

Application for Reinstatement or Policy Change

Full Name (First, Middle, Last)		Birth Date	Height	Weight
Policy No.	Telephone No.	☐ Work ☐ Residence		
Email Address				

The following marked changes are requested on the above policy:

- | | |
|---|---|
| ☐ Reinstatement in accordance with policy provisions | ☐ Decrease waiting period to _____ |
| ☐ Reduce or remove rating | ☐ Increase benefit period to _____ |
| ☐ Remove policy exclusion | ☐ Other _____ |

Financial and General Information

- Is there any other individual or group disability insurance currently in force or pending on you? ☐ Yes ☐ No
If Yes, please give the company, type of insurance, and monthly amount; also give benefit period and waiting (elimination) period.

- What is your current primary occupation? _____
- Your annual earned income from your primary occupation:
If you are self-employed, earned income is after business expenses.
Do not include investment or other passive income. (Passive income includes: capital gains, interest, dividends, net rental income, pensions, annuities, royalties.)
Current year \$ _____ Last year \$ _____
- 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 and b.
a. Business entity: ☐ C Corp ☐ S Corp ☐ LLC ☐ LLP ☐ Sole Proprietor ☐ Partnership
☐ Other _____
b. Percent of business entity owned _____ Years owned _____
- How many hours per week do you work in your primary occupation? _____ hours per week
- List job duties and percentage of time spent in each duty:

- 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:

- Have you ever applied for life or disability insurance and later withdrawn your application; or have you had it cancelled, declined, postponed, rated, modified or approved other than as applied for?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

- In the last 5 years, have you 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.

Standard Insurance Company

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

Application for Reinstatement or Policy Change

10. In the last 5 years, have you had your driver's license suspended or revoked; or have you been convicted of 3 or more moving violations; or have you been 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.

11. 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.

12. In the last 10 years, have you:
a. Used marijuana, cocaine, amphetamines, or narcotics; or any other legal or illegal drug except as prescribed by a medical professional? ☐ Yes ☐ No
If Yes, please provide details, including substance(s) used and dates.

b. Received, or been advised by a medical professional to seek treatment, counseling or support for use of alcohol or prescribed or non-prescribed drugs; or have you been advised by a 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), and dates.

Medical Information

For the remaining questions: Explain all Yes answers. Provide details including dates, durations, test results (except tests related to HIV), diagnoses and treatments. Also provide names and addresses of all medical professionals and facilities.

13. In the last 10 years have you been diagnosed as having, or been treated or tested positive for, or been given medical advice by a medical professional for:

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

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

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

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

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

Standard Insurance Company

Individual Disability Insurance
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Application for Reinstatement or Policy Change

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

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

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

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

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

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

14. In the last 10 years, have you been treated for or been diagnosed by a medical professional as having human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS)? ☐ Yes ☐ No

15. Are you currently pregnant? ☐ Yes ☐ No
If Yes, estimated date of delivery: _____

16. 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 those related to HIV), medical care, surgery or hospitalization that was not completed? ☐ Yes ☐ No

Standard Insurance Company

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

Application for Reinstatement or Policy Change

17. Other than as stated in other answers, have you within the last 3 years taken any prescription or non-prescription medicine or supplement? ☐ Yes ☐ No

18. **Remarks.** (Use this space for any additional information or details regarding any of the above questions.)

Terms and Agreement

1. In this form, "you/your" means the insured named on this application. "We/us/our" and "Standard" mean Standard Insurance Company.
2. Reinstatement and all changes are subject to the policy's provisions and our rules and procedures. This application and all changes made pursuant to it will become part of the policy.
3. To reinstate or make a change, the following may be required: (a) payment of any premium or fee as we determine; and/or (b) any other information we determine is necessary.
4. Reinstatement and/or any change(s) will take effect only when all of our requirements are met and we have given our approval. Once approved, we will notify the owner of the effective date of the reinstatement and/or change(s).
5. If a policy is reinstated or changed on the basis of this application, any corrections or amendments made to this application will be ratified by policy endorsement signed by the owner and made part of the policy.
6. We cannot contest any changes, insurance benefits or reinstatement as a result of this application after two years from the effective date of the reinstatement and/or change, except for fraudulent misrepresentation in this application.
7. I, the undersigned owner and insured, have read this application and **understand** that: (a) Standard will rely on this information in considering my eligibility for reinstatement, change(s), or various premium rates; and (b) Standard may have the right to deny benefits or rescind the policy if any statements are false, incorrect or untrue. **I Represent That** all answers to the above questions are correctly recorded, complete and true to the best of my knowledge and belief; and any and all answers I have provided verbally to a Standard producer or other Standard representative have also been recorded in this application.

I, the undersigned insured, have received a Disclosure Notice-Information Practices.

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.

_____ Signature of Insured	Signed at _____ City, State	on _____ Date
_____ Signature of Owner (if other than insured)	Signed at _____ City, State	on _____ Date
_____ Signature of Producer (if present)	Signed at _____ City, State	on _____ Date

Standard Insurance Company

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

Disclosure Notice - Information Practices

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, health and medical history, personal characteristics and activities, avocations, income and finances. This personal information is obtained and disclosed by us in order to evaluate your insurability, determine appropriate premium rates, support our normal business practices and 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 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 physicians, medical professionals, health care providers, hospitals, clinics, pharmacies and other medical or medically-related facilities; consumer reporting agencies, insurance sales representatives, insurance support organizations, insurance or reinsurance companies, and the MIB, LLC (see below); employers, and personal and business associates. We may also request that you have medical examinations and tests.

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 or persons, including insurance sales representatives, that perform services or functions on your or our behalf, and to regulatory, law enforcement or governmental authorities. We or our reinsurers may also release information 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 us at the address at the bottom 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.

INVESTIGATIVE CONSUMER REPORTS: We may ask that an investigative consumer report be prepared by an independent source called a consumer reporting agency. The report is for insurance purposes only. It may include information about your character, general reputation, personal characteristics and activities and mode of living. The consumer reporting agency may obtain information for the report through personal interviews with your family members, friends, neighbors or others with whom you are acquainted. If we request a report and you wish to be interviewed, please let us know in writing and we will notify the consumer reporting agency. On written request, we will disclose to you whether or not such a report was done and provide a more detailed description of the nature and scope of the report. You have a right to receive a copy of the investigative consumer report from the consumer reporting agency. If you would like a copy of the report, please contact us and we will give you the name and address of the consumer reporting agency.

MIB, LLC: We, or our 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 Underwriting
1100 SW Sixth Avenue Portland OR 97204-1093

Authorization to Obtain and Disclose Information

Types of Personal Information Collected

I understand that it is necessary for Standard Insurance Company (Standard) to collect and review personal information about me in order to offer and administer insurance products. I understand this personal information may be in paper or electronic format and may include information about my age, occupation, avocations, driving record, travel, aviation, character, general reputation, personal characteristics and activities, mode of living, income and finances and other insurance. I also understand that personal information may include medical records, in paper or electronic format, containing health information related to medical history, examinations, diagnoses, prognoses, test results, prescriptions and treatments of any physical or mental conditions.

Authorization to Obtain Personal Information

I authorize MIB, LLC, and any licensed physician, medical professional, health care provider, hospital, medical or medically-related facility, clinic, pharmacy, alcohol or drug treatment facility, insurance or reinsurance company, insurance sales representative, consumer reporting agency, government department or agency, employer, and any 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. I further authorize Standard to request and obtain an investigative consumer report about me from a consumer reporting agency, as described in the Disclosure Notice-Information Practices.

Authorization to Use Personal Information

I authorize Standard to use personal information obtained about me for the purposes of evaluating eligibility for insurance and reinsurance, determining appropriate premium rates, evaluating claims for insurance benefits and conducting other legally permissible activities that relate to my application and insurance coverage.

Authorization to Disclose Personal Information

I authorize Standard to disclose personal information about me to Standard's 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, performing 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 permitted or required by law. I understand that any health information that is disclosed pursuant to this Authorization may be subject to redisclosure as permitted or required by law and may no longer be protected by federal laws governing privacy and confidentiality of health information.

Certain Types of Health Information

I understand that certain health information cannot be released without my specific consent, in accordance with federal and state laws. I hereby expressly consent to the release of information related to my use of alcohol, drugs and tobacco; diagnosis or treatment of Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and sexually transmitted diseases; and diagnosis and treatment of psychological or mental illness (excluding psychotherapy notes). I also understand that blood, urine, saliva or other medical tests or examinations may be required to determine my insurability.

Expiration and Revocation

This Authorization will expire automatically twenty-four (24) months following 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, Attention: Individual Disability Insurance Underwriting, 1100 SW Sixth Avenue, Portland, Oregon 97204-1093. 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. I realize that if I do revoke this Authorization it will not affect any use or disclosure of information prior to the receipt of my revocation and that any action taken before Standard receives my written revocation will be valid.

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

Signature of (Proposed) Insured

Date of Signature

Name (please print)

Date of Birth

Standard Insurance Company

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

**Authorization for Release
of Personal Psychotherapy Notes
to Standard Insurance Company**

Name of (Proposed) Insured/Patient (please print)

Date of Birth

I authorize any licensed physician, medical professional, health care provider, hospital, medical or medically-related facility, laboratory, clinic, pharmacy, alcohol or drug treatment facility that has provided medical treatment, care or services to me to disclose my entire medical record and any other health information **solely relating to psychotherapy notes** to Standard Insurance Company ("Standard") or an insurance support organization acting on behalf of Standard. Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of my medical record.

By my signature below, I acknowledge that any agreements that I have made to restrict my health information do not apply to this Authorization and I instruct my health care providers to release and disclose my entire medical record relating to psychotherapy notes without restriction.

I understand that the health information to be disclosed to Standard will be used for the purposes of evaluating eligibility for insurance and reinsurance, determining appropriate premium rates, evaluating claims for insurance benefits and conducting other legally permissible activities that relate to my application and insurance coverage. I also understand that any health information that is disclosed pursuant to this Authorization may be subject to redisclosure as permitted or required by law and may no longer be protected by federal laws governing privacy and confidentiality of health information.

This Authorization will expire automatically twenty-four (24) months following 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, Attention: Individual Underwriting, 1100 SW Sixth Avenue, Portland, Oregon 97204-1093. 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. I realize that if I do revoke this Authorization it will not affect any collection, use or disclosure of information prior to Standard's receipt of my revocation and any action taken before Standard receives my written revocation will be valid.

I acknowledge that I have read this Authorization and that I have the right to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization is as valid as the original.

Signature of (proposed) Insured/Patient

Date

Authorization for One-Time and/or Recurring Electronic Funds Transfer (EFT)

INSURED NAME		PHONE	FINANCIAL INSTITUTION NAME	
NAME(S) ON ACCOUNT		ACCOUNT TYPE ☐ Checking ☐ Savings	TYPE OF FINANCIAL INSTITUTION ☐ Bank ☐ Credit Union ☐ Savings & Loan	
<i>for recurring payments only:</i> Deduction for the policies listed will be made monthly unless I specify a different mode: ☐ Quarterly ☐ Semi-Annually ☐ Annually	POLICY NUMBER		START DEDUCTION (DAY/MONTH)	DEDUCTION AMOUNT
	POLICY NUMBER		START DEDUCTION (DAY/MONTH)	DEDUCTION AMOUNT
	POLICY NUMBER		START DEDUCTION (DAY/MONTH)	DEDUCTION AMOUNT

1. Read and complete this form. Please print legibly.
2. To identify your account, please copy the "Routing Transit #" and "Account #" from your check (**not a deposit slip**) as instructed below. The illustration shows how to locate these numbers on your check. Alternatively, you may attach a copy of a voided check (not a deposit slip) over this area.
NOTE: Money market checks or credit card "Cash Transfer" checks **cannot** be used for this authorization.
3. For the authorization to be valid, you **must** check the box of the authorization statement that applies, either a one-time debit, recurring payments, or both. You need not check both boxes unless applicable.
4. Retain a copy for your records and mail or fax the form to the address above.

Diagram illustrating the format of a memo:

Left Format:

- Memo
- 080989430 (Routing Transit #)
- 01440984321 (Account #)
- 1249 (Check #)

Right Format:

- Memo
- 1249 (Check #)
- 080989430 (Routing Transit #)
- 01440984321 (Account #)

ACCOUNT # (Ignore spaces, but include dashes, if any)

↓ IMPORTANT: You must check one or both boxes below for this authorization to be valid. ↓

1. Initiation of such debit entries is notice of premiums due.
2. This authorization will remain in full force and effect until Standard Insurance Company has received adequate written notification from me (or from either of us) of its termination. Written notice must be received by Standard Insurance Company at least **three business days** before this payment is scheduled to be made in order to afford Standard Insurance Company and the depository a reasonable opportunity to act. Standard Insurance Company may discontinue this EFT plan for any reason and at any time without prior notice. Premium payments thereafter will be payable on any premium payment plan then available under Standard Insurance Company's rules and procedures.
3. This authorization applies to any increase or decrease in premium (debit amount) that results from authorized and approved changes to the corresponding policy.
4. **I (We) will maintain a balance in the above account adequate to cover insurance premium payments. Additionally, I (We) will notify Standard Insurance Company of any account or debit-agreement changes at least three business days before payment is scheduled. I understand that any returned item from my former account will immediately be re-drafted from the new account.**

2. This authorization shall apply only to one debit from my account in the amount shown above. Once the amount is debited from my account, this authorization shall terminate, and shall be of no further force or effect.

DATE _____

**Consent to Electronic
Transactions and Signatures**

Pursuant to applicable state and federal electronic transaction laws, you consent to sending and receiving electronic records and to the use of electronic signatures. This consent applies to information and documents, including but not limited to, applications for insurance, forms, agreements, disclosures, authorizations, notices, insurance policies or other communications with Standard Insurance Company or The Standard Life Insurance Company of New York (The Standard), whichever company is applicable. These electronic documents and communications may be sent to the email address you provide.

You understand that you will need to have web browser software and Adobe® Reader® software on a computer capable of accessing the Internet and a valid email address to access and retain these electronic records. You may request a paper version of any of the electronically furnished documents at any time by contacting The Standard at 800.247.6888 and we will provide that document. There may be a charge for a paper version of certain documents. You will inform The Standard at **DiChanges@Standard.com** if your email address changes or if you prefer to receive communications at a different email address. In addition, you may withdraw this consent at any time by notifying The Standard by email at **DiChanges@Standard.com** or at 800.247.6888 that you no longer consent to sending and receiving electronic records or to the use of electronic signatures. The withdrawal of your consent shall be effective no later than ten business days after receipt of the withdrawal by The Standard. Withdrawing consent to receive information and documents electronically may result in a charge for a paper version of certain documents.

The Standard may choose to offer additional online services in the future that it will provide under terms and conditions, other than or in addition to those described above. Therefore, as a condition of accessing or receiving those additional services, you may be asked to agree to different or additional terms and conditions.

By signing this consent electronically, I am acknowledging that I have read the terms of this consent and that I agree to electronically complete and sign documents with The Standard.

Signature _____

Date _____

Printed Name _____

The Standard allows producers and agencies, who are licensed and appointed to sell The Standard's individual disability insurance products, to use electronic signatures with our application and service forms. A vendor approved by The Standard must be used and the program requirements stated below must be met.

Approved Vendors

Producers and agencies can choose from the following vendors to electronically complete, sign and submit applications and service forms:

- DocuSign
- Adobe Sign (formerly EchoSign)
- OneSpan Sign (formerly eSignLive)
- RightSignature

Eligible Documents

- Applications and Authorizations
- Increase Option Applications and Authorizations
- Service Forms
- Policy Change Endorsements
- Policy Delivery Documents

Program Requirements

- The producer or agency must own an account with one of the approved vendors identified above.
- An electronic signature account owner or person authorized to sign legal contracts on behalf of the account owner must review, complete, sign and submit The Standard's **Electronic Transactions Certification (21309)**. This certification must be completed only once for each electronic signature account.
 - The account owner can download PDFs of The Standard's eligible applications and forms from standard.com.
 - For Guaranteed Standard Issue (GSI) plans, The Standard provides the account owner with prefilled PDF files of required applications and forms.
- Each transaction must include a signed **Consent to Electronic Transactions and Signatures for The Standard (www.standard.com/eforms/21311.pdf)** for each person signing a document electronically. This is required by law under the Electronic Signatures in Global and National Commerce Act (ESIGN).
- All electronic signature transactions must include multi-factor authentication for all signers.
- All systems provided by the approved vendors will generate a report showing a complete audit trail for every completed transaction. This report provides a history of the transaction and includes record of identity authentication, email address, associated IP address, date, timestamp and name of signer. It must be included with every application and/or form submitted to The Standard.

Standard Insurance Company
The Standard Life Insurance Company of New York

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

Electronic Transactions Certification

This Electronic Transactions Certification ("Certification") between Standard Insurance Company or The Standard Life Insurance Company of New York ("The Standard") and the agency named below ("Agency") is made effective on the date signed below ("Effective Date").

Section 1. Electronic Signature

1.1 Agency will establish a system in which its customers may use electronic signature technology to electronically sign and submit certain insurance records, such as applications for insurance or policy delivery acceptances, related to The Standard's insurance products. Agency will acquire, at its expense, any and all software and hardware necessary to maintain an electronic signature and record retention system to support electronic transactions.

1.2 Agency will utilize a third-party software vendor to develop the system used by it and will only use a vendor that is identified on The Standard's approved vendor list. Agency will receive The Standard's written approval prior to using a selected vendor with any of The Standard's insurance records. If Agency should develop its own system and not use a system designed by a third party vendor, Agency will allow The Standard to perform an assessment of the system to ensure applications and other policy forms are correctly displayed, the proper data elements are collected, and all functionality requirements set forth in this Certification are met.

Section 2. System Functionality

2.1 When implementing an electronic signature program, Agency will ensure the system complies with the following requirements:

- (a) That the system allows the customer to electronically sign insurance records in a manner that is in accordance with ESIGN, UETA and any other applicable laws;
- (b) That the system uses a multi-factor authentication method capable of demonstrating the customer using the electronic signature process is the intended signatory;
- (c) That the system obtains the customer's signed consent to conduct transactions electronically prior to the execution of any insurance record;
- (d) That the insurance record, upon migration into the system, is encrypted and hashed thereby protecting the integrity of the information when in transit or at rest;
- (e) That the system allows the customer to opt-out of signing electronically and to complete the insurance record with a wet signature;
- (f) That the system allows the customer to download and/or print a copy of the insurance record after execution;
- (g) That the system has layers of physical, logical and administrative controls to prevent the insurance record from being altered without detection;
- (h) That the system will retain a copy of each electronically signed record and certificate of completion for as long as required by ESIGN, UETA or other applicable law but for at least a period of not less than three (3) years from the transaction event; and
- (i) That the system maintains an unaltered certificate of completion which contains information related to the identification markers associated with the electronic signature, such as name of signer, date and time stamps of signature, document status indicating signature completion, and the IP address used to access the system, and such certificate is provided to The Standard with each completed application and policy form.

Section 3. Data Security and Privacy

3.1 Agency may obtain personally identifying information, such as name, date of birth, Social Security number, income and health information, about a customer ("Personal Information") through electronic applications and service forms. Agency will keep this Personal Information strictly confidential and will comply with all applicable federal and state laws related to privacy and security when obtaining and using Personal Information.

3.2 Agency will maintain a written information security program compliant with applicable federal and state laws. Such program will include implementing and maintaining reasonable physical, electronic and procedural security measures (i) to ensure the confidentiality of Personal Information, (ii) to protect against any anticipated threats or hazards, and (iii) to protect against unauthorized access to or use of Personal Information that could result in substantial harm or inconvenience to any customer.

3.3 Agency will notify The Standard as expediently as possible, and in any event no later than three (3) calendar days after discovery, of any unauthorized access to, use or disclosure of Personal Information related to any insurance records of The Standard. Such notice will be given via email to **DIChanges@standard.com** or for Guaranteed Standard Issue plans, email **gsi_issue@standard.com**. Agency will give The Standard the following information regarding the incident within five (5) calendar days after discovery: a description of what happened, a description of the types of Personal Information involved, and the name of each individual whose Personal Information has been, or reasonably believed to have been, involved. Agency agrees to bear the expense of any investigation of the incident and to mitigate any harmful effects, including providing affected individuals with identity theft protection.

Section 4. General

4.1 This Certification becomes effective on the Effective Date and may be terminated: (1) by either party by giving thirty (30) days prior written notice to the other party; (2) by either party immediately for a material breach of this Certification by the other party; or (3) by mutual agreement by the parties at any time. Upon termination for any reason, Agency will immediately cease using The Standard's application and service forms on Agency's system.

4.2 Agency agrees to indemnify and hold harmless The Standard, its officers, directors and employees from any and all loss, expense, cost of litigation, including attorney's fees, or damage as a result of any claim or demand made against The Standard arising out of or related to Agency's breach of this Certification, a security incident involving the breach of Personal Information that is stored on the system used by Agency and that is related to a customer of The Standard, Agency's negligent or willful misconduct in relation to use of Agency's system, or Agency's infringement of any intellectual property rights of a third party.

4.3 To ensure adequate financial resources in the event of a security incident, Agency must maintain adequate insurance against cybersecurity liabilities.

4.4 This Certification will be construed in accordance with and governed by the laws of the State of Oregon without giving effect to any conflict of law principles.

Agency

Electronic Signature Account Owner Name _____

Electronic Signature Vendor Name _____

Account Owner's Email Address _____

Account Owner or Legally Authorized Representative Signature _____ Date _____

Printed Name _____ Title _____

Understanding Income Documentation

Income documentation is required for all disability insurance applications (except applications qualifying for Simplified Underwriting and select Students and New Professionals). Required documentation depends on the applicant's business entity.



Entity	Documentation for			What Income Figure to Use	Employer-Paid Limits
	Platinum Advantage	Business Overhead Protector	Business Equity Protector		
Students, Residents, New Professionals	Not required unless requested by the underwriter	For new-in-practice professionals, please contact your underwriter	Not available	See Students and New Professionals in the Special Occupations of The Standard's IDI Product Guide for benefit limits	Not eligible for employer-paid limits
Non-owner employee	Complete Form 1040 for most recent year including all schedules, W-2 of proposed insured OR If income is salary only, provide most recent paystub OR If 1099, complete 1040 and schedule C	Not available	Not available	W-2 box 5 labeled "Medicare wages and tips" OR Projected current annual salary and add year-to-date commission and bonus already earned and paid. Do not project commissions or bonuses OR If 1099, income filed under Schedule C, line 31	May apply for employer-paid limits. ¹ Independent contractors are not eligible for employer-paid limits
Owner of Sole Proprietorship	Complete Form 1040 and Schedule C	Schedule C from personal tax return	Not available	Schedule C line 31	Not eligible for employer-paid limits
C Corporation Owner	W-2 of the proposed insured. Business Tax Form 1120 is required if ≥20% owner	Business tax Form 1120	2 years' complete business tax returns	W-2 box 5 "Medicare wages and tips" and owner's share of Form 1120 line 30	May apply for employer-paid limits
S Corporation Owner	Complete 1040, W-2 and Schedule E OR Corporate Tax Return Form 1120S and Schedule K-1 and W-2	Business tax Form 1120S	2 years' complete business tax returns	W-2 box 5 plus Schedule E Nonpassive income. Subtract nonpassive loss and Section 179 expense. ² Passive income may be counted as unearned income OR Add 1120S line 7 (owner's share shown on W-2) and K-1 line 1, subtract line 11	May apply for employer-paid limits if the proposed insured owns 2% or less of the business ¹
Partnership	Complete 1040 and Schedule E OR Partnership Form 1065 and K-1	Business tax Form 1065	2 years' complete business tax returns	Schedule E Nonpassive income. Subtract nonpassive loss and Section 179 expense. ² Passive income may be counted as unearned income OR Add 1065 K-1 lines 1 and 4, subtract line 12 ²	Not eligible for employer-paid limits
LLC or LLP	The type of business tax return filed for the LLC or LLP will govern the documentation required	See appropriate business entity above	2 years' complete business tax returns	Refer to the appropriate requirements above for regular corporations and partnerships	See appropriate business entity above

The Standard reserves the right to require additional financial information on any applications regardless of amount, if necessary to reach an underwriting decision or to secure reinsurance. The Standard also reserves the right to limit or modify the amount of insurance coverage offered regardless of earned income, other financial information or other insurance in force. A minimum of two years' tax returns are required for certain occupations to qualify for an occupation class; for business owners applying for the Business Owner Upgrade, Business Owner Discount or Earned Income Enhancer; or for bonus or commission income to be considered.

- 1 To be eligible for employer-paid limits, the premium cannot be included in taxable income and the employee may not reimburse the employer for the premium.
- 2 Up to 20% of Section 179 depreciation can be added to the income to allow for an additional benefit of up to \$1,000 a month.

Standard Insurance Company
The Standard Life Insurance Company of New York

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Ore. in all states except New York, where insurance products are offered by The Standard Life Insurance Company of New York of White Plains, N.Y. Product features and availability vary by state and company, and are solely the responsibility of each subsidiary. Each company is solely responsible for its own financial condition.

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14162 (3/23) SI/SNY

Authorization for One-Time and/or Recurring Electronic Funds Transfer (EFT)

INSURED NAME		PHONE	FINANCIAL INSTITUTION NAME	
NAME(S) ON ACCOUNT		ACCOUNT TYPE ☐ Checking ☐ Savings	TYPE OF FINANCIAL INSTITUTION ☐ Bank ☐ Credit Union ☐ Savings & Loan	
<i>for recurring payments only:</i> Deduction for the policies listed will be made monthly unless I specify a different mode: ☐ Quarterly ☐ Semi-Annually ☐ Annually	POLICY NUMBER		START DEDUCTION (DAY/MONTH)	DEDUCTION AMOUNT
	POLICY NUMBER		START DEDUCTION (DAY/MONTH)	DEDUCTION AMOUNT
	POLICY NUMBER		START DEDUCTION (DAY/MONTH)	DEDUCTION AMOUNT

1. Read and complete this form. Please print legibly.
2. To identify your account, please copy the "Routing Transit #" and "Account #" from your check (**not a deposit slip**) as instructed below. The illustration shows how to locate these numbers on your check. Alternatively, you may attach a copy of a voided check (not a deposit slip) over this area.
NOTE: Money market checks or credit card "Cash Transfer" checks **cannot** be used for this authorization.
3. For the authorization to be valid, you **must** check the box of the authorization statement that applies, either a one-time debit, recurring payments, or both. You need not check both boxes unless applicable.
4. Retain a copy for your records and mail or fax the form to the address above.

Diagram illustrating the format of a memo:

Left Format:

- Memo
- 080989430 (Routing Transit #)
- 01440984321 (Account #)
- 1249 (Check #)

Right Format:

- Memo
- 1249 (Check #)
- 080989430 (Routing Transit #)
- 01440984321 (Account #)

ACCOUNT # (Ignore spaces, but include dashes, if any)

↓ IMPORTANT: You must check one or both boxes below for this authorization to be valid. ↓

1. Initiation of such debit entries is notice of premiums due.
2. This authorization will remain in full force and effect until Standard Insurance Company has received adequate written notification from me (or from either of us) of its termination. Written notice must be received by Standard Insurance Company at least **three business days** before this payment is scheduled to be made in order to afford Standard Insurance Company and the depository a reasonable opportunity to act. Standard Insurance Company may discontinue this EFT plan for any reason and at any time without prior notice. Premium payments thereafter will be payable on any premium payment plan then available under Standard Insurance Company's rules and procedures.
3. This authorization applies to any increase or decrease in premium (debit amount) that results from authorized and approved changes to the corresponding policy.
4. **I (We) will maintain a balance in the above account adequate to cover insurance premium payments. Additionally, I (We) will notify Standard Insurance Company of any account or debit-agreement changes at least three business days before payment is scheduled. I understand that any returned item from my former account will immediately be re-drafted from the new account.**

2. This authorization shall apply only to one debit from my account in the amount shown above. Once the amount is debited from my account, this authorization shall terminate, and shall be of no further force or effect.

DATE _____