TheStandard®
Positively different.

CSLEA - California Statewide Law Enforcement Association
Voluntary Term Life and AD&D Insurance for Active Members

About This Booklet

This booklet is designed to answer some common questions about the group Voluntary Term Life and Accidental Death and Dismemberment (AD&D) insurance coverage being offered by California Statewide Law Enforcement Association (CSLEA) to eligible members. It is not intended to provide a detailed description of the coverage.

If you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the *group policy* issued by Standard Insurance Company. Neither the certificate nor the information presented in this booklet modifies the *group policy* or the insurance coverage in any way. If you have additional questions, please contact Myers-Stevens & Toohey & Co., Inc. at 1-800-827-4695.

Please note that defined terms and provisions from the *group policy* are italicized in this booklet.

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Life Insurance

Life Insurance is a type of insurance which provides a sum of money to be paid if the insured person dies while the policy is in effect.

As an active, full member of CSLEA, you and your spouse are eligible to apply for Voluntary Term Life Insurance in multiples of $25,000, up to $500,000 (however, the amount of your spouse's Life Insurance cannot exceed 50% of your Life Insurance).

Cost: The following monthly age-graded rates apply to Life Insurance for you and your spouse.

Age	Rate: Per $25,000
Under 30	$2.00
30 - 34	$2.13
35 - 39	$2.75
40 - 44	$4.10
45 - 49	$6.63
50 - 54	$10.00
55 - 59	$16.75

Note: Contact Myers-Stevens & Toohey & Co., Inc. for premium rates for members and spouses age 60 or older.

Example: 32 year old member is applying for $100,000 of Voluntary Term Life Insurance and $50,000 of Voluntary Term Life Insurance on 28 year old spouse.

Member's premium for $100,000 = $8.52 per month
Spouse's premium for $50,000 = $4.00 per month

TOTAL MONTHLY PREMIUM FOR BOTH IS $12.52 PER MONTH

AD&D Insurance

Accidental Death & Dismemberment (AD&D) is a type of insurance which provides for a sum of money to be paid if the insured person dies or suffers a dismemberment as the result of an accident.

You and your spouse may apply for Additional AD&D Insurance without submitting Evidence of Insurability. The amounts available are the same amounts listed below for Voluntary Term Life Insurance. The amount of your spouse's AD&D Insurance cannot exceed 50% of your AD&D Insurance.

Cost: The premium rate for AD&D Insurance for you and your spouse is $0.80 per $25,000 of AD&D Insurance per month.

Dependent Life Insurance

The premium rate for Life Insurance for your children is based on the amount of coverage you select.

Coverage Amount	Monthly Cost
$5,000	$0.50
$10,000	$1.00

Age Reductions

At age 65, your Voluntary Term Life Insurance, your spouse's Life Insurance, and any AD&D Insurance begin reducing to a percentage of the original amount, as follows:

Insured's Age	Percentage
65 - 69	65%
70 - 74	50%
75 - 79	35%
80 - 84	20%
85 or over	10%

Becoming Insured

You are eligible for insurance if you are an active member of a group participating in CSLEA, regularly working at least 20 hours each week, and a full member in good standing of CSLEA. Fair-Share members and retired members are not eligible for this coverage. (However, any Life Insurance amounts for which you, your spouse and your children are insured immediately prior to your retirement may be continued after you retire if you qualify.)

If you wish to insure your spouse and/or children for Life Insurance, you must be insured for Voluntary Term Life Insurance. (Note that you may not be insured under this plan as both a member and a spouse. If your spouse is also a member, only one of you may insure your children under this plan.)

If you wish to insure your spouse for AD&D Insurance, you must be insured for AD&D Insurance.

For New CSLEA Members, if you apply within 90 days following your hire date and you wish to become insured for an amount of Voluntary Term Life Insurance at or below $50,000, no Evidence of Insurability is required. For amounts over $50,000, you must submit satisfactory Evidence of Insurability.

For All CSLEA Members, if you apply within 90 days following your hire date and you wish to insure your Spouse for Life Insurance in excess of $25,000 your Spouse must submit satisfactory Evidence of Insurability.

Evidence of Insurability is required to become insured for any amounts for which you apply more than 90 days following your hire date.

These amounts will become effective the first of the month following the date The Standard approves the Evidence of Insurability. Premiums are payroll deducted through the State Controller's office.

Evidence of Insurability is not required for (a) Life Insurance for your children (provided you apply within 31 days of becoming eligible), or (b) AD&D for you or your spouse. These coverages will become effective on the date you apply.

Note that you must meet the Active Work requirement before you or your dependents' insurance (or any increase in insurance) will become effective.

A spouse includes the person to whom you are legally married or an individual recognized as your domestic partner under California state law.

Children qualify for coverage from live birth through age 20 (or through age 24 if a full-time student at an accredited educational institution), and include your natural child, adopted child, or children of your spouse living in your home, but do not include a full-time member of the armed forces of any country. Disabled children may also be covered beyond the limiting ages as provided in the group policy.

Other Features

Right To Convert

If you, your spouse, or your children's Life Insurance ends or is reduced for any reason other than your failure to pay your premium, you (or your dependents) may have a right to buy an individual policy of permanent life insurance without submitting a Medical History Statement (during a 31-day conversion period).

AD&D Benefits

The entire amount of an insured's AD&D coverage is payable for these accidental losses:

- Life
- Loss of both hands or both feet
- Loss of sight in both eyes
- Loss of one hand and one foot
- Loss of one hand or foot and sight in one eye

One half of the entire amount of the insured's AD&D coverage is payable for these losses:

- Loss of sight in one eye
- Loss of one hand or one foot

Seat Belt Benefit

The insurance company will pay an additional Accidental Death Benefit if you die as a result of an automobile accident and you were wearing a seat belt at the time of the accident. This benefit will equal the lesser of $10,000 or the amount of your AD&D.

If your spouse dies as a result of an automobile accident while wearing a seat belt, an additional benefit equal to the lesser of $10,000 or the amount of the spouse's AD&D will be payable.

Career Adjustment Benefit

If you die as a result of an accident for which an AD&D benefit is payable, a Career Adjustment Benefit may be paid to your spouse. If your spouse enters a professional or trades program for the purpose of obtaining employment or increasing earnings,

tuition expenses of up to $5,000 per year may be reimbursed, provided the expenses were incurred within 36 months following your death. The cumulative total reimbursement may not exceed $10,000 or 25% of the AD&D benefit, whichever is less.

Child Care Benefit

If you die as a result of an accident for which an AD&D benefit is payable, a Child Care Benefit may be paid to your spouse. Child care expenses for your children under age 13 which are incurred as a result of your spouse's working, or training for work or increased earnings, may be reimbursed, up to $5,000 per year, provided the expenses were incurred within 36 months following your death. The cumulative total reimbursement may not exceed $10,000 or 25% of the AD&D benefit, whichever is less.

Higher Education Benefit

If you die as a result of an accident for which an AD&D benefit is payable, a Higher Education Benefit may be paid to your children. If within 12 months after your death your child is registered and in full-time attendance at an accredited institution of higher education, tuition expenses of up to $5,000 per year may be reimbursed, provided the expenses were incurred within 48 months following your death. The cumulative total reimbursement may not exceed $20,000 or 25% of the AD&D benefit, whichever is less.

Exclusions And Limitations

Voluntary Term Life Insurance for you and your spouse – If death results from suicide or other intentionally self-inflicted injury, while sane or insane, the following will apply:

a. The amount payable will exclude the amount of Voluntary Term Life Insurance which has not been continuously in effect for at least two years on the date of death.
b. The insurance company will refund all premiums paid for that portion of Voluntary Term Life Insurance which is excluded from payment under this suicide exclusion.

AD&D Insurance for you and your spouse – No payment will be made for losses caused by: war; suicide or self-inflicted injury; committing an assault or felony or active participation in a violent disorder or riot (except while performing official duties); the voluntary use of drugs, poison or chemical compound, unless used in accordance with the direction of a physician; sickness, illness, disease, pregnancy, childbirth or related medical condition existing at the time of the accident; heart attack or stroke; medical or surgical treatment for any of the aforementioned items.

When Insurance Ends

Life and AD&D Insurance will end on the earliest of the following dates:

a. The date you cease to be a full member of CSLEA.
b. The date you become a full-time member in the armed forces of any country.
c. The date the Group Policy terminates.
d. The last day of the last period for which you made the required premium contribution.
e. With respect to any AD&D Insurance, the date you cease to be eligible for coverage under the terms of the group policy.
f. With respect to your spouse and children, the date your dependents cease to qualify as dependents, the date your coverage ends, or the date the dependent becomes a full-time member of the armed forces of any country.

If you continue Life Insurance for yourself or your dependents during your retirement, and you or your dependent's coverage ends for any reason, you (or your dependents) may not become insured again.

About This Brochure

This brochure is written in nontechnical language, and is not intended as a complete description of the coverage. The controlling provisions are in the Group Policy. This brochure does not modify that document or the insurance in any way. You may request a certificate which will provide a more detailed description of the coverages. Please call Myers-Stevens & Toohey & Co., Inc. at 800.827.4695 with any questions.

About Standard Insurance Company

As a national leader in the employee benefits industry, Standard Insurance Company offers quality products and superior customer service to deliver employee benefits solutions to our customers. Founded in 1906, The Standard now serves customers from coast to coast with group and individual disability insurance and retirement plans, and group life and dental insurance. For more information about Standard Insurance Company, visit its Web site at www.standard.com.

How to Apply

1. Detach the Group Life Insurance Program Application form at the back of this brochure.
2. Complete, sign and date the Group Life Insurance Program Application.
3. If you are applying for Life Insurance and Evidence of Insurability is required, complete and sign a Medical History Statement. If your spouse is also applying for Additional Life Insurance, they must complete a separate Medical History Statement.
4. Put the forms in an envelope and mail to:

   Myers-Stevens & Toohey & Co., Inc.
   26101 Marguerite Parkway, Mission Viejo, CA 92692
5. If you have any questions, call Myers-Stevens & Toohey & Co., Inc. at 800.827.4695.

Plan is arranged and administered by:

myers-stevens

Myers-Stevens & Toohey & Co., Inc.
26101 Marguerite Parkway
Mission Viejo, CA 92692

CA Lic. #0425842

Notes

GROUP VOLUNTARY TERM LIFE INSURANCE PROGRAM APPLICATION

CSLEA - California Statewide Law Enforcement Association

Please print

Member's Name _____ Soc. Sec. Number _____

Home Address _____

City _____ State _____ Zip _____

Phone Number Home: (___) _____ Work: (___) _____ Date of Birth _____ Sex: ☐ Male ☐ Female
mo/day/yr

Full Name of Your Employer (Department) _____ Date Employed _____
mo/day/yr

Date of CSLEA Membership _____ I am an active: ☐ full member in good standing of CSLEA
mo/day/yr

Email Address (Work): _____

Member's Beneficiary _____

Beneficiary's Soc.Sec.No. _____ Relationship _____

This designation supersedes any previous beneficiary designation for Voluntary Term Life and AD&D Insurance. The member is the beneficiary of any coverage in effect on his/her eligible spouse or children.

I am actively at work for an employer and a member in good standing of CSLEA and having read the attached brochure describing benefits, I hereby apply for insurance under the provisions of the CSLEA Group Term Life Insurance Plan. I certify that I am now able to perform the full-time duties of my occupation. Upon approval of this application, I authorize my employer (if applicable) to make the necessary deductions from my wages or salary to cover my contribution for the cost of this insurance, underwritten by Standard Insurance Company of Portland, Oregon.

Member's Signature _____ Date _____

Note: Beneficiary designation is not valid unless this form is signed and dated.

VOLUNTARY TERM LIFE INSURANCE FOR MEMBER AND/OR SPOUSE:

You may elect any multiple of $25,000 (up to $500,000) for yourself. For your spouse, you may elect any multiple of $25,000 (up to $250,000), not to exceed 50% of your amount.

MEMBER AMOUNT OF COVERAGE REQUESTED: $ _____

SPOUSE AMOUNT OF COVERAGE REQUESTED: $ _____

Spouse Name _____ Soc. Sec. No. _____ Date of Birth _____
mo/day/yr

The Member and Spouse must complete and have approved Medical History Statements to become insured for amounts of Voluntary Term Life Insurance for which Evidence Of Insurability is required.

ADDITIONAL AD&D INSURANCE FOR MEMBER AND/OR SPOUSE:

You may elect any multiple of $25,000 (up to $500,000) for yourself. For your spouse, you may elect any multiple of $25,000 (up to $250,000), not to exceed 50% of your amount.

MEMBER AMOUNT OF COVERAGE REQUESTED: $ _____

SPOUSE AMOUNT OF COVERAGE REQUESTED: $ _____

Spouse Name _____ Soc. Sec. No. _____ Date of Birth _____
mo/day/yr

No Medical History Statement is required to become insured for Additional AD&D Insurance.

CHILDREN'S LIFE INSURANCE:

The Member may choose one of the following amounts for eligible children: ☐ $5,000 ☐ $10,000

The Member may not insure his/her children if the Member is not insured for Voluntary Term Life Insurance. No Medical History Statement is required if the Member applies for Children's Life Insurance within 31 days of becoming eligible.

IMPORTANT: If you are applying for Voluntary Term Life Insurance and Evidence Of Insurability is required, please complete the enclosed Medical History Statement and return to Myers-Stevens & Toohey & Co., Inc. with this application form. Life Insurance amounts subject to Evidence Of Insurability will not become effective until Evidence Of Insurability has been approved by Standard Insurance Company.

Standard Insurance Company
Medical Underwriting, 900 SW Fifth Avenue Portland OR 97204

MEMBER
Medical History Statement
For Residents of California

DIRECTIONS FOR APPLYING FOR COVERAGE

This form must be completed when Evidence Of Insurability is required. To apply for coverage (as a Member/Employee Spouse or Child), read the Information Practices Notice(s). Then complete all items, date, and sign as instructed. Please keep a copy for your records.

MEMBER/EMPLOYEE INFORMATION

Name of Group		Group Number	Check who is Applying (One per form)
CSLEA - California Statewide Law Enforcement Association		**600361-A**	☐ Member/Employee ☐ Spouse ☐ Child
Member/Employee Name		Birthdate (Mo/Day/Year)	Date Hired (Mo/Day/Year)
Occupation	Salary	Social Security Number	Member/Employee Identification No.

APPLICANT INFORMATION

Applicant's Name (Person to be insured)			Street Address City State Zip	
Sex ☐M ☐F	Birthdate (Mo/Day/Year)	Birthplace	Social Security Number	Work Phone ( ) Home Phone ( )

APPLICATION INFORMATION

Type of Application *(check one)* ☐ Initial ☐ Increase in Coverage

Check the insurance coverage you are requesting.

☐ Voluntary Term Life _____ (Current Amount In Force, if any) + _____ (Additional Amount Requested) = _____ (Total Amount Requested)

☐ Dependents Life _____ (Current Amount In Force, if any) + _____ (Additional Amount Requested) = _____ (Total Amount Requested)

MEDICAL HISTORY STATEMENT QUESTIONS

Check yes or no for each of these questions, and give details for any "yes" answers. Attach a separate sheet if necessary.

1. Are you now unable to work full-time because of any physical or mental condition, or injury? ☐ Yes ☐ No
2. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
   - A. Disease of the liver, pancreas, kidney, ulcers, stomach, intestinal ailment, or digestive system disorder? ☐ Yes ☐ No
   - B. Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, blindness, deafness, or any other neurological or muscle disorder? ☐ Yes ☐ No
   - C. Cancer, tumor, lesions, leukemia, lymphoma, blood clotting or other malignancy or growth? ☐ Yes ☐ No
   - D. Cardiovascular disease, heart ailment, arteriosclerosis, abnormal pulse, high blood pressure, heart murmur, valve, circulatory, or vascular disorders? ☐ Yes ☐ No
   - E. Emphysema, asthma, bronchitis, sleep apnea, or other respiratory or lung disease? ☐ Yes ☐ No
   - F. Lupus, scleroderma, vasculitis, connective tissue disease, or other immune system disorder not related to Human Immunodeficiency Disorder (HIV)? ☐ Yes ☐ No
   - G. Osteoarthritis, rheumatoid arthritis, osteoporosis, pain in the joints, amputations, or other disease or disorder of the bones, joints, back, or spine, arthritic or disc conditions? ☐ Yes ☐ No
   - H. Diabetes, thyroid, gland, spleen, or nephritis? ☐ Yes ☐ No
   - I. Drug or alcohol abuse, or have you used alcohol, drugs or nicotine in a manner that has resulted in medical treatment? ☐ Yes ☐ No
   - J. Psychiatric or mental condition, depression, adjustment disorder, affective disorder, anxiety disorder, or obsessive-compulsive disorder? ☐ Yes ☐ No
3. In the past 10 years have you had any illness or injury not listed above which resulted in the use of prescribed medication or physician visits? ☐ Yes ☐ No
4. Has a medical professional ever diagnosed you as having or prescribed medication to you for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ☐ Yes ☐ No
5. Are you currently pregnant? ☐ Yes ☐ No

Height	Weight	Physician or Medical Facility with Applicant's Complete Medical Records
		Name and Full Mailing Address

Applicant Name *(to be completed if applying online)*	Social Security Number

Describe below any "yes" answers. (Please provide the entire question number.)

Question Number	*Description of Injuries, Disorders and Operations*	*Month/Year*	*Duration*	*Final Result*	*Physicians Consulted, City & State*

ACKNOWLEDGMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION *(Please read carefully)*

- I represent that the statements contained herein, including those made in response to the Medical History Statement questions and any attachments, are true and complete, to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, The Standard's liability is limited to the return of any premium which may have been paid.
- To any health plan, physician, health care provider, hospital, clinic, laboratory, pharmacy, medical facility, insurance or reinsurance company, and the Medical Information Bureau Inc. (MIB), I instruct you to disclose my entire medical record and any other protected health information concerning me to The Standard or its reinsurers. This includes information on any disorder of the immune system, including Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, and any communicable or sexually transmitted disease or disorder. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.
- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any of the above to release and disclose my entire medical records without restriction.
- I understand that The Standard will use information obtained by authorization to determine my eligibility for group insurance coverage. I understand The Standard may release information it has about me to its reinsurers and to any person performing business or legal services for The Standard in connection with my application. I understand The Standard may release information it has about me to the MIB for the purpose of reporting to the MIB information exchange and for MIB to audit The Standard's reporting. I understand The Standard may release information it has about me to other insurance companies to which I have applied for insurance coverage or benefits.
- I understand that information disclosed to The Standard pursuant to authorization may be subject to redisclosure with my authorization or as otherwise permitted by law. Life and disability insurance coverages are not subject to the Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA), and therefore release of information to The Standard is not protected under the Act.
- I understand that if my application is approved, premiums shall be paid in accordance with the provisions of the Group Policy(ies), and my coverage will be subject to all terms and conditions of the Group Policy(ies) and state limitations.
- For Member/Employee: If I currently have a Life and/or Trust Life beneficiary designation on file with my plan administrator, I understand the designation(s) on file will also apply to any approved amounts. If I have no beneficiary designation(s) on file or I wish to change the name of the current beneficiary(ies), I will contact my plan administrator.
- I understand that insurance on a Spouse or other Dependent, if any, is payable to the Member/Employee, if living, or as provided under the terms of the Group Policy(ies).
- I acknowledge that I have read and received the Information Practices Notice and I have kept a copy of this Medical History Statement.
- I understand that I am entitled to receive a copy of this authorization. This authorization will remain valid one year from the date of the signature below. A photocopy or facsimile of this authorization shall be as valid as the original.
- I understand that I have the right to refuse to sign this authorization. I further understand that I have a right to revoke this authorization at any time by sending a written statement to The Standard, except to the extent it has been relied upon to disclose requested records. I understand that the revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.

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

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

Applicant Name *(to be completed if applying online)*	Social Security Number

INFORMATION PRACTICES NOTICE

- To help us determine your eligibility for group insurance we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or MIB, Inc. (Medical Information Bureau). We will use the authorization you signed on this form when we seek this information.
- MIB (MEDICAL INFORMATION BUREAU) – Information regarding your insurability will be treated as confidential. Standard Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

  Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

  Standard Insurance Company may release information in its file to its reinsurers, and Standard Insurance Company, or its reinsurers, may release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.
- DISCLOSURE TO OTHERS – The information collected about you is confidential. We will not release any information about you without your authorization, except to the extent necessary to conduct our business or as required or permitted by law.
- YOUR RIGHTS – You have a right to know what information we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices please write to us at Medical Underwriting, Standard Insurance Company, 900 SW Fifth Avenue, Portland, Oregon 97204 or call 1-800-843-7979.

SPOUSE

Standard Insurance Company
Medical Underwriting, 900 SW Fifth Avenue Portland OR 97204

Medical History Statement
For Residents of California

DIRECTIONS FOR APPLYING FOR COVERAGE

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MEMBER/EMPLOYEE INFORMATION

Name of Group		Group Number	Check who is Applying (One per form)
CSLEA - California Statewide Law Enforcement Association		**600361-A**	☐ Member/Employee ☐ Spouse ☐ Child
Member/Employee Name		Birthdate (Mo/Day/Year)	Date Hired (Mo/Day/Year)
Occupation	Salary	Social Security Number	Member/Employee Identification No.

APPLICANT INFORMATION

Applicant's Name (Person to be insured)			Street Address City State Zip	
Sex ☐M ☐F	Birthdate (Mo/Day/Year)	Birthplace	Social Security Number	Work Phone ( ) Home Phone ( )

APPLICATION INFORMATION

Type of Application *(check one)* ☐ Initial ☐ Increase in Coverage

Check the insurance coverage you are requesting.

☐ Dependents Life _____ (Current Amount In Force, if any) + _____ (Additional Amount Requested) = _____ (Total Amount Requested)

MEDICAL HISTORY STATEMENT QUESTIONS

Check yes or no for each of these questions, and give details for any "yes" answers. Attach a separate sheet if necessary.

1. Are you now unable to work full-time because of any physical or mental condition, or injury? ☐ Yes ☐ No
2. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
   - A. Disease of the liver, pancreas, kidney, ulcers, stomach, intestinal ailment, or digestive system disorder? ☐ Yes ☐ No
   - B. Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, blindness, deafness, or any other neurological or muscle disorder? ☐ Yes ☐ No
   - C. Cancer, tumor, lesions, leukemia, lymphoma, blood clotting or other malignancy or growth? ☐ Yes ☐ No
   - D. Cardiovascular disease, heart ailment, arteriosclerosis, abnormal pulse, high blood pressure, heart murmur, valve, circulatory, or vascular disorders? ☐ Yes ☐ No
   - E. Emphysema, asthma, bronchitis, sleep apnea, or other respiratory or lung disease? ☐ Yes ☐ No
   - F. Lupus, scleroderma, vasculitis, connective tissue disease, or other immune system disorder not related to Human Immunodeficiency Disorder (HIV)? ☐ Yes ☐ No
   - G. Osteoarthritis, rheumatoid arthritis, osteoporosis, pain in the joints, amputations, or other disease or disorder of the bones, joints, back, or spine, arthritic or disc conditions? ☐ Yes ☐ No
   - H. Diabetes, thyroid, gland, spleen, or nephritis? ☐ Yes ☐ No
   - I. Drug or alcohol abuse, or have you used alcohol, drugs or nicotine in a manner that has resulted in medical treatment? ☐ Yes ☐ No
   - J. Psychiatric or mental condition, depression, adjustment disorder, affective disorder, anxiety disorder, or obsessive-compulsive disorder? ☐ Yes ☐ No
3. In the past 10 years have you had any illness or injury not listed above which resulted in the use of prescribed medication or physician visits? ☐ Yes ☐ No
4. Has a medical professional ever diagnosed you as having or prescribed medication to you for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ☐ Yes ☐ No
5. Are you currently pregnant? ☐ Yes ☐ No

Height	Weight	Physician or Medical Facility with Applicant's Complete Medical Records
		Name and Full Mailing Address

Applicant Name *(to be completed if applying online)*	Social Security Number

Describe below any "yes" answers. (Please provide the entire question number.)

Question Number	*Description of Injuries, Disorders and Operations*	*Month/Year*	*Duration*	*Final Result*	*Physicians Consulted, City & State*

ACKNOWLEDGMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION *(Please read carefully)*

- I represent that the statements contained herein, including those made in response to the Medical History Statement questions and any attachments, are true and complete, to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, The Standard's liability is limited to the return of any premium which may have been paid.
- To any health plan, physician, health care provider, hospital, clinic, laboratory, pharmacy, medical facility, insurance or reinsurance company, and the Medical Information Bureau Inc. (MIB), I instruct you to disclose my entire medical record and any other protected health information concerning me to The Standard or its reinsurers. This includes information on any disorder of the immune system, including Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, and any communicable or sexually transmitted disease or disorder. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.
- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any of the above to release and disclose my entire medical records without restriction.
- I understand that The Standard will use information obtained by authorization to determine my eligibility for group insurance coverage. I understand The Standard may release information it has about me to its reinsurers and to any person performing business or legal services for The Standard in connection with my application. I understand The Standard may release information it has about me to the MIB for the purpose of reporting to the MIB information exchange and for MIB to audit The Standard's reporting. I understand The Standard may release information it has about me to other insurance companies to which I have applied for insurance coverage or benefits.
- I understand that information disclosed to The Standard pursuant to authorization may be subject to redisclosure with my authorization or as otherwise permitted by law. Life and disability insurance coverages are not subject to the Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA), and therefore release of information to The Standard is not protected under the Act.
- I understand that if my application is approved, premiums shall be paid in accordance with the provisions of the Group Policy(ies), and my coverage will be subject to all terms and conditions of the Group Policy(ies) and state limitations.
- For Member/Employee: If I currently have a Life and/or Trust Life beneficiary designation on file with my plan administrator, I understand the designation(s) on file will also apply to any approved amounts. If I have no beneficiary designation(s) on file or I wish to change the name of the current beneficiary(ies), I will contact my plan administrator.
- I understand that insurance on a Spouse or other Dependent, if any, is payable to the Member/Employee, if living, or as provided under the terms of the Group Policy(ies).
- I acknowledge that I have read and received the Information Practices Notice and I have kept a copy of this Medical History Statement.
- I understand that I am entitled to receive a copy of this authorization. This authorization will remain valid one year from the date of the signature below. A photocopy or facsimile of this authorization shall be as valid as the original.
- I understand that I have the right to refuse to sign this authorization. I further understand that I have a right to revoke this authorization at any time by sending a written statement to The Standard, except to the extent it has been relied upon to disclose requested records. I understand that the revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.

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

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

Applicant Name *(to be completed if applying online)*	Social Security Number

INFORMATION PRACTICES NOTICE

- To help us determine your eligibility for group insurance we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or MIB, Inc. (Medical Information Bureau). We will use the authorization you signed on this form when we seek this information.
- MIB (MEDICAL INFORMATION BUREAU) – Information regarding your insurability will be treated as confidential. Standard Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

  Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

  Standard Insurance Company may release information in its file to its reinsurers, and Standard Insurance Company, or its reinsurers, may release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.
- DISCLOSURE TO OTHERS – The information collected about you is confidential. We will not release any information about you without your authorization, except to the extent necessary to conduct our business or as required or permitted by law.
- YOUR RIGHTS – You have a right to know what information we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices please write to us at Medical Underwriting, Standard Insurance Company, 900 SW Fifth Avenue, Portland, Oregon 97204 or call 1-800-843-7979.

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