Standard Insurance Company

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

Producer Information Report
Guarantee Issue
Application for Disability Income Insurance

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 ____________________

6. Phone Numbers H( ) ____________ W( ) ____________

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:

____
____
____
____
____
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____

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

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

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

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 ____ 8. Email (optional) ____

Insurance Applied For

A. Disability Income

9. Plan Type & Features:
BASIC MONTHLY BENEFIT $________________
WAITING PERIOD _____________ DAYS
BENEFIT PERIOD _____________
- ☐ NONCANCELABLE
- ☐ OWN OCCUPATION
- ☐ MENTAL DISORDER/SUBSTANCE ABUSE LIMITATION
- ☐ INDEXED COST OF LIVING: ☐ 3% / ☐ 6%
- ☐ FUTURE PURCHASE OPTION
  $__________ POOL AMOUNT
- ☑ RESIDUAL/PARTIAL DISABILITY (ALWAYS INCLUDED)
- ☐ CATASTROPHIC $________________
- ☐ PRE-EXISTING CONDITIONS AMENDED
- ☑ ERISA
- ☐ OTHER________________________________

10. Occupation Class: _____ (Available classes: 5A, 4A, 4P, 3A, 3P, 2A, 2P, A, B)
11. Premium Mode: _____ List Bill-monthly. (List bill plan number, if known:____________) ☐ Other______________
12. Other Coverage: Explain all YES answers in the table below. Do not include the insurance you are applying for with this application.
    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. Have you filed a claim for or received any disability insurance benefits in the last 3 months?......... ☐YES ☐NO
    If YES please explain:________________________________

COMPANY OR SOURCE:	TYPE: OF COVERAGE*	IF GROUP INSURANCE: WHO PAYS PREMIUM?	BENEFIT CAP MAXIMUM?	MONTHLY AMOUNT:	BENEFIT PERIOD:	WAITING PERIOD:	WILL THIS COVERAGE BE REPLACED OR REDUCED?
							☐YES ☐NO
							☐YES ☐NO
							☐YES ☐NO

***USE TYPE CODES:** I - INDIVIDUAL; G - GROUP; X - ASSOCIATION; OE - OVERHEAD EXPENSE ; O - OTHER

General Information

13. Current Primary Occupation (Include professional designation, specialty or degree.) ____ 14. Years in Current Primary Occupation ____ 15. Years with Current Employer ____

16. Current Employer ____ 17. Employer Address ____ City, State ____ Zip Code ____

18. For the period of time starting **180 days prior to and including the date of this application:** Have you been continuously at work on a full time basis performing all the duties of your occupation without limitation due to an injury or sickness?.. ☐YES ☐NO
    If NO, please explain:________________________________
19. 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	________	________	________

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: (a) the date a policy has been issued, delivered to and accepted by the owner; and (b) 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 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 listed in answer to Question 12 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 willfully false, or intentionally misleading material misrepresentations have been made, Standard may have the right to deny benefits or rescind my insurance policy. I REPRESENT that: All answers in this application are true and complete and correctly recorded; and that any and all answers I have provided to any Standard representative are recorded in this application. I signed this application in the city and state and on the date shown below.

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.

________________________________ Signed at____________________________ ______ on____/_____/_____
SIGNATURE OF PROPOSED INSURED CITY STATE DATE

If Policyowner is Other Than Proposed Insured:

________________________________ Signed at____________________________ ______ on____/_____/_____
SIGNATURE OF POLICYOWNER CITY STATE DATE

____ ____________________
PRINT NAME AND TITLE OF POLICYOWNER POLICYOWNER'S TAX ID NUMBER

____ ____________________
POLICYOWNER'S ADDRESS CITY, STATE ZIP CODE EMAIL ADDRESS (OPTIONAL)

I declare and affirm that: (1) any answers provided to me by the proposed insured have been truly and accurately recorded on this application; and (2) 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 different.

________________________________ Signed at____________________________ ______ on____/_____/_____
SIGNATURE OF SOLICITING PRODUCER CITY STATE DATE

Standard Insurance Company
Individual Disability Insurance 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 MIB, Inc. (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 MIB, Inc., 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 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.

MIB, Inc.
Standard, or its reinsurers, may make a brief report to the MIB, Inc. MIB, Inc. 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 (TTY 866-346-3642). Information for consumers about MIB, Inc. 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 Personal (Nonmedical) 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 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, MIB, Inc. 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, MIB, Inc., 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 Disability Insurance 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*)

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer that issued your life, annuity or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life & Health Insurance Guaranty Association
4760 White Bear Parkway
Suite 101
White Bear Lake, Minnesota 55110
(651) 407-3149

The maximum amount the Guaranty Association will pay for all policies issued on one life by the same insurer is limited to $500,000. Subject to this $500,000 limit, the Guaranty Association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the Association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the Guaranty Association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The Guaranty Association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

STANDARD INSURANCE COMPANY
P.O. Box 711
Portland, Oregon 97207

Standard Insurance Company

Individual Policy Issue
1100 SW Sixth Avenue   Portland OR 97204-1093

Minnesota Guaranty Association Notice Delivery Receipt

Name of Applicant: ____
(please print)

Signature of Applicant: ______________________________________ Date ______________

To all producers completing a Minnesota application:

Minnesota law requires documentation of the fact that Minnesota's guaranty association notice is given to the applicant at the time of application. For your convenience, we are providing you with this delivery receipt to assist in your compliance with this law.

Please complete this receipt and forward it with the completed application to the home office.

I, the undersigned producer, declare that I provided a copy of Minnesota's required guaranty association notice at the time of application to the above applicant.

______________________ ______________________________________
Date Signature of Producer

Standard Insurance Company

Individual Division
1100 SW Sixth Avenue Portland OR 97204-1093

Catastrophic Disability Benefit
Application Supplement

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: ______________________

____

____

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I have read this Application Supplement. I REPRESENT THAT: 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.

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

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

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 ☐ Checking ☐ Savings	TYPE OF FINANCIAL INSTITUTION ☐ Bank ☐ Credit Union ☐ Savings & Loan	
for recurring payments only: **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

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.*

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