

DIRECTIONS FOR APPLYING FOR COVERAGE

Read the Information Practices Notice(s) on page 6. A separate form must be submitted for each applicant (Employee/Member, Spouse and/or Child) when Evidence Of Insurability or Proof of Good Health is required to apply for coverage. Complete all items, date and sign in the space at the bottom of page 5. Keep a copy for your records, and send the original to Standard Insurance Company at the address given above.

MEMBER INFORMATION

| | | | | | | | |
|-------------|--|-------------------|--------|--------------|--|--|--|
| Group Name | | Division/Location | | Group Number | | Who is Applying? <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child | |
| Member Name | | | | Birth Date | | Social Security Number | |
| Job Title | | | Salary | Date of Hire | | Employee ID | |

APPLICANT INFORMATION (Person to be Insured)

| | | | | | | |
|--|----------------|--|--------------------------------|-------------------------------|------------------------|-------------|
| Applicant's Name | | | Birth Date | | Social Security Number | |
| Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X | Place of Birth | | Phone | | Email Address | |
| Mailing Address | | | City | | State/Province | Postal Code |
| Preferred Method of Contact | | | <input type="checkbox"/> Email | <input type="checkbox"/> Mail | | |

COVERAGE INFORMATION

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 *Do you have a physician or medical facility that can provide health records if needed?* Yes No

| | | | | |
|--|--|--------------------|----------------|-------------|
| Physician's full name and/or Clinic Name | | | | |
| Address | | City | State/Province | Postal Code |
| Phone Number | | Date of Last Visit | | |

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| Applicant Name | Social Security Number |
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MEDICAL HISTORY STATEMENT QUESTIONS

Complete for **Dependent Child Applications ONLY**

| | |
|--|--------|
| Height | Weight |
| <p>1. In the past five years has a medical professional treated your dependent child for or diagnosed them as having any of the following:</p> <p>A congenital health disorder (including heart defect, neural tube defect, down syndrome, cystic fibrosis, spina bifida, cerebral palsy, or muscular dystrophy); developmental delay, brain or neurological disorder (including seizures); heart or circulatory disease; chronic lung disease (not including asthma); kidney disorder; diabetes; cancer, malignancy, blood or bleeding disorder; mental health or substance abuse disorder; attempted suicide; Acquired Immune Deficiency Syndrome (AIDS) or HIV antibodies; any undiagnosed condition requiring ongoing care?..... <input type="checkbox"/>Yes <input type="checkbox"/>No</p> | |

Complete for **Member and Dependent Spouse Applications**

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|---|--------|
| Height | Weight |
| <p>1. In the past five years has a medical professional treated you for, diagnosed you as having, or prescribed medication for any of the following:</p> <p>A. Hepatitis B or C, liver disease, cirrhosis, liver failure, chronic pancreatitis, inflammatory bowel disease (IBD), Crohn’s disease, or ulcerative colitis?.....<input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>B. Chronic kidney disease, kidney failure, or dialysis?.....<input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>C. Stroke, transient ischemic attacks (TIA), muscular dystrophy (MD), multiple sclerosis (MS), amyotrophic lateral sclerosis (ALS), dementia, Alzheimer’s disease, Parkinson’s disease, Huntington’s disease?.....<input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>D. Systemic lupus, scleroderma, connective tissue disease, rheumatological disease, or immune system disorder (not related to HIV)?.....<input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>E. Cancer or malignancy (excluding basal cell and squamous cell carcinoma)?.....<input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or HIV antibodies?.....<input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>G. Heart disease, blood vessel or artery disease, heart valve disorder, heart failure, heart attack, or heart surgery?.....<input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>H. Lung disease (excluding asthma), lung failure, chronic obstructive pulmonary disease, chronic bronchitis, or emphysema?.....<input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>I. Diabetes, pre-diabetes, or impaired fasting glucose?.....<input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>J. Blood disorder, blood clotting disorder, or bleeding disorder?.....<input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>K. Substance abuse or alcohol use disorder (excluding nicotine and tobacco use)?.....<input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>L. Psychosis, schizophrenia, bipolar disorder, psychiatric hospitalization, or attempted suicide?.....<input type="checkbox"/>Yes <input type="checkbox"/>No</p> | |

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| Applicant Name | Social Security Number |
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ACKNOWLEDGMENT

- I represent that the statements contained herein, including those made in response to the Medical History Statement questions and any supplemental information, are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). **I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim.**
- I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement. I understand that if my application is approved, premiums shall be paid in accordance with the provisions of the Group Policy(ies), and my coverage will be subject to all terms and conditions of the Group Policy(ies) and state limitations. I agree that if my application is declined, The Standard's liability is limited to the return of any premium which may have been paid.
- For Member/Employee: If I currently have a Life and/or Trust Life beneficiary designation on file with my plan administrator, I understand the designation(s) on file will also apply to any approved amounts. If I have no beneficiary designation(s) on file or I wish to change the name of the current beneficiary(ies), I will contact my plan administrator.
- I understand that insurance on a Spouse or other Dependent, if any, is payable to the Member/Employee, if living, or as provided under the terms of the Group Policy(ies).
- By signing on page 5, I acknowledge that I have read this Acknowledgment section.

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| Applicant Name | Social Security Number |
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AUTHORIZATION FOR USE AND RELEASE OF INFORMATION

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health:

- Any physician, medical practitioner, health care provider, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, health plan, or other medical or medically related facility; any insurance or reinsurance company, or insurance support organization; any consumer reporting agency; any third party performing a service for us related to my application(s); any organization holding information about my health; Department of Motor Vehicles (DMV); and MIB, LLC (MIB).

TO GIVE THIS INFORMATION:

- 1) My entire medical record and any other protected health information, including charts, notes, operative reports, lab and medication and prescription records, my medical history, consultations, treatments, benefits and health risk score or health analysis. This includes information on any disorder of the immune system, including Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, and any communicable or sexually transmitted disease or disorder. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.
- 2) Non-medical information about me, including but not limited to: Motor vehicle reports; criminal activity; credit score or credit history information; information collected by a wearable device; risk evaluations or risk scoring performed by others.

TO STANDARD INSURANCE COMPANY, ITS REINSURERS, AND TO REPRESENTATIVES PERFORMING SERVICES ON THEIR BEHALF ("THE STANDARD")

- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any of the above to release and disclose my entire medical records without restriction.
- I understand that The Standard will use information to determine my eligibility for group insurance coverage and for internal research and business analysis. I understand The Standard may release information about me to others necessary to identify me and provide requested information about me. I understand The Standard may release information it has about me to its reinsurers and to others performing business or legal services for The Standard in connection with my application. I understand The Standard may release information it has about me to MIB for the purpose of reporting to the MIB information exchange and for MIB to audit The Standard's reporting. I understand The Standard may release information it has about me to other insurance companies to which I have applied for insurance coverage.
- I understand that information disclosed to The Standard pursuant to authorization may be subject to redisclosure with my authorization or as otherwise permitted by law. Life and disability insurance coverages are not subject to the Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA), and therefore release of information to The Standard is not protected under the Act.
- I understand that I am entitled to receive a copy of this authorization. This authorization will remain valid 12 months from the date of the signature below. A photocopy or facsimile of this authorization shall be as valid as the original.
- I understand that I have the right to refuse to sign this authorization. I further understand that I have a right to revoke this authorization at any time by sending a written statement to Standard Insurance Company, except to the extent it has been relied upon to disclose requested records. I understand that the revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.
- I acknowledge that I have read this Authorization to Use and Release Information and the Fraud Notice on page 7 and agree to this authorization. Further, that I have made a copy of this Medical History Statement, including this Authorization for Use and Release of Information.

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| Signature of Applicant (or Member/Employee for Dependent Child) | Date |
|---|------|

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| Applicant Name | Social Security Number |
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INFORMATION PRACTICES NOTICE

- **INFORMATION WE GATHER** – To help us determine your eligibility for group insurance we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, pharmacy and prescription benefit manager, health care clearinghouses, other insurance companies or benefit plan administrators, consumer reporting agencies, any organization holding information about you or your health, DMV, insurance support organizations or MIB, LLC (MIB), and others performing services on our behalf. We may use third parties to collect information about you on our behalf and we may also obtain risk evaluations or risk scoring performed by others. These evaluations or scoring may be based on data analysis models or algorithms. We will use the authorization you signed on this form when we seek the above information. We may use information collected about you for our internal research and analysis.
- **MIB** – Information regarding your insurability will be treated as confidential. The Standard or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health (including short and long term disability) insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a 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. Information for consumers about MIB may be obtained on its website at www.mib.com.
- **DISCLOSURE TO OTHERS** – The information collected about you is confidential. We will not release information about you without your authorization, except to the extent required or permitted by law. The Standard may release information about you to its reinsurers, and The Standard, or its reinsurers, may release information it has about you to other insurance companies to whom you may apply for life or health (including short and long term disability) insurance, or to whom a claim for benefits may be submitted. The Standard may release information about you to others, necessary to identify you so that they may provide requested information to us. The Standard may also provide information to others for business or legal services in connection with your application and for purposes of third party data analysis, models or algorithms to help assess our insurance risk.
- **YOUR RIGHTS** – You have a right to know what information we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices please write to us at Medical Underwriting, The Standard, P.O. Box 2753 Portland, OR 97208 or call 1-800-713-6274.
- By signing on page 5, I acknowledge that I have read this Information Practices Notice.

Note: Declinations do not affect either Guarantee Issue Amounts not subject to Evidence Of Insurability or other coverages already in force with Standard Insurance Company.

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| Applicant Name | Social Security Number |
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FRAUD NOTICE

- ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.
- ARKANSAS, LOUISIANA, RHODE ISLAND, WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- CALIFORNIA: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- MAINE, TENNESSEE, WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
- MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.
- NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.
- VIRGINIA: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.