visa or green card, number, and expiration date:

\_\_\_\_\_

6. In the last 5 years have you personally, or has any business owned in whole or in part by you,  
 filed for bankruptcy? .....  Yes  No  
 If Yes, please provide details. Include the chapter of bankruptcy and date discharged.

\_\_\_\_\_

\_\_\_\_\_

7. Have you been alerted to or received orders for active service with any armed forces or military unit? ....  Yes  No  
 If Yes, please provide details, including dates and locations of service.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. For the past 180 days, have you been continuously at work on a full-time basis performing all the duties of your primary occupation without limitation due to an injury or sickness? .....  Yes  No  
If No, please provide details, including dates, duration and reason.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Have you ever applied for life or disability insurance and later withdrawn your application or had it cancelled, declined, postponed, rated, modified or approved other than as applied for? .....  Yes  No  
If Yes, please provide details.

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\_\_\_\_\_  
\_\_\_\_\_

10. 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.

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\_\_\_\_\_  
\_\_\_\_\_

11. Do you have a pilot's license? .....  Yes  No  
If Yes, please complete a, b and c.

a. Is flying as a pilot a requirement of your primary occupation? .....  Yes  No

b. Number of flight hours for business in the past 12 months: \_\_\_\_\_

c. Anticipated number of flight hours for business in the next 12 months: \_\_\_\_\_

12. In the last 5 years, have you participated, or do you intend within the next 12 months to participate in: underwater diving, caving, outdoor rock, ice or mountain climbing; hang gliding, heli-skiing, or other aeronautics; or racing activities including motor, boat or cycle racing or any other hazardous sports? .....  Yes  No  
If Yes, please provide details.

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\_\_\_\_\_  
\_\_\_\_\_

13. In the last 2 years have you traveled, worked or lived outside the USA or Canada for more than one continuous month; or do you plan to do so in the next 2 years? .....  Yes  No  
If Yes, please provide details, including location(s), purpose of trip(s) and dates.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. 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.

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\_\_\_\_\_  
\_\_\_\_\_

15. 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. Been on parole or probation or been arrested for or charged with a felony or misdemeanor? .....  Yes  No  
 If Yes, please provide details including dates.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

c. Received, or been advised by a counselor or medical professional to seek treatment, counseling or support for alcohol or prescribed or non-prescribed drugs; or 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), dates.

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\_\_\_\_\_

\_\_\_\_\_

16. Have you consumed alcoholic beverages in the past 10 years?.....  Yes  No  
 If Yes: How many drinks per week? \_\_\_\_\_ Date last consumed? \_\_\_\_\_

17. 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.

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**Medical Information**

Name of Your Current Primary Medical Provider ( <i>If none, name of most recent medical provider seen within the last 5 years</i> )			Year first seen
Street Address of Your Primary Medical Provider			
City	State	ZIP	Phone No.

18. Date you last saw your primary medical provider or other health care practitioner: \_\_\_\_\_

a. Reason seen: \_\_\_\_\_

b. Treatment provided or prescribed: \_\_\_\_\_

c. Results: \_\_\_\_\_

19. What is your height? \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight? \_\_\_\_\_ lbs.

20. Within the last 12 months, have you lost more than 10 pounds? .....  Yes  No  
 If Yes, please provide details.

\_\_\_\_\_

***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.***

21. In the last 10 years have you had, been told you had, been treated or seen by a medical professional for, or been diagnosed as having:

a. Disorder of the eye, ear, nose, throat or skin?.....  Yes  No

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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.**

b. Anxiety, depression, nervousness, stress or post-traumatic stress disorder (PTSD); or any other mental, emotional, adjustment or psychiatric disorder? .....  Yes  No

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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

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d. Fibromyalgia, chronic fatigue, rheumatoid arthritis or lupus; or any other disease or disorder of the immune system? .....  Yes  No

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e. Kidney, urinary system or prostate disorder? .....  Yes  No

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f. Sleep apnea, asthma or bronchitis; or any other disease or disorder of the lungs or respiratory system?.....  Yes  No

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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

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h. Hepatitis, colitis, or ulcer; or any other disease or disorder of the liver, gallbladder, pancreas or digestive tract? .....  Yes  No

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i. Diabetes, pre-diabetes, impaired glucose tolerance or thyroid disorder; or any other disease or disorder of the glandular systems?.....  Yes  No

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j. Complications of pregnancy, C-section or infertility; or any disorder of the breasts, reproductive or genital organs?.....  Yes  No

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**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.**

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

22. 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

\_\_\_\_\_  
\_\_\_\_\_

23. Are you currently pregnant? .....  Yes  No  
If Yes, estimated date of delivery: \_\_\_\_\_

24. 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 tests related to HIV), medical care, surgery or hospitalization that was not completed?.....  Yes  No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

25. 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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_