DIRECTIONS FOR APPLYING FOR COVERAGE

Read the Information Practices Notice(s) on page 4. A separate form must be submitted for each applicant (Employee/Member, Spouse and/or Child) when Evider... at the bottom of page 3. K... given above.

Due to state regulatory requirements,
this Medical History Statement form is now out of date.

Use the link below
to access the correct form for your state.

Please update your link or bookmark.
https://www.standard.com/eforms/sny24169.pdf

If you have questions, please contact your employer
or call The Standard at 888.456.3505.
Thank you

MEMBER

Name of G...	...ne per form) ...use ☐ Child
Member/Er...	...ar)
Occupation...	...tification No.

APPLICA...

Applicant's...			
Street Addr...			...Postal Code
Sex ☐ M ☐ F			

APPLICATION INFORMATION

Type of Application *(check one)* ☐ Initial ☐ Increase in Coverage ☐ Late Application

Check the type and provide details on the amount of coverage you are requesting.

☐ Short Term Disability

☐ Long Term Disability _____ (Current Amount In Force, if any) + _____ (Additional Amount Requested) = _____ (Total Amount Requested)

☐ Life _____ (Current Amount In Force, if any) + _____ (Additional Amount Requested) = _____ (Total Amount Requested)

☐ Dependents Life _____ (Current Amount In Force, if any) + _____ (Additional Amount Requested) = _____ (Total Amount Requested)

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			