

**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

**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 Disability Insurance  
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: 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.

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 certify that I have truly and accurately recorded on this form all information provided by the proposed insured and owner, if different. 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

**NOTE: A person commits a fraudulent act when that person knowingly files an application for insurance which either:  
(a) contains materially false information; or (b) conceals material information with intent to mislead.**

**Standard Insurance Company**

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

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**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. (Medical Information Bureau)**

Standard, or its reinsurers, may make a brief report to the MIB, Inc., formerly known as Medical Information Bureau. 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](http://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**

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**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. (Medical Information Bureau) 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)