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

Disability Insurance Application Checklist and Cover Sheet

CALIFORNIA

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. The **Outline of Coverage** is required at the time of application. Verify that you have printed the correct product specific "Outline of Coverage" from the DI site at www.standard.com.
2. Review Discussion Topics, Income Documentation Requirements and Medical Underwriting Requirements.
3. Complete Part I and Part II* of the application fully (questions 1-61) with proposed insured and owner (if different).
   . *If TeleApp, complete Part I and skip Part II. See TeleApp Instructions.
4. Obtain signatures from proposed insured and owner (if different) on Part III, and on all applicable authorizations, receipts and notices.
5. Complete the Outline of Coverage and give it to the applicant.
6. Send completed application packet and additional requirements to your MGA/SMP.

For TeleApps: Once your completed application is received, Standard Insurance Company or your MGA/SMP will order a telephone interview. Please notify your customers to expect a call to schedule an interview. See TeleApp Instructions.

Contents of CA Application Packet (in order of appearance) & Instructions

- ☐ **Discussion Topics, Income Documentation Requirements, Medical Underwriting Requirements** - for producer review.
- ☐ **Producer Instructions and Information Report** (11302) - producer completes.

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 Part II (pages 3 - 5). See TeleApp Instructions.
- ☐ **Part III Application for Disability Insurance** - obtain signature and date.
- ☐ **HIV Test Informed Consent** (6440) - complete both copies of with proposed insured, obtain signature and date; give one copy to proposed insured.
- ☐ **HIV Infection and AIDS: An Overview** (11907) – give to proposed insured.
- ☐ **Authorization for Release of Health Information** (9935) – obtain signature and dates.
- ☐ **Authorization for Release of Personal Psychotherapy Notes** (11338) - obtain signature and dates if proposed insured indicates he or she has been seen by a mental health counselor, psychiatrist or therapist, or has taken antidepressant medication.
- ☐ **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. Complete form and obtain the authorized signature.

Additional Requirements at Time of Application:

All Products
- ❑ Product-specific Outline of Coverage – complete and leave with applicant
- ❑ Matching Illustration
- ❑ Required Income Documentation

Business Overhead Expense
- ❑ Business Overhead Expense Supplemental Form (2967)

Business Buy-Out Expense
- ❑ Business Buy-Out Expense Supplemental Forms (7202 and 7204)

Important Reminders:

- Submit applications within 30 business days of signature date
- Make sure all questions are answered completely
- Obtain all required signatures and accurate dates; do not alter dates
- Changes/corrections must be initialed by applicant
- Do not use white-out on any forms

Thank you for choosing The Standard.
We look forward to working with you.

Discussion Topics

For Your Disability Insurance Prospects

As you begin your discussions with customers who are interested in individual disability insurance with The Standard, you may find discussion of the topics below helpful.

Occupation

- Your customer's occupation and duties at work
- Location of your customer's work, e.g., office, in the field, home
- Number of hours and percentage of duties performed at each location
- If self-employed, for how long
- If the customer is a business owner,
    - percent of the business owned by the customer
    - number of employees

Hazardous Activities

- Work-related or recreational activities, hobbies, and avocations that might be considered hazardous

Health

- Use of tobacco products or nicotine substitutes
- Customer's height and weight
- Significant health history including long-term treatment, hospitalization or surgery
- Medications currently being taken
- Antidepressant medications taken or mental health counseling received

continued

Any applicant who wishes to submit an application for disability insurance must be permitted to do so regardless of the information shared during the use of these discussion topics.

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For producer use only. Not for use with consumers.

Income

- The customer's taxable earned income for the current and previous year*
- For business owners, The Standards look at net income after expenses (as noted in Schedule C), net profit of a proprietorship, etc.
- For non-owner employees, The Standard considers gross income to be their insurable income

Other Disability Insurance

- Existing group or individual disability insurance, or pending applications for such coverage

* Income documentation is required for most applications. Please see Understanding Income Documentation, Form 14162, for more details.

Individual Disability Insurance

Understanding Income Documentation

Income documentation is required for all disability income insurance applications (except applications qualifying for Simplified Underwriting, and select Students and New Professionals). The documentation required depends on the applicant's business entity, as shown in the table below.

Entity	Documentation[1] for			What Income Figure to Use	Employer-Paid Limits
	Protector Platinum, Protector+ and Protector Essential	Business Protector	Business Equity Protector		
Students, Residents, New Professionals	Not required unless requested by the underwriter	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
Non-owner employee	Complete Form 1040 for most recent year including all schedules, W-2s of the proposed insured **OR** If income is from salary only, provide copy of paystub showing a minimum of six months of YTD income **OR** If 1099 income, complete 1040 to include related Schedule C	Not available	Not available	W-2 box #5 labeled "Medicare Wages and Tips" **OR** Project year to date salary to determine annual income. Do not project commissions or bonuses.[2] **OR** 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.[3] Independent contractors are not eligible for employer-paid limits
Owner of Sole Proprietorship	Complete Form 1040 and Schedule C	Schedule C from personal tax return	Not available	Schedule C line #31	Not eligible for employer-paid limits.
C Corporation Owner	Complete W-2s 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[3]
S Corporation Owner	Complete 1040, W-2s, and Schedule E **OR** 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, Section 179 Expense.[4] "Passive" may be counted as unearned income. **OR** 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[3]
Partnership	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.
LLC or LLP	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' tax returns are required for business owners applying for the Business Owner Upgrade or Business Owner Discount.					

1 For some occupations The Standard 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.

2 For bonus or commission to be considered as income, at least two years' documentation is required.

3 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.

4 Up to 20 percent of Section 179 depreciation can be added to the income to allow for an additional benefit of up to $1,000 a month.

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Understanding Income Documentation
14162 (8/13) **SI/SNY**

Medical Underwriting Requirements

The Standard has one set of medical underwriting requirements for both the TeleApp and the Traditional application process. Medical underwriting requirements are as follows:

Medical Underwriting Requirements[1]

Amount*	Age		
	18 - 40	41 - 50	51 - 64[2]
$0 - 2,499	0	0	0
$2,500 - 5,000	1	2	2
$5,001 - 10,000	2	2	2
$10,001 or more	2	2	3

0 = No medical requirements needed

1 = Urine HIV testing

2 = Blood profile, urinalysis, mini - exam (height, weight, pulse, blood pressure)

3 = Mini - exam, blood profile, urinalysis, EKG

* The amount of monthly indemnity with The Standard, either in force or applied for in the last three years. This includes Supplemental Social Insurance benefits, Protector Platinum, Protector+, Protector Essential, Business Protector, and Business Equity Protector. Disregard amounts provided by all other benefits and riders. For Business Equity Protector, divide any lump sum by 36 and add in the monthly benefits. Underwriting has the discretion to order medical requirements, regardless of the amount applied for.

Part II of the Application must be completed in all cases except TeleApplications.

For those employed in the following health care occupations, a blood profile and urinalysis are required for any amount:

- anyone performing invasive procedures or drawing or handling blood
- dental hygienists
- dentists
- dialysis technicians
- emergency medical technicians
- paramedics
- physician assistants
- physicians (MD and DO)
- podiatrists
- registered nurses
- surgical assistants

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

Vendor For Paramedic Services

The Standard's preferred vendor to provide paramedic services for your individual disability insurance applicants is Superior Mobile Medics. ExamOne processes the lab tests.

1. Not required with Simplified Underwriting 2. Ages 61 - 64 for Protector Platinum only.

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Medical Underwriting Requirements
12244 (4/13) **SI/SNY**

Reset

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 _____

4. Telephone Numbers HOME (____) _____ WORK (____) _____ OTHER (____) _____

5. Fax Number _____ 6. Email 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 read, 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 disability insurance carriers? If yes, please explain in REMARKS. ☐YES ☐NO

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

15. Discounts Applied (if any) (Please review the Discounts section of the Product Guide for requirements):
   ☐ MULTI-LIFE Number of Lives_____
   Employer's Name_____
   Employer's TIN_____
   You must list names, and policy numbers if available, other insureds in REMARKS area below.
   ☐ ASSOCIATION ☐ RESIDENT/HOSPITAL ENDORSEMENT
   (Underwriting pre-approval required.)
   Assoc./Resident/Hospital Name(s)_____
   _____
   Assoc./Resident/Hospital Program Number(s)_____
   ☐ BUSINESS OWNER (25% OR MORE OWNERSHIP)
   ☐ MULTI-PRODUCT; other product applied for_____
   ☐ OTHER_____

16. TELEAPP? ☐YES ☐NO

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

Print

Standard Insurance Company

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

Disclosure Notice - Information Practices

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.: We, or our reinsurers, may make a brief report to the MIB, Inc. MIB, Inc. is a not-for-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply the company with the information in its file. At your request, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The telephone number is 866-692-6901 (TTY 866-346-3642). Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

ADDITIONAL INFORMATION: We hope this information helps you understand how and why we obtain information about you. To obtain a more detailed explanation of your rights and our information practices, please contact Standard Insurance Company, Individual Disability Insurance Underwriting, 1100 SW Sixth Ave., Portland, OR 97204-1093.

Reset

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

Application for Disability Insurance
Part I

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. Email Address (optional) _____

7. Date of Birth _____ 8. State of Birth _____ 9. Length of US Residence _____ 10. Driver's License No./Issue State _____

11. Phone Numbers HOME( ) WORK( ) OTHER( ) 12. Preferred Place to Call ☐H ☐W ☐OTHER

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 & Features:

A. Disability Income

BASIC MONTHLY BENEFIT $_____
BENEFIT WAITING PERIOD _____ DAYS
BENEFIT PERIOD _____
SELECT ONE:
☐ **PROTECTOR PLATINUM**SM ☐ **PROTECTOR ESSENTIAL**SM
SELECT ADDITIONAL BENEFIT(S):
☐ NONCANCELABLE (PLATINUM ONLY)
☐ INDEXED COST OF LIVING: ☐ 3% / ☐ 6%
☐ CATASTROPHIC $_____ (PLATINUM ONLY)
☐ FUTURE PURCHASE OPTION
$_____ POOL AMOUNT
☑ PARTIAL DISABILITY (ALWAYS INCLUDED)
☐ OTHER_____

B. Business Overhead Expense

(Application Supplement required)
BASE AMOUNT $_____
WAITING PERIOD _____ DAYS
BENEFIT MULTIPLE _____ MONTHS
☐ PARTIAL 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: WHO PAYS PREMIUM?	IF GROUP: BENEFIT CAP MAXIMUM?	IF GROUP: % OF INCOME:	WILL COVERAGE BE REPLACED OR REDUCED?
									☐YES ☐NO
									☐YES ☐NO
									☐YES ☐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.

Proposed Insured_______________________________

General, Financial and Avocation Information

18. Your current annual earned income from your current primary Occupation is $__________. For last year it was $_________. "Earned income" means: salary, other compensation for services rendered or commissions. If you are self employed, earned income is after business expenses, but before personal income taxes. Explain any significant fluctuations between years. Do not include any income that is not reported to the IRS. Do not include investment or other unearned income.
19. Complete questions a and b only if the amount of disability coverage currently in force plus the amount applied for exceeds $5,000 per month:
    a. Is unearned income greater than 25% of earned income or $50,000? Unearned income includes: capital gains, interest, dividends, net rental income, pensions, annuities, royalties. .... ☐YES ☐NO
    b. Is net worth, excluding primary residence, greater than $6,000,000? .... ☐YES ☐NO
20. Will your employer pay for any part of this requested insurance? .... ☐YES ☐NO
    If YES, answer a, b and c. If NO, go to question 21.
    a. What percent of premium will employer pay?________%
    b. Will employer's contribution be included in your taxable income? .... ☐YES ☐NO
    c. Will you reimburse employer for any premium? .... ☐YES ☐NO
21. Are you currently working in your primary occupation at least 30 hours per week? .... ☐YES ☐NO
    If NO, please explain in REMARKS.
22. Do you own any part of the business where you work? .... ☐YES ☐NO
    If YES, answer a, b and c. If NO, go to question 23.
    a. Percent owned:______; years owned:______.
    b. Number of employees: full-time______, part-time_______
    c. Business type: ☐C Corp; ☐S Corp; ☐LLC; ☐LLP; ☐Sole Proprietor; ☐Partnership; ☐Other____________________________
23. Have you ever applied for life, disability or health insurance and had it declined, postponed or withdrawn; or has any such policy issued on you been modified, or rated up or canceled; or has renewal of any such policy been refused? If YES, please explain.. ☐YES ☐NO
24. Have you been alerted to, received orders for, or had any indication of an overseas assignment or active service with any armed forces or military unit? .... ☐YES ☐NO

QUESTION NUMBER:	**REMARKS AREA.** EXPLAIN ALL YES ANSWERS. GIVE ADDITIONAL INFORMATION REGARDING ANY QUESTIONS AND RESPONSES SHOWN ON THIS APPLICATION.

If TeleApp complete 24A; then go to Part III. If Traditional process, skip 24A and proceed to Part II.

24A. In the last 5 years have you had, been treated for, or been diagnosed as having: A heart condition; chest pain; stroke; back or neck problem; psychological condition including, but not limited to, counseling from a mental health or substance abuse provider, and/or psychotherapy; cancer; diabetes; alcohol or drug abuse or dependency? .... ☐YES ☐NO
If YES, give details in the REMARKS area above. Include date, diagnosis, duration and severity; treatment and results; and include health care provider name(s) and address(es).

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Application for Disability Insurance
Part II

Proposed Insured_____

25. List any professional designation, specialty or degree.

26. Years in Current Primary Occupation

27. Years with Current Employer

28. Current Employer

29. Employer Address City, State Zip Code

30. Type of Business or Industry

31. Job duties and percentage of time spent in each duty

32. Do you perform any of your current primary duties at your place of residence? If YES, explain and give percent of time. ..... ☐YES ☐NO

33. Except for commuting, do you travel for business purposes? If YES, explain the nature of your travel, including whether it is local or long distance; and give the average number of days per month and miles per day. ..... ☐YES ☐NO

34. Do you have any other part-time or full-time occupation or employment? If YES, list your annual earned income from such occupation or employment; and list your duties and the percent of time you spend at each duty. ..... ☐YES ☐NO

35. Do you intend to change any occupations or employers within the next 6 months? If YES, please explain. ..... ☐YES ☐NO

36. When was your last previous application or medical examination for life or disability insurance?
YEAR_____ COMPANY_____ TYPE_____
☐Check if no prior applications or exams.

37. In the last 10 years, have you ever applied for, received or been denied disability benefits from Worker's Compensation, Social Security or any other disability insurance? If YES, please explain. ..... ☐YES ☐NO

38. In the last 5 years have you participated, or do you intend to participate:
    a. As a pilot or student pilot; or as a crew member in any type of aircraft? ..... ☐YES ☐NO
    If YES, complete application supplement.
    b. In parachuting, hang gliding or other aeronautics; in rock climbing, underwater diving or motor sports; or in any other hazardous sport? ..... ☐YES ☐NO
    If YES, complete application supplement.

39. In the last 5 years have you traveled, worked or lived outside the USA or Canada for more than one continuous month; or do you plan to do so in the next 2 years? If YES, please explain. ..... ☐YES ☐NO

40. In the last 5 years have you personally, or has any business owned in whole or in part by you, filed for bankruptcy? If YES, give details. Include whether discharged and date discharged. ..... ☐YES ☐NO

QUESTION NUMBER:	**REMARKS AREA.** EXPLAIN ALL YES ANSWERS. GIVE ADDITIONAL INFORMATION REGARDING ANY QUESTIONS AND RESPONSES SHOWN ON THIS APPLICATION.

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

Proposed Insured________________________________

Medical Information

FT. IN. LBS.

41. Height ______ 42. Weight ______ 43. Weight Loss in Last Year ______ 44. Explain if more than 10 pounds ______

45. Name of Your Physician or Health Care Facility ______ 46. Phone Number (   ) ______

47. Address of Your Physician or Health Care Facility ______ City, State ______ Zip Code ______

48. Date Last Seen ______ 49. Reason Seen ______ 50. Results ______ 51. Treatment or Medication Prescribed ______

52. Have you had, been told you had, been treated or diagnosed by a medical practitioner as having:

a. Disorder of the eye, ear, nose, throat or skin (such as glaucoma, cataracts, iritis, Meniere's disease, eczema or psoriasis)? ... ☐YES ☐NO

b. Anxiety, depression, nervousness or stress; or other mental, emotional or psychiatric disorder (such as post traumatic stress disorder, panic disorder, adjustment disorder or bipolar disorder)? .... ☐YES ☐NO

c. Stroke, seizure, paralysis, headaches, dizziness, fainting, vertigo, mental deficiency; or any other disease or disorder of the brain or nervous system (such as multiple sclerosis, restless leg syndrome, dementia or Alzheimer's disease)? .... ☐YES ☐NO

d. Fibromyalgia, chronic fatigue or chronic fatigue syndrome; or Epstein-Barr virus? .... ☐YES ☐NO

e. Sleep apnea or other sleep disorder (such as narcolepsy, chronic insomnia or hypersomnia)? .... ☐YES ☐NO

f. Asthma, bronchitis, emphysema or tuberculosis; or any other disease or disorder of the lungs or respiratory system (such as shortness of breath, bronchitis, pleurisy, cystic fibrosis or chronic obstructive pulmonary disease)? .... ☐YES ☐NO

g. High blood pressure, heart attack or chest pain; heart murmur or irregular heart beat; or any other disease or disorder of the heart or blood vessels (such as coronary artery disease, aneurysm, deep vein thrombosis or peripheral artery disease)? .... ☐YES ☐NO

h. Hepatitis, colitis, ulcer, cirrhosis, irritable bowel; or any other disease or disorder of the liver, gallbladder, pancreas or digestive tract (such as gastrointestinal reflux disease, barrett's, esophagitis, colitis, intestinal bleeding or diverticulitis)? .. ☐YES ☐NO

i. Diabetes, borderline diabetes, or sugar in the urine; thyroid disorder or any other disease or disorder of the endocrine system (such as metabolic syndrome, hypoglycemia, hyperglycemia, grave's disease, pituitary dysfunction or high cholesterol)? .... ☐YES ☐NO

j. Disease or disorder of the breasts, reproductive or genital organs, kidney, prostate or urinary systems (such as fibroycystic breast disease, uterine fibroids, polycystic ovarian syndrome, endometriosis, enlarged prostate or prostatitis)? .... ☐YES ☐NO

k. Cyst, growth, polyp, tumor, cancer or any disease or disorder of the blood, skin or lymph glands (such as lymphoma, basal cell carcinoma, malignant melanoma, anemia, myeloma, leukemia, platelet disorders or bleeding problems)? .... ☐YES ☐NO

l. Back or neck pain; sciatica, arthritis or carpal tunnel syndrome; or any other disease, disorder or injury of the bones, joints, nerves or muscles (such as gout, degenerative joint or disc disease, neuritis or atrophy)? .... ☐YES ☐NO

m. C-section, miscarriage, infertility treatments, multiple gestations or complications of pregnancy? .... ☐YES ☐NO

QUESTION NUMBER:	**REMARKS AREA.** EXPLAIN ALL **YES** ANSWERS. GIVE DATE, REASON, DIAGNOSIS, DURATION, SEVERITY, TREATMENT AND RESULTS; AND GIVE NAMES AND ADDRESSES OF ALL PHYSICIANS AND MEDICAL FACILITIES.

Proposed Insured________________________________

53. Are you currently pregnant? ....☐YES ☐NO
54. Other than as stated in other answers, have you within the last 5 years:
    a. Been hospitalized or been seen by a physician, chiropractor, counselor, psychiatrist, therapist or other medical practitioner? ....☐YES ☐NO
    b. Had an EKG or blood test (excluding HIV); sleep study or other medical procedure, study or test? ....☐YES ☐NO
    c. Been advised to have any medical test, surgery or hospitalization that was not completed?............☐YES ☐NO
55. Have you:
    a. Been told you had, been treated for or been diagnosed as having: any sexually transmitted disease, AIDS, AIDS-Related Complex or immune system disease or disorder?................☐YES ☐NO
    b. Had a positive (unfavorable) AIDS test which was taken in conjunction with an application of insurance? ....☐YES ☐NO
56. Do you now take, or in the last 3 years have you taken, any prescription medicine? ....☐YES ☐NO
57. In the last 3 years have you had any symptom or disorder lasting more than 30 days for which you have taken any non-prescription medication or natural or herbal supplement?...................................☐YES ☐NO
58. In the last 3 years have you had any physical or mental condition or symptom that has not been treated or diagnosed?☐YES ☐NO
59. Have you:
    a. Had recommended any treatment, or received any treatment for the use of a controlled substance, drug or alcohol? ....☐YES ☐NO
    b. Used marijuana, cocaine, barbiturates, amphetamines, narcotics or hallucinogens; or any other controlled or illegal substance? ....☐YES ☐NO
    c. Been cited or arrested for driving under the influence of a controlled substance, drug or alcohol? ....☐YES ☐NO
    d. Been on parole or probation; or been arrested or charged with a felony?......................................☐YES ☐NO
60. Do you drink alcoholic beverages? ....☐YES ☐NO
    If no, check one:
    ☐ MONTH AND YEAR LAST USED:_______________; OR
    ☐ NEVER USED.
    If yes, complete table below:

		AMOUNT PER WEEK		
a.	WINE	____________	GLASSES	(glass = 4 oz.)
b.	BEER	____________	BOTTLES	(bottle = 12 oz.)
c.	LIQUOR	____________	DRINKS	(serving = 1 oz.)

61. Have you used tobacco or nicotine in any form in the last 5 years? ....☐YES ☐NO
    If YES, circle types below and complete table.

		HOW LONG	AMT. PER DAY	DATE LAST USED
a.	CIGARETTES	____________	____________	____________
b.	CIGAR	____________	____________	____________
c.	PIPE	____________	____________	____________
d.	SMOKELESS	____________	____________	____________
e.	GUM, PATCH, OTHER	____________	____________	____________

QUESTION NUMBER:	**REMARKS AREA.** EXPLAIN ALL **YES** ANSWERS. GIVE DATE, REASON, DIAGNOSIS, DURATION, SEVERITY, TREATMENT AND RESULTS; AND GIVE NAMES AND ADDRESSES OF ALL PHYSICIANS AND MEDICAL FACILITIES.

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

Application for Disability Insurance
Part III

Agreement and Signatures

I, THE UNDERSIGNED, UNDERSTAND AND AGREE TO THE FOLLOWING:

In this application, "you" and "your" mean the proposed insured unless otherwise specified.

This application includes Parts I, II and III, and all signed application supplements and amendments. If this is a TELEAPP, this application also includes all questions Standard Insurance Company (Standard) or its representatives will ask the proposed insured, and all answers given in response to those questions, after I sign this form. This application will become part of the policy issued by Standard based on this application.

Standard will rely on the information given in this application in considering the proposed insured's eligibility for insurance and for various premium rates. By obtaining and using this information, or information from other authorized sources, Standard is not giving a medical opinion about the proposed insured's health. I will not rely on any inquiry or decision by Standard as a statement regarding, or evaluation of, the proposed insured's health.

This application will not be effective unless signed and dated by the proposed insured and owner, if different. **No insurance will be in force until: (a) a policy has been issued, delivered to and accepted by the owner; and (b) the first full premium is paid while all answers in this application remain true and complete.** The only exceptions are as provided in a Disability Insurance Conditional Receipt, issued at the same time as this application. Premium will be calculated to begin on the Policy Effective Date.

No sales representative, medical examiner, or TELEAPP interviewer is authorized to determine insurability, change any of Standard's requirements, or waive any rights Standard may have. No corrections or amendments to this application will be made without the owner's written consent.

Standard may require that any disability policy(s) listed in answer to Question 17 of Part I be permanently terminated or reduced as a condition of issuing the insurance applied for. Standard will rely on the information in this answer in determining the amount, if any, of disability insurance it will issue. If such insurance is not terminated or reduced as required by Standard, any policy issued and accepted pursuant to this application may be rescinded and considered void from the beginning, and all premiums returned. If any insurance applied for is intended to replace other insurance in force with Standard, the Standard policy being replaced will end the moment the insurance applied for becomes effective.

I have read this application. I understand that if any answers are false, incorrect or untrue, Standard may have the right to deny benefits or rescind my insurance policy in accordance with the TIME LIMIT ON CERTAIN DEFENSES provision of the policy. I REPRESENT that: All answers in this application are true and complete to the best of my information and belief and correctly recorded; and that any and all answers I have provided to any Standard representative are recorded in this application. No knowledge of any fact on the part of any sales representative, medical examiner or TELEAPP interviewer shall be considered to be knowledge of Standard unless such fact is stated in the application. I signed this application in the city and state and on the date shown below.

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

_____ Signed at _____ _____ on____/____/_____
Signature of Proposed Insured City State Date

_____ Signed at _____ _____ on____/____/_____
Signature of Policyowner (If Other than Proposed Insured) City State Date
If a company is policyowner, signature of authorized representative.

_____ _____
Print Name of Policyowner Owner's Tax ID Number (If Other than Proposed Insured)
If a company is policyowner, also print title of authorized rep and co. name.

_____ _____
Owner's Address City, State Zip Code Email Address (optional)

I declare and affirm that: (1) any answers provided to me by the proposed insured have been truly and accurately recorded on this application; and (2) no changes, additions or alterations of any kind have been made to this form after it was signed by the proposed insured and owner, if different.

_____ Signed at _____ _____ on____/____/_____
Signature of Soliciting Producer City State Date

Print

Standard Insurance Company

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

HIV Test Informed Consent Form

In order for us to evaluate your eligibility for insurance coverage, Standard Insurance Company (Standard) may require that you provide blood, urine and/or saliva samples for testing and analysis. One of the tests performed on these bodily fluids will determine the presence of antibodies to the human immunodeficiency virus (HIV). By signing and dating this form, you agree that the HIV antibody test may be performed on samples of your blood, urine and saliva and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

THE HIV VIRUS

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to HIV are found in most people with AIDS and AIDS-Related Complex (ARC). They can also be found in people who do not have AIDS or ARC but have been exposed to the virus. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant. Symptoms of AIDS include, but are not limited to: fever, tiredness, lymph node enlargement, pneumonia, diarrhea and certain tumors and infections.

The HIV antibody test is actually a series of tests performed upon a sample of your blood, urine and/or saliva by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory. Testing will include, but may not be limited to, antibody, antigen or viral culture.

PRE-TESTING CONSIDERATIONS

Many public health organizations have recommended that before taking an HIV test a person seek counseling to become informed concerning the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested. You may obtain further information about HIV testing and AIDS by contacting the organizations on the List of Counseling Resources in California on page 2 of this form.

DISCLOSURE AND CONFIDENTIALITY OF TEST RESULTS

All test results are confidential, except as provided by law. The results of the test will be reported to us. We may not, by law, release positive test results except as provided below.

If your HIV antibody test result is normal, you will not be notified. However, we will disclose any positive test result to you through a physician of your choice. If you do not name a physician for this purpose, we will disclose positive test results directly to you.

We may disclose abnormal test results to reinsurers involved in the underwriting process, or as otherwise allowed by law. We may also disclose positive test results to legal counsel, if such information is needed to represent us in regard to an insurance application on you.

In addition, if your HIV antibody test is abnormal, a generic code signifying a non-specific blood, oral fluid (saliva) or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB). The MIB is an organization of life insurance companies, which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test. However, there will be a record that you have some blood, oral fluid (saliva) or urine abnormality. If you apply to another MIB member company for life or disability income insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

TEST RESULTS

While a positive HIV test result does not necessarily mean that you have AIDS, it does mean that you are at serious risk of developing AIDS or AIDS-related conditions. You may be infected with the HIV virus and infectious to others. If you test positive, you should seek medical follow-up care with your personal health care provider.

HIV test results are highly reliable but not 100% accurate. If the test gives a positive result you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected persons. It takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months. If you have reason to believe that a negative test result is incorrect, you should be retested.

(THIS FORM CONTINUES ON THE NEXT PAGE.)

OTHER SOURCES OF INFORMATION
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CONSENT FOR HIV TESTING
I have read and understand this HIV Test Informed Consent Form, and I have received a copy. I voluntarily consent to the withdrawal of blood, the obtaining of my urine and saliva, and the testing of my blood, urine and saliva for HIV antibodies, and the disclosure of the test results as described in this form. A photocopy of this form is as valid as the original.

HIV/AIDS PUBLICATION

I have received a copy of the National Institute of Allergy and Infectious Diseases publication, "HIV Infection and AIDS: An Overview."

NOTIFICATION OF POSITIVE TEST RESULTS

I understand that Standard Insurance Company will disclose any HIV positive test result to me through a physician of my choice, named below. If I do not name a physician for this purpose, Standard will disclose a positive result directly to me.

Name of Physician

Street Address City State Zip

Signature of Proposed Insured or Parent/Guardian Date Signed

Print Name of Proposed Insured

LIST OF COUNSELING RESOURCES IN CALIFORNIA

The following counseling centers can assist you in understanding the meaning of the Human Immunodeficiency Virus (HIV) Antibody Test and its results.

SAN FRANCISCO AIDS FOUNDATION
25 Van Ness Avenue, Suite 660
San Francisco, CA 94102
(415) 864-5855

SACRAMENTO AIDS FOUNDATION
1900 K Street, Suite 201
Sacramento, CA 95814
(916) 448-2437

CENTRAL VALLEY AIDS TEAM
P.O. Box 4640
Fresno, CA 93744
(209) 264-2436

AIDS PROJECT LOS ANGELES
3670 Wilshire Blvd., Suite 300
Los Angeles, CA 90010
(213) 380-2000

AIDS SERVICES FOUNDATION OF ORANGE COUNTY
1685-A Babcock Street
Costa Mesa, CA 92627
(714) 646-0411

SAN DIEGO AIDS PROJECT
3777 Fourth Avenue
San Diego, CA 92103
(619) 543-0300

AIDS PROJECT - EAST BAY
400 40th Street, Suite 20
Oakland, CA 94609
(415) 420-8181

ARIS PROJECT
595 Millich Drive, Suite 104
Campbell, CA 95008
(408) 370-3171

Standard Insurance Company

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

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Street Address City State Zip

Signature of Proposed Insured or Parent/Guardian Date Signed

Print Name of Proposed Insured

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CENTRAL VALLEY AIDS TEAM
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400 40th Street, Suite 20
Oakland, CA 94609
(415) 420-8181

ARIS PROJECT
595 Millich Drive, Suite 104
Campbell, CA 95008
(408) 370-3171

Exploring
National Institute of Allergy and Infectious Diseases
National Institutes of Health
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

October 2003

HIV Infection and AIDS: An Overview

AIDS - acquired immunodeficiency syndrome - was first reported in the United States in 1981 and has since become a major worldwide epidemic. AIDS is caused by the human immunodeficiency virus (HIV). By killing or damaging cells of the body's immune system, HIV progressively destroys the body's ability to fight infections and certain cancers. People diagnosed with AIDS may get life-threatening diseases called opportunistic infections, which are caused by microbes such as viruses or bacteria that usually do not make healthy people sick.

More than 830,000 cases of AIDS have been reported in the United States since 1981. As many as 950,000 Americans may be infected with HIV, one-quarter of whom are unaware of their infection. The epidemic is growing most rapidly among minority populations and is a leading killer of African-American males ages 25 to 44. According to the U.S. Centers for Disease Control and Prevention (CDC), AIDS affects nearly seven times more African Americans and three times more Hispanics than whites.

HOW IS HIV TRANSMITTED?

HIV is spread most commonly by having unprotected sex with an infected partner. The virus can enter the body through the lining of the vagina, vulva, penis, rectum, or mouth during sex.

HIV also is spread through contact with infected blood. Before donated blood was screened for evidence of HIV infection and before heat-treating techniques to destroy HIV in blood products were introduced, HIV was transmitted through transfusions of contaminated blood or blood components. Today, because of blood screening and heat treatment, the risk of getting HIV from such transfusions is extremely small.

HIV frequently is spread among injection drug users by the sharing of needles or syringes contaminated with very small quantities of blood from someone infected with the virus. It is rare, however, for a patient to give HIV to a health care worker or vice-versa by accidental sticks with contaminated needles or other medical instruments.

Women can transmit HIV to their babies during pregnancy or birth. Approximately one-quarter to one-third of all untreated pregnant women infected with HIV will pass the infection to their babies. HIV also can be spread to babies through the breast milk of mothers infected with the virus. If the mother takes the drug AZT during pregnancy, she can significantly reduce the chances that her baby will get infected with HIV. If health care providers treat mothers with AZT and deliver their babies by cesarean section, the chances of the baby being infected can be reduced to a rate of 1 percent.

A study sponsored by the National Institute of Allergy and Infectious Diseases (NIAID) in Uganda found a highly effective and safe drug for preventing transmission of HIV from an infected mother to her newborn. This regimen is more affordable and practical than any other examined to date. Results from the study show that a single oral dose of the antiretroviral drug nevirapine (NVP) given to an HIV-infected woman in labor and another to her baby within three days of birth reduces the transmission rate of HIV by half compared with a similar short course of AZT.

Although researchers have found HIV in the saliva of infected people, there is no evidence that the virus is spread by contact with saliva. Laboratory studies reveal that saliva has natural properties that limit the power of HIV to infect. Research studies of people infected with HIV have found no evidence that the virus is spread to others through saliva by kissing. No one knows, however, whether so-called "deep" kissing, involving the exchange of large amounts of saliva, or oral intercourse increase the risk of infection. Scientists also have found no evidence that HIV is spread through sweat, tears, urine, or feces.

Studies of families of HIV-infected people have shown clearly that HIV is not spread through casual contact such as the sharing of food utensils, towels and bedding, swimming pools, telephones, or toilet seats. HIV is not spread by biting insects such as mosquitoes or bedbugs.

HIV can infect anyone who practices risky behaviors such as

- Sharing drug needles or syringes
- Having sexual contact with an infected person without using a condom
- Having sexual contact with someone whose HIV status is unknown

Having a sexually transmitted disease such as syphilis, genital herpes, chlamydial infection, gonorrhea, or bacterial vaginosis appears to make people more susceptible to getting HIV infection during sex with infected partners.

SYMPTOMS OF HIV INFECTION

Many people do not have any symptoms when they first become infected with HIV. Some people, however, have a flu-like illness within a month or two after exposure to the virus. This illness may include

- Fever
- Headache
- Tiredness
- Enlarged lymph nodes (glands of the immune system easily felt in the neck and groin

These symptoms usually disappear within a week to a month and are often mistaken for those of another viral infection. During this period, people are very infectious, and HIV is present in large quantities in genital fluids.

More persistent or severe symptoms may not appear for 10 years or more after HIV first enters the body in adults, or within two years in children born with HIV infection. This period of "asymptomatic" infection is highly individual. Some people may begin to have symptoms within a few months, while others may be symptom-free for more than 10 years.

Even during the asymptomatic period, the virus is actively multiplying, infecting, and killing cells of the immune system. The most obvious effect of HIV infection is a decline in the number of CD4 positive T cells (also called T4 cells) found in the blood -- the immune system's key infection fighters. At the beginning of its life in the human body, the virus disables or destroys these cells without causing symptoms.

As the immune system worsens, a variety of complications start to take over. For many people, the first signs of infection are large lymph nodes or "swollen glands" that may be enlarged for more than three months. Other symptoms often experienced months to years before the onset of AIDS include

- Lack of energy
- Weight loss
- Frequent fevers and sweats
- Persistent or frequent yeast infections (oral or vaginal)
- Persistent skin rashes or flaky skin
- Pelvic inflammatory disease in women that does not respond to treatment
- Short-term memory loss

Some people develop frequent and severe herpes infections that cause mouth, genital, or anal sores, or a painful nerve disease called shingles. Children may grow slowly or be sick a lot.

AIDS

The term AIDS applies to the most advanced stages of HIV infection. CDC developed official criteria for the definition of AIDS and is responsible for tracking the spread of AIDS in the United States.

CDC's definition of AIDS includes all HIV-infected people who have fewer than 200 CD4 positive T cells (abbreviated CD4+ T cells) per cubic millimeter of blood (Healthy adults usually have CD4 positive T-cell counts of 1,000 or more.). In addition, the definition includes 26 clinical conditions that affect people with advanced HIV disease. Most of these conditions are opportunistic infections that generally do not affect healthy people. In people with AIDS, these infections are often severe and sometimes fatal because the immune system is so ravaged by HIV that the body cannot fight off certain bacteria, viruses, fungi, parasites, and other microbes.

Symptoms of opportunistic infections common in people with AIDS include

- Coughing and shortness of breath
- Seizures and lack of coordination
- Difficult or painful swallowing
- Mental symptoms such as confusion and forgetfulness
- Severe and persistent diarrhea
- Fever
- Vision loss
- Nausea, abdominal cramps, and vomiting
- Weight loss and extreme fatigue
- Severe headaches
- Coma

Children with AIDS may get the same opportunistic infections as do adults with the disease. In addition, they also have severe forms of the bacterial infections all children may get, such as conjunctivitis (pink eye), ear infections, and tonsillitis.

People with AIDS are particularly prone to developing various cancers, especially those caused by viruses such as Kaposi's sarcoma and cervical cancer, or cancers of the immune system known as lymphomas. These cancers are usually more aggressive and difficult to treat in people with AIDS. Signs of Kaposi's sarcoma in light-skinned people are round brown, reddish, or purple spots that develop in the skin or in the mouth. In dark-skinned people, the spots are more pigmented.

During the course of HIV infection, most people experience a gradual decline in the number of CD4 positive T cells; although some may have abrupt and dramatic drops in their CD4 positive T-cell counts. A person with CD4 positive T cells above 200 may experience some of the early symptoms of HIV disease. Others may have no symptoms even though their CD4 positive T-cell count is below 200.

Many people are so debilitated by the symptoms of AIDS that they cannot hold steady employment or do household chores. Other people with AIDS may experience phases of intense life-threatening illness followed by phases in which they function normally.

A small number of people first infected with HIV 10 or more years ago have not developed symptoms of AIDS. Scientists are trying to determine what factors may account for their lack of progression to AIDS, such as particular characteristics of their immune systems or whether they were infected with a less aggressive strain of the virus, or if their genes may protect them from the effects of HIV. Scientists hope that understanding the body's natural method of control may lead to ideas for protective HIV vaccines and use of vaccines to prevent the disease from progressing.

DIAGNOSIS

Because early HIV infection often causes no symptoms, a doctor or other health care provider usually can diagnose it by testing a person's blood for the presence of antibodies (disease-fighting proteins) to HIV. HIV antibodies generally do not reach detectable levels in the blood for one to three months following infection. It may take the antibodies as long as six months to be produced in quantities large enough to show up in standard blood tests.

People exposed to the virus should get an HIV test as soon as they are likely to develop antibodies to the virus - within 6 weeks to 12 months after possible exposure to the virus. By getting tested early, people with HIV infection can discuss with a health care provider when they should start treatment to help their immune systems combat HIV and help prevent the emergence of certain opportunistic infections (see section on treatment below). Early testing also alerts HIV-infected people to avoid high-risk behaviors that could spread the virus to others.

Most health care providers can do HIV testing and will usually offer counseling to the patient at the same time. Of course, individuals can be tested anonymously at many sites if they are concerned about confidentiality.

Health care providers diagnose HIV infection by using two different types of antibody tests, ELISA and Western Blot. If a person is highly likely to be infected with HIV and yet both tests are negative, the health care provider may request additional tests. The person also may be told to repeat antibody testing at a later date, when antibodies to HIV are more likely to have developed.

Babies born to mothers infected with HIV may or may not be infected with the virus, but all carry their mothers' antibodies to HIV for several months. If these babies lack symptoms, a doctor cannot make a definitive diagnosis of HIV infection using standard antibody tests until after 15 months of age. By then, babies are unlikely to still carry their mothers' antibodies and will have produced their own, if they are infected. Health care experts are using new technologies to detect HIV itself to more accurately determine HIV infection in infants between ages 3 months and 15 months. They are evaluating a

number of blood tests to determine if they can diagnose HIV infection in babies younger than 3 months.

TREATMENT

When AIDS first surfaced in the United States, there were no medicines to combat the underlying immune deficiency and few treatments existed for the opportunistic diseases that resulted. During the past 10 years, however, researchers have developed drugs to fight both HIV infection and its associated infections and cancers.

The U.S. Food and Drug Administration (FDA) has approved a number of drugs for treating HIV infection. The first group of drugs used to treat HIV infection, called nucleoside reverse transcriptase (RT) inhibitors, interrupts an early stage of the virus making copies of itself. Included in this class of drugs (called nucleoside analogs) are AZT, ddC (zalcitabine), ddI (dideoxyinosine), d4T (stavudine), 3TC (lamivudine), abacavir (ziagen), and tenofovir (viread). These drugs may slow the spread of HIV in the body and delay the start of opportunistic infections.

Health care providers can prescribe non-nucleoside reverse transcriptase inhibitors (NNRTIs), such as delvaridine (Rescriptor), nevirapine (Viramune), and efravirenz (Sustiva), in combination with other antiretroviral drugs.

FDA also has approved a second class of drugs for treating HIV infection. These drugs, called protease inhibitors, interrupt virus replication at a later step in its life cycle. They include

- Ritonavir (Norvir)
- Saquinivir (Invirase)
- Indinavir (Crixivan)
- Amprenivir (Agenerase)
- Nelfinavir (Viracept)
- Lopinavir (Kaletra)

Because HIV can become resistant to any of these drugs, health care providers must use a combination treatment to effectively suppress the virus. When RT inhibitors and protease inhibitors are used in combination, it is referred to as highly active antiretroviral therapy, or HAART, and can be used by people who are newly infected with HIV as well as people with AIDS.

Researchers have credited HAART as being a major factor in significantly reducing the number of deaths from AIDS in this country. While HAART is not a cure for AIDS, it has greatly improved the health of many people with AIDS and it reduces the amount of virus circulating in the blood to nearly undetectable levels. Researchers, however, have shown that HIV remains present in hiding places, such as the lymph nodes, brain, testes, and retina of the eye, even in patients who have been treated.

Despite the beneficial effects of HAART, there are side effects associated with the use of antiviral drugs that can be severe. Some of the nucleoside RT inhibitors may cause a decrease of red or white blood cells, especially when taken in the later stages of the disease. Some may also cause inflammation of the pancreas and painful nerve damage. There have been reports of complications and other severe reactions, including death, to some of the antiretroviral nucleoside analogs when used alone or in combination. Therefore, health care experts recommend that people on antiretroviral therapy be routinely seen and followed by their health care providers. The most common side effects associated with protease inhibitors include nausea, diarrhea, and other gastrointestinal symptoms. In addition, protease inhibitors can interact with other drugs resulting in serious side effects.

A number of drugs are available to help treat opportunistic infections to which people with HIV are especially prone. These drugs include

- Foscarnet and ganciclovir to treat cytomegalovirus (CMV) eye infections
- Fluconazole to treat yeast and other fungal infections
- Trimethoprim/sulfamethoxazole (TMP/SMX) or pentamidine to treat Pneumocystis carinii pneumonia (PCP)

In addition to antiretroviral therapy, health care providers treat adults with HIV, whose CD4+ T-cell counts drop below 200, to prevent the occurrence of PCP, which is one of the most common and deadly opportunistic infections associated with HIV. They give children PCP preventive therapy when their CD4+ T-cell counts drop to levels considered below normal for their age group. Regardless of their CD4+ T-cell counts, HIV-infected children and adults who have survived an episode of PCP take drugs for the rest of their lives to prevent a recurrence of the pneumonia.

HIV-infected individuals who develop Kaposi's sarcoma or other cancers are treated with radiation, chemotherapy, or injections of alpha interferon, a genetically engineered protein that occurs naturally in the human body.

PREVENTION

Because no vaccine for HIV is available, the only way to prevent infection by the virus is to avoid behaviors that put a person at risk of infection, such as sharing needles and having unprotected sex.

Many people infected with HIV have no symptoms. Therefore, there is no way of knowing with certainty whether a sexual partner is infected unless he or she has repeatedly tested negative for the virus and has not engaged in any risky behavior.

People should either abstain from having sex or use male latex condoms or female polyurethane condoms, which may offer partial protection, during oral, anal, or vaginal sex. Only water-based lubricants should be used with male latex condoms.

Although some laboratory evidence shows that spermicides can kill HIV, researchers have not found that these products can prevent a person from getting HIV.

The risk of HIV transmission from a pregnant woman to her baby is significantly reduced if she takes AZT during pregnancy, labor, and delivery, and if her baby takes it for the first six weeks of life.

RESEARCH

NIAID-supported investigators are conducting an abundance of research on all areas of HIV infection, including developing and testing preventive HIV vaccines and new treatments for HIV infection and AIDS- associated opportunistic infections. Researchers also are investigating exactly how HIV damages the immune system. This research is identifying new and more effective targets for drugs and vaccines. NIAID-supported investigators also continue to trace how the disease progresses in different people.

Scientists are investigating and testing chemical barriers, such as topical microbicides, that people can use in the vagina or in the rectum during sex to prevent HIV transmission. They also are looking at other ways to prevent transmission, such as controlling sexually transmitted diseases and modifying people's behavior, as well as ways to prevent transmission from mother to child.

MORE INFORMATION

AIDSinfo is a comprehensive information and referral service that provides the most current information on federally and privately funded clinical trials for AIDS patients and others infected with HIV. AIDS clinical trials evaluate experimental drugs and other therapies for adults and children at all stages of HIV infection -- from patients who are HIV positive with no symptoms to those with various symptoms of AIDS.

As the main dissemination point for federally approved HIV treatment and prevention guidelines, AIDSinfo provides information about the current treatment regimens for HIV infection and AIDS-related illnesses, including the prevention of HIV transmission from occupational exposure and mother-to-child transmission during pregnancy. As an education and resource center, AIDSinfo also offers links and other downloadable resources that are designed for patients, health care providers, researchers and the general public.

AIDSinfo is primarily web-based and can be found at http://aidsinfo.nih.gov. AIDSinfo also operates a telephone service from 12:00 p.m. to 5:00 p.m. Eastern Time, Monday through Friday. English and Spanish-speaking health information specialists are available to answer questions about HIV/AIDS, treatment options, and navigating the website.

Telephone: 800-HIV-0440 (1-800-448-0440)
International: 301-519-0459
TTY/TDD: 888-480-3739
Email: ContactUs@aidsinfo.nih.gov

For information specifically about clinical trials conducted by the NIAID Intramural AIDS Research Program, call 1-800-243-7644 (http://clinicaltrials.gov).

To receive materials or to talk with a Health Communication Specialist, contact the CDC National HIV and STD Hotline. This service is available 24 hours a day.

1-800-2278922
1-800-342-2437
1-800-243-7889 (TTY/Deaf Access)

NIAID is a component of the National Institutes of Health (NIH), which is an agency of the Department of Health and Human Services. NIAID supports basic and applied research to prevent, diagnose, and treat infectious and immune-mediated illnesses, including HIV/AIDS and other sexually transmitted diseases, illness from potential agents of bioterrorism, tuberculosis, malaria, autoimmune disorders, asthma and allergies.

News releases, fact sheets and other NIAID-related materials are available on the NIAID Web site at http://www.niaid.nih.gov.

Prepared by:
Office of Communications and Public Liaison
National Institute of Allergy and Infectious Diseases
National Institutes of Health
Bethesda, MD 20892

Standard Insurance Company

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

Authorization to Obtain and Disclose Information

Types of Personal Information Collected
I understand that it is necessary for Standard Insurance Company (Standard) to collect and review personal information about me in order to offer and administer insurance products. I understand 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., 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

Standard Insurance Company

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

Authorization for Release of Personal Psychotherapy Notes to Standard Insurance Company

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 **Disability Insurance Conditional Receipt**

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

This Conditional Receipt (this "Receipt") is part of the Application for Disability Insurance having the same proposed insured, owner, and date as this Receipt (the "Application"). Proposed Insured (please print): _____

In this Receipt "we/us/our" mean Standard Insurance Company. "You/your" mean the proposed insured.

PREMIUM PAYMENT: Check all that apply. Required premium paid with the Application MUST equal at least ONE MONTHLY PREMIUM, based on the Insurance Applied For in the Application:

1. ☐ Disability Income (DI): Premium paid with the Application *: $_____.
2. ☐ Business Overhead Expense (BOE): Premium paid with the Application *: $_____.

*All premium checks must be made payable to Standard Insurance Company. Do not make check payable to the producer. Do not leave the payee blank.

We acknowledge receipt of the above sum(s) with the Application. This Receipt may NOT be used for Disability Buy-Out applications or Future Purchase Option applications.

CONDITIONS: Insurance coverage will be provided as of the date of this Receipt, prior to delivery and acceptance of any policy offered in connection with the Application completed with this Receipt, only if ALL of the following Conditions are met:

1. You are insurable, as determined by our underwriters using our underwriting guidelines, on the date you sign this Receipt;
2. The Application is completed for every policy covered by this Receipt;
3. The required premium is paid with the Application; and
4. You, and the owner if different, each sign this Receipt on the same date you and the owner each sign the Application.

DATE COVERAGE STARTS: Coverage under a policy applied for along with this Receipt, if any, starts on the policy's Effective Date, subject to the COVERAGE TERMS AND LIMITATIONS below. The Effective Date of any policy offered and accepted in connection with the Application is the Effective Date elected on the Policy Acceptance and Application Supplement executed by you, and the owner if different, upon delivery of the policy. You may elect an Effective Date as early as the date of this Receipt. The initial premium paid with this Receipt will be applied to the premium owed for your coverage under the policy as of the Effective Date.

COVERAGE TERMS AND LIMITATIONS:

1. If you become disabled under the terms of a policy offered and accepted in connection with the Application completed with this Receipt, we will pay benefits for that disability under that policy, subject to the terms, conditions, limitations and exclusions of this Receipt and that policy. All benefits paid as a result of a disability incurred before the policy is delivered to and accepted by you, and the owner if different, shall, for the entire period during which benefits are payable for that disability, be limited to the lesser of: (a) the benefit amount issued; or (b) $5,000 per month for DI and $10,000 per month for BOE.
2. This Receipt is not in effect for any policy we decline to issue or do not approve within 90 days after the date that you, and the owner if different, have signed this Receipt. We will return any premium paid with this Receipt.
3. This Receipt is void in its entirety and does not affect any policy applied for along with this Receipt, and any premium paid for that policy will be returned, if: (a) there is misrepresentation or fraud in the Application or any application supplement; (b) any check provided in connection with this Receipt is not honored when first presented for payment; or (c) any of the CONDITIONS listed above are not met.
4. This Receipt is not a "binder" and does not commit us to issue any policy.
5. Using our underwriting rules and practices, we will decide what policy to offer, if any, based on your insurability, including your health history, as of the date you sign this Receipt. In underwriting the Application we may rely on the results of medical tests and exams, and on other information, performed or obtained after the date of this Receipt. However, we will not consider any change in your health or insurability occurring after the later of: (a) the date you sign this Receipt; or (b) the date the policy is accepted, if you elect an Effective Date that is after the date you sign this Receipt.
6. No one may change or waive anything in this Receipt, except that we may waive Condition number 3, above, in certain employer-paid cases. Such waiver must be in writing to be effective.

DECLARATION AND AGREEMENT OF OWNER AND PROPOSED INSURED: I have read this Receipt and agree to its terms. I understand that issuance of this Receipt does not guarantee issuance of any policy. I agree that coverage, if any, is subject to the terms, conditions, limitations and exclusions of this Receipt and any policy(s) issued. Each copy of this Receipt is considered to be a duplicate original.

_____ Signed at _____, _____ on ___/___/___
Signature of Proposed Insured City State Date

_____ Signed at _____, _____ on ___/___/___
Signature of Owner if other than Proposed Insured City State Date

_____ Signed at _____, _____ on ___/___/___
Signature of Soliciting Producer City State Date

PRODUCER INSTRUCTIONS: The proposed insured, owner and producer must complete, sign and date both copies of this Receipt on the same date each person signed the Application. Each copy must be identical. Give one copy to the owner. Send the other copy with the Application and premium to the home office. DO NOT ISSUE THIS RECEIPT if it is apparent that ALL of the Conditions above are not met.

Standard Insurance Company **Disability Insurance Conditional Receipt**

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

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1. You are insurable, as determined by our underwriters using our underwriting guidelines, on the date you sign this Receipt;
2. The Application is completed for every policy covered by this Receipt;
3. The required premium is paid with the Application; and
4. You, and the owner if different, each sign this Receipt on the same date you and the owner each sign the Application.

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2. This Receipt is not in effect for any policy we decline to issue or do not approve within 90 days after the date that you, and the owner if different, have signed this Receipt. We will return any premium paid with this Receipt.
3. This Receipt is void in its entirety and does not affect any policy applied for along with this Receipt, and any premium paid for that policy will be returned, if: (a) there is misrepresentation or fraud in the Application or any application supplement; (b) any check provided in connection with this Receipt is not honored when first presented for payment; or (c) any of the CONDITIONS listed above are not met.
4. This Receipt is not a "binder" and does not commit us to issue any policy.
5. Using our underwriting rules and practices, we will decide what policy to offer, if any, based on your insurability, including your health history, as of the date you sign this Receipt. In underwriting the Application we may rely on the results of medical tests and exams, and on other information, performed or obtained after the date of this Receipt. However, we will not consider any change in your health or insurability occurring after the later of: (a) the date you sign this Receipt; or (b) the date the policy is accepted, if you elect an Effective Date that is after the date you sign this Receipt.
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_____ Signed at _____, _____ on ___/___/___
Signature of Proposed Insured City State Date

_____ Signed at _____, _____ on ___/___/___
Signature of Owner if other than Proposed Insured City State Date

_____ Signed at _____, _____ on ___/___/___
Signature of Soliciting Producer City State Date

PRODUCER INSTRUCTIONS: The proposed insured, owner and producer must complete, sign and date both copies of this Receipt on the same date each person signed the Application. Each copy must be identical. Give one copy to the owner. Send the other copy with the Application and premium to the home office. DO NOT ISSUE THIS RECEIPT if it is apparent that ALL of the Conditions above are not met.

Reset

Standard Insurance Company

Individual Disability Insurance (800) 247-6888 Tel (800) 378-2407 Fax
1100 SW Sixth Avenue Portland OR 97204-1093 **www.standard.com**

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

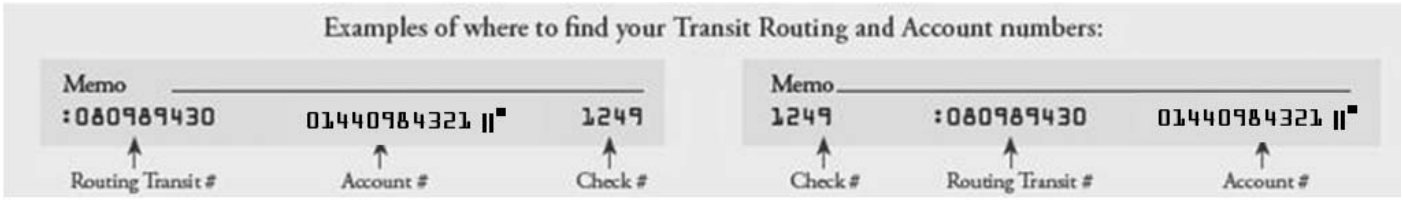
INSURED NAME	**PHONE**	FINANCIAL INSTITUTION NAME
NAME(S) ON ACCOUNT	ACCOUNT TYPE ☐ Checking ☐ Savings	TYPE OF FINANCIAL INSTITUTION ☐ Bank ☐ Credit Union ☐ Savings & Loan

for recurring payments only: **Deduction** for the policies listed will be made **monthly** unless I specify a different mode: ❑ Quarterly ❑ Semi-Annually ❑ Annually	POLICY NUMBER	START DEDUCTION (DAY/MONTH)	DEDUCTION AMOUNT
	POLICY NUMBER	START DEDUCTION (DAY/MONTH)	DEDUCTION AMOUNT
	POLICY NUMBER	START DEDUCTION (DAY/MONTH)	DEDUCTION AMOUNT

Instructions:

1. *Read and complete this form. Please print legibly.*
2. *To identify your account, please copy the "Routing Transit #" and "Account #" from your check (**not a deposit slip)** as instructed below. The illustration shows how to locate these numbers on your check. Alternatively, you may attach a copy of a voided check (not a deposit slip) over this area.*
   ***NOTE**: Money market checks or credit card "Cash Transfer" checks **cannot** be used for this authorization.*
3. *For the authorization to be valid, you **must** check the box of the authorization statement that applies, either a one-time debit, recurring payments, or both. You need not check both boxes unless applicable.*
4. *Retain a copy for your records and mail or fax the form to the address above.*

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

Print