

Producer Information Report

1. Multi-life Employer Name _____ 2. Requested Effective Date
(Must be the first of the month) _____

3. Producer Name (Please Print) _____ 4. Producer Number _____ 5. Agency _____

H() _____ W() _____ () _____
6. Phone Numbers _____ 7. Fax Number _____ 8. E-mail Address _____

9. Other Producer(s) to Receive Credit for these Applications:
NAME (PRINT) _____ PRODUCER NO. _____ PERCENT _____
NAME (PRINT) _____ PRODUCER NO. _____ PERCENT _____

Do the split credit arrangements (if applicable) apply to the whole case? YES NO
If no, submit a new Producer Information Report with each application.

10. Has all licensing and appointment paperwork, for all states involved, been submitted to Producer Services, on all
Producers receiving commissions on this case? If no, explain in REMARKS. YES NO

11. Do the proposed insureds read, speak and understand English? If no, explain in REMARKS. YES NO

12. To the best of your knowledge, is replacement involved or intended to be involved with any application
submitted in this multi-life case? YES NO

13. Who will the policyowner be? (check one) Each Insured The Employer (as named in number 1, above)

14. Number of Applications submitted with this producer report? _____

15. REMARKS:

I DECLARE THAT: The Disclosure Notice-Information Practices was provided to each proposed insured with their application. I understand that each proposed insured completed and signed each application personally, and each application indicates the actual place of signing. I know of nothing affecting the risk that is not recorded on these applications or in any accompanying written statement or letter. I understand that any exception to the statements made in this declaration for any proposed insured must be disclosed and explained in REMARKS above, and such an exception may affect Standard's offer of coverage to the proposed insured.

Producer Signature _____ Date _____

Proposed Insured

1. Full Name (Last, First, Middle) _____ 2. Sex _____ 3. Social Security Number _____
 4. Home Address _____ City _____ State _____ Zip Code _____
 5. Date of Birth _____ 6. State of Birth _____ 7. Length of US Residence _____

Insurance Applied For

8. Plan Type and Features: _____ Indexed Cost of Living: ___ 3% / ___ 6% _____ Own Occupation
Disability Income _____ GI - Pre-X Waived _____ Noncancelable
 Basic Monthly Benefit \$ _____ GI - Pre-X Amended _____ Residual Disability
 Waiting Period _____ days _____ GI - Vol. Open Enrollment _____ Catastrophic \$ _____
 Benefit Period _____ Supplemental Social Ins. \$ _____
 SSI Waiting Period _____ days
 _____ Mental Disorder/Substance Abuse Limitation
 _____ Other _____

9. Occupation Class: _____ (Available classes: 5A, 4A, 4P, 3A, 3P, 2A, 2P, A, B)
 10. Premium Mode: _____ List Bill-monthly. (List bill plan number, if known: _____) Other _____
 11. Other Coverage: 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. Is there any other individual or group disability insurance currently in force or pending on you? YES NO
 c. Will you become eligible for any disability insurance in the next 12 months? YES NO
 d. Have you applied for or received any disability insurance benefits in the last 3 months?..... YES NO
 If YES please explain: _____

STATUS CODES: NOW IN FORCE (N); PENDING (P); APPLIED FOR IN THE LAST 12 MONTHS (A); WILL BECOME ELIGIBLE IN THE NEXT 12 MONTHS (F).
TYPE CODES: INDIVIDUAL (I); SOCIAL SECURITY SUBSTITUTE (S); GROUP (G); ASSOCIATION (X); OVERHEAD EXPENSE (OE); OTHER (O - EXPLAIN.)

COMPANY:	STATUS:	TYPE:	IF GROUP:		MONTHLY AMOUNT:	BENEFIT PERIOD:	WAITING PERIOD:	WILL COVERAGE BE REPLACED/REDUCED?
			WHOPAYS PREMIUM?	BENEFIT CAP MAXIMUM?				
								<input type="checkbox"/> YES* <input type="checkbox"/> NO
								<input type="checkbox"/> YES* <input type="checkbox"/> NO
								<input type="checkbox"/> YES* <input type="checkbox"/> NO

* If yes, write policy number next to company name.

General Information

12. Current Primary Occupation. (Include professional designation, specialty or degree.) _____ 13. Years in Current Primary Occupation _____ 14. Years with Current Employer _____

15. Current Employer _____ 16. Employer Address _____ City, State _____ Zip Code _____

17. Have you been working in your current primary occupation at least 30 hours per week, continuously for the past 6 months?..... YES NO
 If no, please explain: _____

18. Have you used tobacco or nicotine in any form in the last 5 years? If yes, circle types below and complete table. YES NO

	HOW LONG:	AMT PER DAY:	DATE LAST USED:
A. CIGARETTES	_____	_____	_____
B. CIGAR	_____	_____	_____
C. PIPE	_____	_____	_____
D. SMOKELESS	_____	_____	_____
E. GUM, PATCH, OTHER	_____	_____	_____

**Short Form Application for Disability Income Insurance
GI (Guarantee Issue) Program**

Standard Insurance Company - Individual Division
1100 SW Sixth Avenue Portland OR 97204-1093

Proposed Insured (print): _____

Agreement

I, THE UNDERSIGNED, AGREE TO THE FOLLOWING: This application includes pages 1 and 2 and all signed application supplements and amendments. In this application, "you" and "your" mean the proposed insured unless otherwise specified. I understand that 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. This application will not be effective unless signed and dated by the proposed insured and owner, if different. **No insurance will be in force until the date a policy has been issued, delivered to and accepted by the owner, and the first full premium is paid while all answers in this application remain true and complete.** The only exceptions are as outlined in a written agreement between Standard and the employer as payor for the policy. Premium will be calculated to begin on the policy's Effective Date. No sales representative is authorized to judge insurability or change any of Standard's requirements. No corrections or amendments to this application may be made without the owner's written consent. We may require that any disability policy(s) listed in answer to Question 11 be permanently terminated or reduced. Standard will rely on the information in this answer in determining the amount, if any, of disability insurance it will issue. If such insurance is not terminated or reduced as required by Standard, any policy issued and accepted pursuant to this application may be rescinded and all premiums returned. If any insurance applied for is intended to replace other insurance in force with Standard, the Standard policy(s) being replaced will end the moment the insurance applied for becomes effective. 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 insurance policy. I REPRESENT that: To the best of my knowledge and belief, all answers in this application are true and complete and correctly recorded; and that any and all answers I have provided verbally to any Standard representative are recorded in this application. I signed this application in the city and state and on the date shown below.

Note: 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.

If Proposed Insured is Owner of the Policy:

Provided there are no corrections or amendments made by Standard to this application, I AUTHORIZE my employer to accept delivery of the policy on my behalf; and I UNDERSTAND AND AGREE that my employer will then deliver the policy to me.

SIGNATURE OF PROPOSED INSURED

Signed at _____ on ____/____/____
CITY STATE DATE

If Policyowner is Other Than Proposed Insured:

SIGNATURE OF POLICYOWNER

Signed at _____ on ____/____/____
CITY STATE DATE

PRINT NAME AND TITLE OF POLICYOWNER

POLICYOWNER'S TAX ID NUMBER

POLICYOWNER'S ADDRESS

CITY, STATE ZIP CODE

E-MAIL ADDRESS (OPTIONAL)

I declare and affirm that no changes, additions or alterations of any kind have been made to this form after it was signed by the proposed insured and owner (if other than the proposed insured). If this form has been sent to Standard electronically, the copy of the form sent to Standard is a true and exact copy of the original.

SIGNATURE OF SOLICITING PRODUCER

Signed at _____ on ____/____/____
CITY STATE DATE

PRINT NAME OF SOLICITING PRODUCER

FLORIDA LICENSE IDENTIFICATION NUMBER

Standard Insurance Company

Individual 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 Medical Information Bureau (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 Medical Information Bureau, 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 life 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.

Medical Information Bureau (MIB)

Standard, or its reinsurers, may make a brief report to the MIB. The MIB is a nonprofit membership organization of life and health 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, the MIB, upon request, will supply the company with the information in its file. At your request, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the MIB's file, you may contact the MIB and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

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 Underwriting, 1100 SW Sixth Ave., Portland, OR 97204-1093.

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 that personal information may include information about my age, occupation, other insurance, income and finances. I also understand that personal information does not include any information related to my physical or mental condition, medical history or medical treatment.

Authorization to Obtain Personal Information

I authorize any insurance or reinsurance company, insurance sales representative, employer, the Medical Information Bureau (MIB) and any other person, organization or institution having records or knowledge of me, to release personal information about me, as described above, to Standard, its reinsurers, and any insurance support organization acting on behalf of Standard.

Authorization to Use Personal Information

I authorize Standard to use personal information obtained about me for the purposes of determining eligibility for insurance and reinsurance and 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 any personal information about me to Standard's reinsurers, the Medical Information Bureau, 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.

Expiration and Revocation

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. 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.

This Authorization will expire automatically twenty-four (24) months following the date of my signature below.

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, or my authorized representative, 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)

This Application Supplement is part of the application(s) for insurance on: _____
Proposed Insured (Please print.)

In this Application Supplement: "You" and "your" mean the proposed insured; and "Standard" means Standard Insurance Company.

Please complete all questions. Explain all "YES" answers in the REMARKS AREA. Give date, reason and diagnosis; and duration, severity, treatment and results. Also give the names and addresses of medical and health care practitioners and facilities.

1. Do you require assistance from another person to perform any of the Activities of Daily Living? YES NO
Activities of Daily Living means: bathing, continence, dressing, eating, toileting and transferring. (An example of transferring is moving from your chair to your bed.)

2. Are you currently receiving, or have you received within the past year: Any treatment, attention or advice from a licensed medical or health care practitioner for any condition related to:
a. Your loss of ability to see, hear or speak? YES NO
b. Your loss of ability to use your arms or your legs? YES NO

3. Are you currently receiving, or have you received within the past year: Any treatment, attention or advice from a licensed medical or health care practitioner for: Loss of memory or confusion; stroke, Alzheimer's Disease, senility or dementia; or loss of comprehension of spoken language? YES NO

4. REMARKS AREA: _____

I have read this Application Supplement. I REPRESENT THAT: To the best of my knowledge and belief, all information provided in response to the above questions is correctly recorded, complete and true. I understand that Standard will rely on this information in considering my eligibility for insurance and for various premium rates. I also understand and agree that if any information on this application supplement is false, incorrect or untrue, Standard may have the right: (a) to deny benefits; or (b) to rescind my insurance policy. I agree that this Application Supplement shall become part of any contract of insurance based on such application.

Note: 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.

Signature of Proposed Insured Signed at _____ on ____/____/____
City, State Date

Signature of Soliciting Producer Signed at _____ on ____/____/____
City, State Date

Name of Soliciting Producer (Print) Florida License Identification Number

Standard Insurance Company

Individual Disability Insurance (800) 247-6888 Tel (800) 378-2407 Fax
 1100 SW Sixth Avenue Portland OR 97204-1093 www.standard.com

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

INSURED NAME		PHONE	FINANCIAL INSTITUTION NAME	
NAME(S) ON ACCOUNT		ACCOUNT TYPE <input type="checkbox"/> Checking <input type="checkbox"/> Savings		TYPE OF FINANCIAL INSTITUTION <input type="checkbox"/> Bank <input type="checkbox"/> Credit Union <input type="checkbox"/> Savings & Loan
<i>for recurring payments only:</i> Deduction for the policies listed will be made monthly unless I specify a different mode: <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> 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

Instructions:

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.

Examples of where to find your Transit Routing and Account numbers:



ROUTING TRANSIT # (the 9 digits to the left of your account number)

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

I have identified my account and financial institution either by attaching a copy of a voided check or by completing the "Routing Transit #" and "Account #" boxes above. I (We) ask and authorize Standard Insurance Company to debit my account electronically, to pay premium(s) as indicated below. I (We) authorize the financial institution named above to debit the account indicated.

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

Preauthorized Recurring Premium Collection Authorization

By my/our signature(s) below, I (We) request and agree as follows:

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.**

One-Time Debit Authorization

By my/our signature below, I (We) request and agree as follows:

1. I (We) authorize Standard Insurance Company to debit my account identified above, by electronic means, in the amount of

 \$ _____ which represents a premium payment for my policy. I authorize debit from my account immediately upon receipt.
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.

AUTHORIZED SIGNATURE(S) (Must match the name on the account)

DATE