

**NEVADA**

**Note: Please contact your MGA/SMP before proceeding if the proposed insured has been declined or offered a modified policy in the past, or has any serious medical conditions.**

**What to do:**

1. Review Discussion Topics, Income Documentation Requirements and Medical Underwriting Requirements.
2. Complete Part I and Part II\* of the application fully (questions 1-59) with proposed insured and owner (if different).  
\*If TeleApp, complete Part I and pages 2-3 of Part II.
3. After proposed insured and owner (if different) have reviewed, obtain signatures on Part III, and on all applicable authorizations, receipts and notices in the application packet.
4. Send application packet and additional requirements to your MGA/SMP.

**Contents of NV Application Packet (in order of appearance) & Instructions**

- TeleApp Producer Instructions** - for producers who choose the TeleApp process.
- Discussion Topics, Income Documentation Requirements, Medical Underwriting Requirements** - for producer to review.
- Producer Information Report for Disability Insurance (11302)** - producer completes. If TeleApp, see TeleApp Producer Instructions regarding information required from the Discussion Topics.  
*Review the following forms with the proposed insured before obtaining signatures.*
- Disclosure Notice-Information Practices (3519)** - give to proposed insured.
- Part I and Part II Application for Disability Insurance (DIAPP)** - complete all questions with proposed insured. If TeleApp, skip pages 4-5 in Part II.
- Part III Application for Disability Insurance** - obtain all signatures and dates.
- Authorization to Obtain and Disclose Information (9935)** - obtain signature and dates.
- Authorization for Release of Personal Psychotherapy Notes to Standard Insurance Company (11338)** - obtain signature and dates if proposed insured has answered "Yes" to question 50b, or to question 52a in regard to a counselor, psychiatrist or therapist. For TeleApp, obtain signature and dates if proposed insured has provided information for Discussion Topics number 3.
- Disability Insurance Conditional Receipt (DICR)** - use only if premium is collected with application; complete with proposed insured and owner (if different); give copy to owner. Application and Conditional Receipt must be signed on the same date and submitted with required premium.
- Authorization for One-Time and/or Recurring Electronic Funds Transfer (EFT) (1804)** - use if the proposed insured (or owner if different) prefers premium payment by one-time debit authorization with the application and/or recurring premium payment by EFT is the billing mode chosen. Mark one or both box(es), to indicate the portion(s) of the form that will apply. Complete routing transit and account numbers, or attach voided check from payor. Obtain the authorized signature.

<p><b>Additional Requirements at Time of Application:</b></p> <p><b>All Products</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Matching Illustration</li> <li><input type="checkbox"/> Required Income Documentation</li> </ul> <p><b>Business Overhead Expense</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Business Overhead Expense Supplemental Form (2967)</li> </ul> <p><b>Business Buy-Out Expense</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Business Buy-Out Expense Supplemental Forms (7202 and 7204)</li> </ul>	<p><b>Important Reminders:</b></p> <ul style="list-style-type: none"> <li>• Submit applications within 30 business days of signature date</li> <li>• Make sure all questions are answered completely</li> <li>• Obtain all required signatures and accurate dates; do not alter dates</li> <li>• Changes/corrections must be initialed by applicant</li> <li>• Do not use white-out on any forms</li> </ul> <p style="text-align: center;">Thank you for choosing The Standard. We look forward to working with you.</p>
---	--

## TeleApp Producer Instructions

The TeleApp process is optional and available for use with all Individual Disability Insurance applications, occupation classes and underwriting programs. The Standard recommends that you choose this option to reduce call backs to your customers as well as for faster, more efficient underwriting.

### Here's how to proceed with a TeleApp:

- **Use the application form (DIAPP) and all other forms in the Application Packet for your state.** (See Checklist and Cover Sheet)
- **Complete all application questions except the medical questions on pages 4 and 5 of the DIAPP form.** (You might need to check your state version to see which pages are medical only)
- **You and your customer must complete the financial questions and submit the required income documentation,** as the TeleApp vendor (LifePlans, Inc.) will not ask these questions.
- **You must obtain detailed information for numbers 1 – 4 on the Discussion Topics form (included in the application packet).** The information to be discussed includes:
  1. The proposed insured's height and weight.
  2. The proposed insured's significant health history requiring hospitalization, long term treatment and/or surgery and any prescription or over the counter medications.
  3. Whether the proposed insured is taking any anti-depression or anxiety medication or seeing any counselors and, if so, the reason(s).
  4. Any use of tobacco products or nicotine substitutes.
- **Record responses to the topics either on the Producer Information Report form (in this application packet) or on the Discussion Topics form itself. Then submit them with the application and all other applicable forms in the Application Packet.**

If your customer discloses medical history in discussing the topics above, contact your underwriter at The Standard before you submit the application. This will help The Standard to manage your customer's expectations with regard to their application.

- **The Standard will order a telephone interview once the completed application and the discussion topics information have been received.**

Please let your customers know that LifePlans, which will conduct the telephone interview, will contact them to schedule an interview. Since the interviews are completed by nursing personnel, your customers will not be able to call LifePlans to complete their interviews. This practice ensures that a nurse is available and your customer is fully prepared for the interview.

Please advise your customer to be ready with details of medical history, including names of physicians, dates and medications.

## Standard Insurance Company

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

## Discussion Topics for Disability Insurance Prospects

You may want to discuss these topics with your prospective clients. This can help provide a starting point for discussing your client's interest in disability insurance with Standard Insurance Company.

**Note:** Any applicant wishing to submit an application for disability insurance, regardless of discussion of these topics, must be allowed to complete the application.

---

Individual Disability Insurance  
Underwriting  
800.378.6058

Sales and Marketing  
800.992.4446

---

1. Height and weight.
2. Any significant health history which has required hospitalization, long term treatment and/or surgery; any prescription or over the counter medications being taken.
3. Any antidepressant medication or counseling; reasons.
4. Any use of tobacco products or nicotine substitutes.
5. Occupation and duties at work.
6. Location of work, e.g. office, field, at home; and percentage of duties performed there.
7. Number of hours working per week.
8. Any activities, hobbies, or avocations that might be considered hazardous (including work-related or recreational activities).
9. If self-employed, how long; percentage of ownership in the company; number of employees.
10. Taxable earned income\* for this year and last year.
11. Any current or pending group or individual disability coverage.

\* Income documentation will be required for all applications. See *Understanding Income Documentation for IDI, form 14132, in this packet.*

**FOR PRODUCER USE ONLY—THIS IS NOT PART OF AN APPLICATION OR POLICY FOR INSURANCE.**

# Understanding Income documentation for IDI

Entity	Documentation <sup>1</sup> for			What Income Figure to Use	Employer - Paid Limits
	The Protector+ and The Protector <sup>2</sup>	The Business Protector	The Business Equity Protector		
<b>Students, Residents, New Professionals</b>	Non Required	For new in private practice professionals, please contact your underwriter.	Not available	See Student/New Professional Guidelines in the Special Occupations Section for benefit limits	Not eligible for employer - paid limits.
<b>Non - owner employee</b>	Complete Form 1040 for most recent year including all schedules, W - 2's and 1099's of the proposed insured <b>OR</b> If income is from salary only, provide copy of paystub showing a minimum of six months of YTD income <b>OR</b> If 1099 income, complete 1040 to include related Schedule C	Not available	Not available	W - 2 box #5 labeled "Medicare Wages and Tips" <b>OR</b> Project year to date salary to determine annual income. Do not project commissions or bonuses. <sup>3</sup> <b>OR</b> 1099's report income from independent contractors. Most likely filed under a Schedule C, but may be reported as "other income"	May apply for employer - paid limits. <sup>4</sup> Independent contractors are not eligible for employer - paid limits.
<b>Owner of Sole Proprietorship</b>	Complete Form 1040 and Schedule C	Schedule C from personal tax return	Not available	Schedule C line #31	Not eligible for employer - paid limits.
<b>C Corporation Owner</b>	Complete 1040 and W - 2's of the proposed insured. Business Tax Form 1120 is required if 50%+ owner (non-medical occupations only)	Business tax form 1120	2 years' complete business tax returns	W - 2 box #5 labeled "Medicare Wages and Tips"	May apply for employer - paid limits. <sup>4</sup>
<b>S Corporation Owner</b>	Complete 1040, W - 2's, and Schedule E <b>OR</b> Corporate Tax Return Form 1120S and Schedule K - 1 (1120S)	Business tax form 1120S	2 years' complete business tax returns	W - 2 box #5 plus Schedule E Nonpassive income, subtract Nonpassive loss, subtract Section 179 Expense. "Passive" may be counted as unearned income. <b>OR</b> Add 1120S line 7 (owner's share shown on W - 2) and K - 1 box number 1, subtract line 11	May apply for employer - paid limits if the proposed insured owns 2% or less of the business. <sup>4</sup>
<b>Partnership</b>	Complete 1040, Partnership Form 1065, Schedule K - 1 (1065)	Business tax form 1065	2 years' complete business tax returns	Add K - 1 lines 1 and 4, subtract line 12	Not eligible for employer - paid limits.
<b>LLC or LLP</b>	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.

Two years of tax returns are required for business owners applying for the Business Owner Upgrade under Old Fashioned Underwriting.

<sup>1</sup> For some occupations, the occupation rating schedule in The Standard's Individual Disability Insurance Manual requires documentation of more than one year's earned income to qualify for an occupation classification. Examples include stockbrokers, real estate agents and insurance producers.

<sup>2</sup> The Protector is only available in California

<sup>3</sup> For bonus or commission to be considered as income, at least two years' documentation is required.

<sup>4</sup> 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.

<b>MEDICAL UNDERWRITING REQUIREMENTS<sup>1</sup></b>			
Amount <sup>2</sup>	Age		
	18-40	41-50	51-60
0-2,499	0	0	0
2,500-3,500	1	2	2
3,501-5,000	1	2	2
5,001-10,000	2	2	2
10,001 & over	2	2	3

- 0 = no medical requirements needed
- 1 = Urine HIV test
- 2 = Blood profile, Home Office Specimen (HOS) and Mini-exam (height, weight, pulse, blood pressure)
- 3 = Mini-exam, Blood profile, HOS, EKG

**NOTES:** Underwriting has the discretion to order any medical requirements regardless of the amount applied for.

**Health Care Occupations: A blood profile and HOS are required for any amount for those employed in the following occupations:**

Physicians (MD or DO), physicians assistants, podiatrists, registered nurses, dentists, dental hygienists, surgical assistants, dialysis technicians, emergency medical technicians, paramedics and others performing invasive procedures or drawing blood.

**An examination and EKG are not necessary unless required for the issue age and amount applied for.**

**APPROVED FACILITIES:**

Paramedical Facilities: The Standard requires that you use a facility that has been approved by The Standard's home office. The approved facility is Superior Mobile Medics (800) 898-3926. Exams may also be ordered on The Standard's IDI producer web pages: [www.standard.com/di](http://www.standard.com/di).

Lab Test Processing: Effective April 1, 2008, The Standard uses Lab One exclusively to process lab tests.

1 These requirements do not apply under *Old Fashioned Underwriting*<sup>SM</sup>. For further information regarding *Old Fashioned Underwriting*, please refer to The Protector Series<sup>SM</sup> Product Guide, form 9251.

2 The amount of monthly indemnity with The Standard, either in force or applied for in the last three years time. This includes Supplemental Social Insurance benefits, The Business Protector<sup>SM</sup>, The Business Equity Protector<sup>SM</sup>, The Protector<sup>SM</sup> and The Protector+<sup>SM</sup>. Disregard amounts provided by all other benefits and riders. For The Business Equity Protector, divide any lump sum by 36 and add in the monthly benefits.

**EXAMPLE:**

John Smith has a \$2,000 policy issued within the last three years time. He is now applying for an additional \$2,000 base, \$1,000 of SSI, \$2,000 CAT rider and \$5,000 of FPO. Please include the \$2,000 from the inforce policy plus the \$2,000 base and \$1,000 of SSI currently being applied for. Disregard the CAT rider and FPO rider benefits being applied for when determining the medical requirements.

Standard Insurance Company

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

Producer Information Report  
for Application for Disability Insurance

1. Producer Name (Please Print) \_\_\_\_\_ 2. Producer Number \_\_\_\_\_ 3. Agency \_\_\_\_\_

HOME ( ) WORK ( ) OTHER ( )  
4. Telephone Numbers \_\_\_\_\_

5. Fax Number \_\_\_\_\_ 6. E-mail Address \_\_\_\_\_

7. Other Producer(s) to Receive Credit for This Application:

NAME (PRINT) \_\_\_\_\_ PRODUCER NO. \_\_\_\_\_ PERCENT \_\_\_\_\_

NAME (PRINT) \_\_\_\_\_ PRODUCER NO. \_\_\_\_\_ PERCENT \_\_\_\_\_

NAME (PRINT) \_\_\_\_\_ PRODUCER NO. \_\_\_\_\_ PERCENT \_\_\_\_\_

8. Source of Sale:  CLIENT RESALE  RELATIVE/FRIEND/NEIGHBOR  UNSOLICITED (EXPLAIN IN REMARKS)  
 CLIENT REFERRAL  DIRECT MAIL/COLD CALL  OTHER (EXPLAIN IN REMARKS)

9. How long and how well do you know the proposed insured? \_\_\_\_\_

10. Does the proposed insured speak and understand English? If no, explain in REMARKS.  YES  NO

11. Did you personally see and talk with the proposed insured and owner at the time this application was completed and signed? **If no, explain in REMARKS.**  YES  NO

12. To the best of your knowledge, is replacement involved or intended to be involved with this application?  YES  NO

13. Are you aware of prior (last 12 mos.) or pending applications with other companies? If yes, explain.  YES  NO

14. Give billing instructions (if other than bill to policyowner). \_\_\_\_\_

15. Discounts Applied (if any, check only one):

MULTI-LIFE (3 OR MORE LIVES) Number of Lives \_\_\_\_\_  
Employer's Name \_\_\_\_\_  
Employer's TIN \_\_\_\_\_

ASSOCIATION  RESIDENT/HOSPITAL ENDORSEMENT  
(Underwriting pre-approval required.)  
Assoc./Resident/Hospital Name(s) \_\_\_\_\_  
Assoc./Resident/Hospital Program Number(s) \_\_\_\_\_

**You must list names, and policy numbers if available, of at least two other insureds in REMARKS area below.**

OTHER \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. TELEAPP?  YES  NO If yes, please complete numbers 1 through 4 of the Discussion Topics form and submit it with the application.

17. REMARKS. Note anything not disclosed in the application that might affect the proposed insured's insurability.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I DECLARE THAT: I gave the Disclosure Notice - Information Practices to the proposed insured. This application was read and signed by the proposed insured and owner, if different, after all required questions were asked and answered. I have accurately recorded on this application all information given to me by the proposed insured and owner, if different. Regardless of whether medical questions will be asked of the proposed insured in any telephone or other interview process, I know of nothing affecting the risk that is not recorded on this application or in any accompanying written statement or letter.

Producer Signature \_\_\_\_\_ Date \_\_\_\_\_

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, Inc. (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, Inc., 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, INC. (MEDICAL INFORMATION BUREAU):** We, or our 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.

**Proposed Insured**

1. Full Name (Last, First, Middle) \_\_\_\_\_ 2. Sex \_\_\_\_\_ 3. Social Security Number \_\_\_\_\_

4. Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

5. Current Primary Occupation \_\_\_\_\_ 6. E-mail Address (optional) \_\_\_\_\_

7. Date of Birth \_\_\_\_\_ 8. State of Birth \_\_\_\_\_ 9. Length of US Residence \_\_\_\_\_ 10. Driver's License No./Issue State \_\_\_\_\_  
 HOME( ) WORK( ) OTHER( ) H W OTHER

11. Phone Numbers \_\_\_\_\_ 12. Preferred Place to Call \_\_\_\_\_

13. Rates Illustrated as: SMOKER NONSMOKER OTHER

14. Occupation Class: 5A 4A 4P 3A 3P 2A 2P A B

15. Premium Mode: EFT (MONTHLY) LIST BILL (MONTHLY) ANNUAL OTHER

**Insurance Applied For**

16. Plan Type **A. Disability Income** & Features: BASIC MONTHLY BENEFIT \$ \_\_\_\_\_  
 WAITING PERIOD \_\_\_\_\_ DAYS  
 BENEFIT PERIOD \_\_\_\_\_  
 SUPPL. SOC. INS. (SSI) \$ \_\_\_\_\_  
 SSI WAITING PERIOD \_\_\_\_\_ DAYS  
 RESIDUAL DISABILITY  
 NONCANCELABLE  
 OWN OCCUPATION  
 MENTAL DISORDER/SUBSTANCE ABUSE LIMITATION  
 INDEXED COST OF LIVING:  3% /  6%  
 CATASTROPHIC \$ \_\_\_\_\_  
 FUTURE PURCHASE OPTION  
 \$ \_\_\_\_\_ POOL AMOUNT  
 OTHER \_\_\_\_\_

**B. Business Overhead Expense**  
 (Application Supplement required)  
 BASE AMOUNT \$ \_\_\_\_\_  
 WAITING PERIOD \_\_\_\_\_ DAYS  
 BENEFIT MULTIPLE \_\_\_\_\_ MONTHS  
 RESIDUAL DISABILITY  
 FUTURE PURCHASE OPTION \$ \_\_\_\_\_  
 OTHER \_\_\_\_\_

**C. Business Buy-Out Expense**  
 (Application Supplement required)  
 WAITING PERIOD \_\_\_\_\_ DAYS  
 AGGREGATE BENEFIT LIMIT \$ \_\_\_\_\_  
 FUNDING METHOD (SELECT AND COMPLETE ONE):  
 LUMP SUM AMOUNT \$ \_\_\_\_\_  
 MONTHLY AMOUNT \$ \_\_\_\_\_  
 FOR \_\_\_\_\_ YEARS  
 DOWN PAYMENT AMOUNT  
 \$ \_\_\_\_\_ LUMP SUM; AND  
 \$ \_\_\_\_\_ MONTHLY FOR \_\_\_\_\_ YEARS  
 FUTURE BUY-OUT EXPENSE RIDER  
 AGGREGATE BENEFIT LIMIT \$ \_\_\_\_\_  
 FUNDING METHOD (Must be same as base)  
 (SELECT AND COMPLETE ONE):  
 LUMP SUM AMOUNT \$ \_\_\_\_\_  
 MONTHLY AMOUNT \$ \_\_\_\_\_  
 DOWN PAYMENT AMOUNT/MO. \$ \_\_\_\_\_  
 EXTENDED BENEFIT OPTION  
 OTHER \_\_\_\_\_

**Other Insurance Coverage**

17. 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. Will you become eligible for any disability insurance in the next 12 months? ..... YES NO
- c. Is there any other individual or group disability insurance currently in force or pending on you? ..... YES NO

**STATUS CODES:** NOW IN FORCE WITH STANDARD INSURANCE COMPANY (STANDARD) OR OTHER COMPANY (**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 AND POLICY NUMBER:	STATUS:	TYPE:	MONTHLY AMOUNT:	BENEFIT PERIOD:	WAITING PERIOD:	IF GROUP:			WILL COVERAGE BE REPLACED OR REDUCED?
						WHO PAYS PREMIUM?	BENEFIT CAP MAXIMUM?	% OF INCOME:	
									<input type="checkbox"/> YES <input type="checkbox"/> NO
									<input type="checkbox"/> YES <input type="checkbox"/> NO
									<input type="checkbox"/> YES <input type="checkbox"/> NO

**Note:** By signing the Agreement in Part III, the owner agrees to terminate or reduce the insurance coverage indicated as being replaced or reduced after a Standard policy is delivered. The owner understands that, if that insurance is not terminated or reduced as required by Standard, any policy issued based on this application may be rescinded.

**TeleApp:** Complete pages 2-3, then proceed to Part III on page 6. (Skip pages 4-5)

**Paper Application:** Complete all questions in Part II, then proceed to Part III on page 6.











**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 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 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, Inc. (Medical Information Bureau), 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, as described above, 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, 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. 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

\_\_\_\_\_  
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





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](http://www.standard.com)

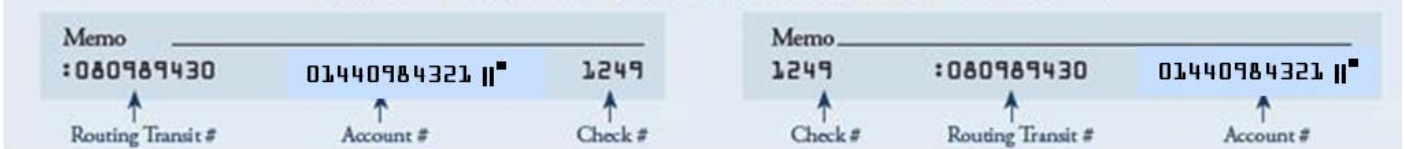
**Authorization for One-Time and/or Recurring  
 Electronic Funds Transfer (EFT)**

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> <b>Deduction</b> for the policies listed will be made <b>monthly</b> 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