GROUP DISABILITY INSURANCE WITH MEDICAL HISTORY STATEMENT

(to be used during non-open enrollment periods)

for employees of

FLORIDA ATLANTIC UNIVERSITY

Underwritten by:
Standard Insurance Company (The Standard)

How to apply:
1. Complete the Application
2. Complete the Medical History Statement
3. Send the completed forms to The Gabor Agency

We will process your application with The Standard and notify you and your employer if your application is approved.

Enrollment conducted by:

GABOR

The Gabor Agency, Inc.
3500 Financial Plaza, Suite 400, Tallahassee, Florida 32312
Phone: (850) 894-9611 option 5 Toll-free: (800) 330-6115 option 5 Fax: (850) 894-4268
www.gaboragency.com/faultd

BRIEF DESCRIPTION OF THE GROUP DISABILITY INSURANCE

ENROLLMENT – If you are an active employee of Florida Atlantic University, regularly working at least 20 hours per week, and a citizen or resident of the United States or Canada, you are a member and eligible to enroll in group disability insurance. After the first 90 days of employment, you must complete and remit the enrollment form and Medical History Statement at the end of this brochure to apply.

You have 2 plan options to choose from:

- 30-Day Plan - Coverage under the 30-Day Plan is provided under the group Short Term Disability (STD) and Long Term Disability (LTD) insurance policies issued by The Standard to Florida Atlantic University.
- 90-Day Plan - Coverage under the 90-Day Plan is provided under the group Long Term Disability (LTD) insurance policy issued by The Standard to Florida Atlantic University.

If you become insured, you will receive access to the Group Insurance Certificates containing a detailed description of the insurance coverage. The information presented in this booklet is controlled by the Group Policy and does not modify it in any way. The controlling provisions are in the Group Policy issued by Standard Insurance Company.

Your coverage will become effective on the first day of the calendar month following the approval of your application, provided the required premium contribution has been made for that month and you are actively at work. Actively at work will include regularly scheduled days off, holidays, or vacation days, so long as you are capable of active work on those days.

I understand that I need to provide proof of good health to obtain this coverage. I also understand that should I be declined for coverage because of the proof of good health provided, I may be excluded from participating in future open enrollments.

CHOICE OF BENEFIT WAITING PERIODS – A benefit waiting period means a period of continuous disability, which must be satisfied before you are eligible to receive benefits from The Standard. Benefits are not payable during the benefit waiting period.

- Under the 30-Day Plan, weekly STD benefits begin on the 31st day of disability and monthly LTD benefits begin on the 91st day of disability.
- Under the 90-Day Plan, monthly LTD benefits begin on the 91st day of disability.

"Disability "or "Disabled" under the 30-Day Plan (STD and LTD insurance) means that, during the first 26 months (during the first 24 months under the 90-Day Plan (LTD insurance)) for which disability payments are made, you are limited from performing with reasonable continuity, the material duties of your own occupation because of injury, physical disease, pregnancy or mental disorder. After 26 months of payments (24 months of payments under the 90-Day Plan (LTD insurance)), you are disabled when The Standard determines that, due to the same physical disease, injury, pregnancy or mental disorder, you are unable to perform the duties of any occupation for which you are reasonably fitted by education, training or experience, and in which you can be expected to earn at least 80% of your indexed predisability earnings within 12 months following your return to work. You are not disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license. You must be under the ongoing care of a physician in order to be considered disabled.

MAXIMUM BENEFIT PERIOD – If you are participating in the 30-Day Plan, a weekly STD insurance benefit is payable, provided you remain disabled, for up to 9 weeks. If you remain disabled beyond that, or if you are insured only under the 90-Day Plan (LTD insurance), and the period of disability begins before age 62, a monthly LTD insurance benefit is payable, provided you remain disabled, until you reach age 65, or to Social Security Normal Retirement Age (SSNRA), or 3 years 6 months, whichever is longest. SSNRA means your normal retirement age under the Federal Social Security Act, as amended. If a period of disability begins after age 62, monthly benefits are payable, while you remain disabled, according to the following schedule:

Age when disability begins	Maximum Benefit Period
62	To SSNRA, or 3 years 6 months, whichever is longer
63	To SSNRA, or 3 years, whichever is longer
64	To SSNRA, or 2 years 6 months, whichever is longer
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69 or older	1 year

DISABILITY BENEFITS – If you are insured under the 30-Day Plan (STD and LTD insurance), after your 30 days of disability, you will be paid a weekly STD benefit equal to 66 2/3% of your weekly predisability earnings. This weekly benefit is subject to reduction by deductible income. The maximum weekly STD benefit is $3,462; the minimum weekly STD benefit will never be less than $25 or 10% of your gross weekly benefit, whichever is greater. If you are insured either under the 30-Day Plan (STD and LTD insurance) or 90-Day Plan (LTD insurance), beginning on the 91st day of disability, if you remain disabled you will be eligible to receive a monthly LTD benefit equal to 66 2/3% of your monthly predisability earnings. (If you received STD benefits, these will end when LTD benefits begin.) This monthly benefit is subject to reduction by deductible income. The maximum monthly LTD benefit is $15,000; the minimum monthly LTD benefit will never be less than $100 or 10% of your gross monthly LTD benefit, whichever is greater.

BENEFITS FROM OTHER INCOME – The Standard will subtract deductible income from your gross disability payment. Deductible income is income you receive or are eligible to receive while benefits are payable. It includes, but is not limited to, the following:

- Your work earnings (your gross weekly earnings from work you perform for your employer while disabled)
- Any amount you receive or are eligible to receive because of your disability under a state disability income benefit law.
- Earnings or compensation included in your predisability earnings and which you receive or are eligible to receive while benefits are payable
- Any amount you receive or are eligible to receive under any unemployment compensation law or similar act or law
- Any amount you receive by compromise, judgment, settlement or other method as a result of a claim for any of the above, whether disputed or undisputed
- Sick pay, annual or personal leave pay, severance pay, or other salary continuation, including donated amounts, (but not vacation pay) paid to you by your employer
- Social Security disability or retirement benefits, including benefits for your spouse and children
- Income you receive or are eligible to receive because of your disability under another group insurance coverage
- Disability or retirement benefits under your employer's retirement plan
- Amounts due from or on behalf of a third party because of your disability

ADDITIONAL FEATURES

These features are included under the group 90-Day Plan (LTD insurance) and 30-Day Plan (under the LTD insurance group policy, on the 91st day of disability, provided you are receiving monthly LTD benefits)

ASSISTED LIVING BENEFIT – Under the LTD insurance policy, this benefit provides an income replacement equal to 80% of your insured monthly predisability earnings up to a maximum monthly LTD benefit of $18,000. Your Assisted Living Benefit will be paid to you at the same time your monthly disability LTD benefits are payable, provided satisfactory proof of loss has been submitted.

If you meet the requirements below, we will pay Assisted Living Benefits according to the terms of the Group Policy after we receive proof of loss satisfactory to us.

1. You are disabled and LTD benefits are payable to you.
2. While you are disabled:
   a. You, due to loss of functional capacity as a result of physical disease or injury, become unable to safely and completely perform two or more activities of daily living without hands-on assistance or standby assistance; or
   b. You require substantial supervision for your health or safety due to severe cognitive impairment as a result of physical disease or injury.
3. The condition in 2.a or 2.b above is expected to last 90-Days or more as certified by a physician in the appropriate specialty as determined by us.

LIFETIME SECURITY BENEFIT – The Lifetime Security Benefit provides lifetime income to severely disabled employees, by extending LTD benefits beyond the regular Maximum Benefit Period. This enhancement reduces worries for disabled employees during their retirement years.

ANNUITY CONTRIBUTION BENEFIT – You will be eligible for an Annuity Contribution Benefit if you are disabled and LTD benefits have been payable to you for 9 months.

The amount of the Annuity Contribution Benefit is 11% of your monthly predisability earnings, but not to exceed $2,475. The Annuity Contribution Benefit is not reduced by deductible income.

COST OF LIVING ADJUSTMENT (COLA) BENEFIT – The Standard will make a cost of living adjustment on the first of the month following 12 full months of payable LTD benefits. Your COLA Benefit Factor is 2%. If you remain continuously disabled and are receiving monthly disability LTD benefits, your monthly benefit payments will increase by 2% on each anniversary of the first Cost of Living Adjustment, for a maximum of 5 adjustment periods.

REHABILITATION PLAN – Under the LTD insurance policy, while benefits are payable, you may qualify to participate in a rehabilitation plan that prepares you to return to work. If you qualify, The Standard may pay for return to work expenses you incur, such as job search, training, education and family care expenses.

We will pay an additional monthly disability benefit of the lesser of $1,000 or 10% of your monthly predisability earnings, provided you are receiving monthly benefits and are participating in an approved rehabilitation plan.

To participate in a Rehabilitation Plan you must apply on The Standard's forms or in a letter to The Standard. The terms, conditions and objectives of the plan must be accepted by you and approved by The Standard in advance.

FAMILY CARE EXPENSES – Under the LTD insurance policy, during the first 24 months after you return to work, while you are still disabled, your work earnings may be adjusted for family care expenses paid to a licensed care provider for the care of your family which is necessary in order for you to work.

- The adjustment caps at $250 per family member or $500 for all family members per month.
- Family member includes
    - Your child (age 11 and younger) regardless of mental or physical handicap, or
    - Your child (age 12 and older), spouse, parent, grandparent, sibling, or other close family member residing in your home who is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on you for support and maintenance.

WORK INCENTIVE BENEFIT – Under the LTD insurance policy, if you return to work while disabled, your monthly payment will not be reduced during the first 24 months of payments, as long as your return to work earnings, plus gross disability payment, does not exceed 100% of your monthly predisability earnings. After the first 24 months of payments under the LTD insurance policy, while working, you will receive payments based on the percentage of income you are losing due to your disability.

SURVIVOR BENEFIT – If you die while monthly disability LTD insurance benefits are payable, and on the date you die you have been continuously disabled for at least 180 days, a Survivor Benefit equal to three times your unreduced monthly disability LTD benefit may be payable. (Any survivor benefit payable will first be applied to any overpayment of your claim due to The Standard.)

The Survivor's Death Benefit will be paid at our option to any one or more of the following:

a. Your surviving spouse;
b. Your surviving unmarried children, including adopted children, under age 25;
c. Your surviving spouse's unmarried children, including adopted children, under age 25; or
d. Any person providing the care and support of any person listed in a., b., or c. above.

No survivor's death benefit will be paid if you are not survived by any person listed in a., b., or c. above.

EXCLUSIONS – You are not covered for a disability caused or contributed to by any of the following:
- Under the STD insurance policy: a disability arising out of or in the course of any employment for wage or profit, if you are receiving benefits for the disability under any workers' compensation or occupational disease law
- Under the LTD insurance policy: committing or attempting to commit an assault or felony, or your active participation in a violent disorder or riot
- Under the LTD insurance policy: the loss of your professional or occupational license or certification

Under the STD and LTD insurance policies:
- An intentionally self-inflicted injury, while sane or insane
- War or any act of war (declared or undeclared, and any substantial armed conflict between organized forces of a military nature)
- A pre-existing condition or the medical or surgical treatment of a pre-existing condition unless on the date you become disabled, you have been continuously insured under the group policy for the 12-month exclusion period and actively at work for at least one full day after the end of the exclusion period

A pre-existing condition is a mental or physical condition, whether or not diagnosed or misdiagnosed:
- Which was discovered or suspected as a result of any routine or other medical examination at any time during the pre-existing condition period; or
- For which you have consulted a physician or other licensed medical professional, received medical treatment, services or advice, undergone diagnostic procedures, including self-administered procedures, or taken prescribed drugs or medications at any time during the pre-existing condition period.

The pre-existing condition period is the 90-day period just before your disability insurance becomes effective.

LIMITATIONS – To receive STD and LTD benefits, you must be under the ongoing care of a physician in the appropriate specialty as determined by The Standard.

Weekly disability STD benefits are not payable for any period when you are:
- Working for wage or profit for any employer other than your employer, or when you are self-employed
- Eligible to receive benefits for your disability under a workers' compensation or similar law

Monthly disability LTD benefits are not payable for any period when you are confined for any reason in a penal or correctional institution

In addition, payment of monthly disability LTD insurance benefits is limited in duration:
- To 12 months if you reside outside of the United States or Canada
- To 24 months for each period of continuous disability if your disability is caused or contributed to by mental disorders or substance abuse

TERMINATION OF YOUR DISABILITY BENEFITS – Weekly disability STD benefits end automatically on the earliest of:
- The date you are no longer disabled
- The date your maximum benefit period ends
- The date you die
- The date monthly disability LTD benefits become payable to you under the LTD insurance policy sponsored by your employer
- The date you begin working for an employer other than your employer, or become self-employed
- The date you fail to provide proof of continued disability and entitlement to weekly STD insurance benefits

Monthly disability LTD benefits end automatically on the earliest of:
- The date you are no longer disabled
- The date your maximum benefit period ends (unless monthly disability LTD insurance benefits are continued by the Lifetime Security Benefit)
- The date you die
- The date benefits become payable under any other disability plan under which you become insured through employment during a period of temporary recovery
- The date you fail to provide proof of continued disability and entitlement to monthly disability LTD insurance benefits

RENEWAL PROVISION – Your insurance will remain in force subject to payment of the required premium, even if you are on authorized leave of absence or sabbatical, until the date you cease to be an active eligible member of the Florida Atlantic University, unless the policy is terminated. You may terminate this coverage at any time by notifying your Personnel Department.

PREMIUM EXAMPLES

The monthly cost to participate in the 30-Day Plan is **$0.85 per $100** (STD and LTD combined premiums) of covered monthly salary. Should you prefer to participate in the 90-Day Plan, the monthly cost is **$0.59 per $100** (LTD premium) of covered monthly salary, collected on a bi-weekly basis.

To help you calculate your monthly premium cost, please refer to the examples below:

If you participate in the:

30 day Elimination Period Option (STD and LTD Combined Premiums)

$20,000	÷	12	÷	100	x	$0.85 =	**$14.17 Monthly Premium**
(Annual salary)		(months)		(per $100 salary rate-based)			
$40,000	÷	12	÷	100	x	$0.85 =	**$28.33 Monthly Premium**
(Annual salary)		(months)		(per $100 salary rate-based)			
$60,000	÷	12	÷	100	x	$0.85 =	**$42.50 Monthly Premium**
(Annual salary)		(months)		(per $100 salary rate-based)			

Benefits are paid on a **WEEKLY** basis once you have been disabled for 30 days.

90 day Elimination Period Option (LTD Premiums)

$20,000	÷	12	÷	100	x	$0.59 =	**$9.83 Monthly Premium**
(Annual salary)		(months)		(per $100 salary rate-based)			
$40,000	÷	12	÷	100	x	$0.59 =	**$19.67 Monthly Premium**
(Annual salary)		(months)		(per $100 salary rate-based)			
$60,000	÷	12	÷	100	x	$0.59 =	**$29.50 Monthly Premium**
(Annual salary)		(months)		(per $100 salary rate-based)			

Benefits are paid on a **MONTHLY** basis once you have been disabled for 90 days.

This information is designed to answer some common questions about the group Voluntary Short Term Disability (STD) and Voluntary Long Term Disability (LTD) insurance coverage being offered by your employer to eligible employees. It is not intended to provide a detailed description of the coverage.

TO APPLY FOR GROUP DISABILITY INSURANCE,
PLEASE COMPLETE THE REVERSE SIDE OF THIS PAGE

Standard Insurance Company

Late Entrant

Enrollment and Change

To Be Completed By Applicant ☐ Apply for Coverage ☐ Change in Coverage ☐ Name Change

Employer Name	Group Number	Date of Employment	Job Title/Occupation
Florida Atlantic University	**648969**		

Your Name (Last, First, Middle)			

Employee ID	Your Social Security Number	Birth Date	☐ Male ☐ Female

Your Address	City	State	ZIP

Hours Worked Per Week	Annual Earnings	Choose one: I am employed on a
	$_____	☐ 9 ☐ 10 ☐ 12 month contract

Coverage

Short Term Disability (STD) and Long Term Disability (LTD) Insurance

☐ 30 Day Plan (Voluntary STD and Voluntary LTD)

Long Term Disability Insurance

☐ 90 Day Plan (Voluntary LTD)

The 30 Day (STD and LTD) and 90 Day (LTD) Disability Plans have a pre-existing condition limitation. If I have received medical or surgical treatment, services or advice, undergone diagnostic procedures, including self administered procedures, taken prescribed drugs or medicines, or consulted with a physician or other licensed medical professional, for any mental or physical condition which was discovered or suspected as a result of any routine or other medical examination at any time within the 90 days prior to my effective date of coverage, these conditions will not be covered unless the disability begins more than twelve (12) consecutive months after my effective date of coverage. Review your booklet for additional information about the effective date of your coverage and the pre-existing condition exclusion.

I understand that I need to provide proof of good health to obtain this coverage. I also understand that should I be declined for coverage because of the proof of good health provided, I may be excluded from participating in future open enrollments.

Signature: I wish to make the choices indicated on this form. I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____

Return completed form and Medical History to your local Gabor Representative.

DIRECTIONS FOR APPLYING FOR COVERAGE

Read the Information Practices Notice(s) on page 3. Complete all items, date and sign in the space at the bottom of page 2. Keep a copy for your records and give the original to your local Gabor Representative.

MEMBER/EMPLOYEE INFORMATION

Name of Group **Florida Atlantic University**		Group Number **648969**	
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)			Email Address	
Street Address	City	State Zip		Residency ☐ USA ☐ Other
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 ☐ Late Application

Check the type and provide details on the amount of coverage you are requesting.

☐ 30 Day Plan (Short Term Disability and Long Term Disability)

☐ 90 Day Plan (Long Term Disability) _____ (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.

NOTE: Medical questions do not relate to Disability products for amounts over the Guaranteed Issue.

1. Are you now unable to maintain full time employment as defined by a licensed medical professional because of any physical or mental condition, or injury? ☐ Yes ☐ No
2. Has a licensed member of the medical profession 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 any disease of the digestive system? ☐ 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 disease? ☐ Yes ☐ No
   - E. Emphysema, asthma, bronchitis, sleep apnea, or other respiratory or lung disease? ☐ Yes ☐ No
   - F. Lupus, scleroderma, vasculitis, connective tissue disease, or an immune system disorder not related to Human Immunodeficiency Virus (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 (AD), Generalized Anxiety Disorder (GAD), or Obsessive Compulsive Disorder (OCD)? ☐ Yes ☐ No
3. In the past 7 years have you had any illness or injury not listed above which resulted in the use of prescribed medication or visits to a licensed member of the medical profession? ☐ Yes ☐ No
4. Have you tested positive for exposure to the HIV infection or been diagnosed as having AIDS Related Complex (ARC) or AIDS caused by the HIV infection or other sickness or condition derived from such infection? ☐ Yes ☐ No
5. Have you been advised by a licensed medical professional to have any operation or to schedule an appointment for an existing physical or mental condition, or injury? ☐ Yes ☐ No
6. Have you been diagnosed by a licensed medical professional as currently being pregnant? ☐ Yes ☐ No

Height	Weight	Physician Name or Medical Facility with Applicant's Complete Medical Records (provide name and full mailing address)

Applicant Name	Social Security Number

Describe any "yes" answers below. (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, 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 MIB, 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 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 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 I am entitled to receive a copy of this authorization. This authorization will remain valid six months 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.
- 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.

FRAUD NOTICE

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature of Applicant	**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	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. (MIB), formerly known as Medical Information Bureau. We will use the authorization you signed on this form when we seek this information.
- MIB – 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 (including short and long term disability) 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: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

  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 (including short and long term disability) insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.
- 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.