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. Review Discussion Topics, Income Documentation Requirements and Medical Underwriting Requirements.
2. Complete Application pages 1 through 7* fully with proposed insured and owner (if different). Give page 2 to proposed insured. *If TeleApp, skip pages 6-7.
3. After proposed insured and owner (if different) have reviewed Application, obtain signatures on pages 8 and 9, and on all applicable authorizations, receipts and notices in the application packet.
4. Send completed application packet and additional requirements to your MGA/SMP.

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

- ❑ **TeleApp Producer Instructions** - for producers who choose the TeleApp process.
- ❑ **Discussion Topics, Income Documentation Requirements, Medical Underwriting Requirements** - for producer review.
- ❑ **Application page 1, Producer Instructions and Information Report** (DIAPP) - producer completes. If TeleApp, indicate by writing "TeleApp" below signature. See TeleApp Producer Instructions regarding information required from the Discussion Topics.

  Review the following forms with the proposed insured before obtaining signatures.
- ❑ **Application page 2, Information for the Proposed Insured-Disclosure Notice, Personal History Interview** (DIAPP) - give to proposed insured.
- ❑ **Application pages 3 through 7** (DIAPP) - complete all questions with proposed insured. If TeleApp, skip pages 6-7.
- ❑ **Application page 8, Agreement** - obtain <u>all</u> signatures and dates.
- ❑ **Application page 9, Authorization & Acknowledgment** - 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** (11337) – obtain signature and dates.
- ❑ **Authorization for Release of Personal Psychotherapy Notes** (11338) - obtain signature and dates if proposed insured has answered "Yes" to question 49b, or question 51a in regard to a counselor, psychiatrist or therapist. For TeleApp, obtain signature and dates if proposed insured has provided information for Discussion Topics number 3.
- ❑ **Disability Insurance Conditional Receipt** (DICR) - use only if premium is collected with application; complete with proposed insured and owner (if different); give copy to owner. Application and Conditional Receipt must be signed on the same date and submitted with required premium.
- ❑ **Authorization for One-Time and/or Recurring Electronic Funds Transfer (EFT)** (1804) - use if the proposed insured (or owner if different) prefers premium payment by one-time debit authorization with the application and/or recurring premium payment by EFT is the billing mode chosen. Mark one or both box(es), to indicate the portion(s) of the form that will apply. Complete routing transit and account numbers, or attach voided check from payor. Obtain the authorized signature.

Additional Requirements at Time of Application:

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

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.

TeleApp Producer Instructions

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

Here's how to proceed with a TeleApp:

- **Use the application form (DIAPP) and all other forms in the Application Packet for your state.** (See Checklist and Cover Sheet) Write "TeleApp" below your signature on DIAPP page 1, the Producer Information Report.

- **Complete all application questions except the medical questions on pages 6 and 7 of the DIAPP form.**

- **You and your customer must complete the financial questions and submit the required income documentation**, as the TeleApp vendor (LifePlans, Inc.) will not ask these questions.

- **You must obtain detailed information for numbers 1 – 4 on the Discussion Topics form (included in the application packet).** The information to be discussed includes:

    1. The proposed insured's height and weight.
    2. The proposed insured's significant health history requiring hospitalization, long term treatment and/or surgery and any prescription or over the counter medications.
    3. Whether the proposed insured is taking any anti-depression or anxiety medication or seeing any counselors and, if so, the reason(s).
    4. Any use of tobacco products or nicotine substitutes.

- **Record responses to the topics either on the Producer Information Report form (in this application packet) or on the Discussion Topics form itself. Then submit them with the application and all other applicable forms in the Application Packet.**

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

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

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

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

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Discussion Topics for Disability Insurance Prospects

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

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

Individual Disability Insurance
Underwriting
800.378.6058

Sales and Marketing
800.992.4446

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

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

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

Understanding Income documentation for IDI

Entity	Documentation[1] for			What Income Figure to Use	Employer-Paid Limits
	The Protector+ and The Protector[2]	The Business Protector	The Business Equity Protector		
Students, Residents, New Professionals	Non Required	For new in private practice professionals, please contact your underwriter.	Not available	See Student/New Professional Guidelines in the Special Occupations Section for benefit limits	Not eligible for employer-paid limits.
Non-owner employee	Complete Form 1040 for most recent year including all schedules, W-2's and 1099's 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.[3] **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.[4] 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 1040 and W-2's of the proposed insured. Business Tax Form 1120 is required if 50%+ owner (non-medical occupations only)	Business tax form 1120	2 years' complete business tax returns	W-2 box #5 labeled "Medicare Wages and Tips"	May apply for employer-paid limits.[4]
S Corporation Owner	Complete 1040, W-2's, 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, subtract Section 179 Expense. "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.[4]
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 of tax returns are required for business owners applying for the Business Owner Upgrade under Old Fashioned Underwriting.

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

[2] The Protector is only available in California

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

[4] 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.

Standard Insurance Company
1100 SW Sixth Avenue
Portland, Oregon 97204
800.992.4446

www.standard.com/di

14162 (10/09)

TheStandard®

MEDICAL UNDERWRITING REQUIREMENTS[1]			
Amount[2]	Age		
	18-40	41-50	51-60
0-2,499	0	0	0
2,500-3,500	1	2	2
3,501-5,000	1	2	2
5,001-10,000	2	2	2
10,001 & over	2	2	3

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

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

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

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

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

APPROVED FACILITIES:

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

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

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

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

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

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

Application for Disability Income Insurance
Producer Instructions and Information Report

Producer Instructions

1. Prior to completing this application, please give page 2, Information for the Proposed Insured, to the proposed insured to read carefully.
2. Complete each question in this application. Please print all responses.
3. Have proposed insured read and sign the HIV Informed Consent Form for the state in which this application is taken. Give a copy of the form and any required informational brochure(s) or form(s) to the proposed insured.
4. Complete Producer Information Report. Use REMARKS to provide special instructions or requests.
5. Staple all pages together, including all application supplements, and submit to your Standard Insurance Company regional office or assigned agency. Include a copy of the Sales Illustration used as a basis for the sale.

Producer Information Report

1. Producer Name (Please Print) _____ 2. Agent Number _____ 3. Agency or Region _____

4. Ways to Reach You H ( ) _____ W ( ) _____ 5. Fax Number ( ) _____ 6. Email Address _____

7. Other Producer(s) to Receive Credit for This Application:
   NAME (PRINT)_____ AGENT NO._____ PERCENT_____
   NAME (PRINT)_____ AGENT NO._____ PERCENT_____

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

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

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

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

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

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

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

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

_____

_____

_____

I DECLARE THAT: I gave page 2, Information for the Proposed Insured, to the proposed insured. I solicited and recorded the information on this application and all application supplements in person and not by mail or telephone. I understand that any exception to this must have prior approval from Standard's Individual Underwriting Department and must be explained in remarks above. The application was signed by the proposed insured and owner, if other than the proposed insured, after all questions were asked and answered, and all responses accurately recorded. I know of nothing affecting the risk that is not recorded on this application or in any accompanying written statement or letter.

_____ _____
Producer Signature Date

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

Application for Disability Income Insurance
Information for the Proposed Insured

Disclosure Notice

To help Standard Insurance Company (Standard) determine your eligibility for insurance we may request information from other persons or organizations such as your doctor or hospital, insurance companies or the Medical Information Bureau (MIB). We will do this using the authorization which you sign as part of your application.

CONSUMER REPORTS: We may ask a consumer reporting agency to prepare an investigative consumer report. The report may include information regarding such things as your occupation, avocations, aviation activity, driving record, finances, and drug and alcohol use. Information for the report may be obtained through personal interviews with your neighbors, friends 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.

You have a right to receive a copy of the consumer report from the consumer reporting agency. For information on how to obtain a copy please contact us at the address shown at the top of this page.

MEDICAL INFORMATION BUREAU (MIB): Information regarding your insurability and/or any past or future claims will be treated as confidential. However, Standard or its reinsurers may make a brief report to the MIB. The MIB is a nonprofit corporation which operates an information exchange on behalf of member life insurance companies. If you later apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply that company with the information in its file. Standard or its reinsurers may also release information in their files to additional reinsurers or to other insurance companies to whom you may apply for life or health insurance or submit a claim for benefits.

At your request, the MIB will arrange disclosure of information it has in your file. If you question the accuracy of the MIB's information, you may contact the MIB and seek a correction in accordance with the procedures outlined in the Federal Fair Credit Reporting Act. The address of the MIB information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number 617-426-3660.

DISCLOSURE TO OTHERS: Personal information about you obtained during the underwriting process is confidential. It will not be released to persons or organizations without your authorization except to the extent necessary for the conduct of our business or as permitted or required by law.

DISCLOSURE TO YOU: In general, you have a right to learn the nature and substance of any personal information about you in our file. You also have a right to ask us to correct or amend such information, if necessary. We will carefully review your comments and make requested changes where justified. To obtain further information on these rights and on Standard's information practices in general, please contact the Individual Underwriting Department at the address at the bottom of this page and ask for a copy of our Notice of Information Practices.

Personal History Interview (PHI)

You may be contacted for a telephone interview called a Personal History Interview (PHI). The purpose of our telephone interview is to obtain supplementary information and to confirm information you provided on the application. We may ask about such things as your medical history, occupation, avocations, aviation activity, driving record, drug and alcohol use and finances.

The personnel who call are well-trained, professional and courteous. They will identify themselves and the purpose of their call. The interview generally takes about 10 minutes. We will attempt to call at the time of day you prefer. If you have any questions, please ask the telephone interviewer or your sales representative. If you have suggestions or comments please contact us at the address provided below.

Thank you for the confidence you have placed in Standard Insurance Company and your sales representative. We look forward to providing you with excellent service.

Standard Insurance Company – Individual Underwriting
P.O. Box 711, Portland, OR 97207
email: uwall@standard.com

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.

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

Application for Disability Income Insurance

Proposed Insured

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

4. Home Address _____ City, State Zip Code _____ 5. Email Address _____

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

10. Phone Numbers HOME( ) _____ WORK( ) _____ 11. Best Time to Call ☐AM ☐PM Best Place to Call ☐H ☐W ☐OTHER

Insurance Applied For

12. Plan Type and Features:

A. Disability Income

BASIC MONTHLY BENEFIT $_____
WAITING PERIOD _____ DAYS
BENEFIT PERIOD _____
SUPPL. SOC. INS. $_____
SSI WAITING PERIOD _____ DAYS
☐ RESIDUAL DISABILITY
☐ NONCANCELABLE
☐ OWN OCCUPATION
☐ INDEXED COST OF LIVING
☐ FUTURE PURCHASE OPTION
$_____ POOL AMOUNT
OTHER _____

B. Business Overhead Expense

BASE AMOUNT $_____
WAITING PERIOD _____ DAYS
BENEFIT MULTIPLE _____ MONTHS
☐ PARTIAL DISABILITY
☐ FUTURE PURCHASE OPTION $_____
OTHER _____

C. Disability Buy-Out

WAITING PERIOD _____ DAYS
AGGREGATE BENEFIT LIMIT $_____
FUNDING METHOD (SELECT 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 ONE:
☐ LUMP SUM AMOUNT $_____
☐ MONTHLY AMOUNT $_____
☐ DOWN PAYMENT AMOUNT/MO. $_____
☐ EXTENDED BENEFIT OPTION
OTHER _____

13. Occupation Class: ☐ 5A ☐ 4A ☐ 4P ☐ 3A ☐ 3P ☐2A ☐ A ☐ B

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

15. Other Coverage: EXPLAIN YES ANSWERS IN THE TABLE BELOW. USE **STATUS** AND **TYPE** CODES PROVIDED.

a. Have you applied for any disability insurance in the last 12 months?.....☐YES ☐NO
b. Is there any other disability insurance currently in force or pending on you? ..... ☐YES ☐NO
c. Will you become eligible for any disability insurance in the next 12 months?.....☐YES ☐NO

STATUS CODES: NOW IN FORCE (**N**); PENDING (**P**); APPLIED FOR IN THE LAST 12 MONTHS (**A**); WILL BECOME ELIGIBLE IN THE NEXT 12 MONTHS (**F**).
TYPE CODES: INDIVIDUAL (**I**); SOCIAL SECURITY SUBSTITUTE (**S**); GROUP (**G**); ASSOCIATION (**X**); OVERHEAD EXPENSE (**OE**); OTHER (**O** - EXPLAIN).

COMPANY	**STATUS**:	**TYPE**:	YEAR APPLIED FOR	MONTHLY AMOUNT:	BENEFIT PERIOD:	WAITING PERIOD:	WILL COVERAGE BE REPLACED OR REDUCED?
							☐YES ☐NO
							☐YES ☐NO
							☐YES ☐NO

General Information

16. Current Primary Occupation ____ 17. Years in Current Primary Occ. ____ 18. Years with Current Employer ____

19. Current Employer ____ 20. Employer Address ____ City, State ____ Zip Code ____

21. Describe the substantial and material duties of your current primary occupation in the REMARKS. Give percent of time spent at each duty.

22. Do you work in your current primary occupation less than 30 hours per week? ☐YES ☐NO

23. Do you perform any of your current primary occupational duties at your place of residence? If yes, explain and give % of time. ☐YES ☐NO

24. 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

25. Do you own any part of the business where you you work? If yes, answer a, b and c. If no, go to question 23. ☐YES ☐NO
    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_______________

26. Will your employer pay for this requested insurance? If yes, answer a, b and c. If no, go to question 27. ☐YES ☐NO
    a. What percentage of premium?__________
    b. Will employer's contribution be included in your taxable income? ☐YES ☐NO
    c. Will you reimburse employer for any premium? ☐YES ☐NO

27. 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. Exclude investment or other unearned income.

28. Do you have any other part-time or full-time occupation or employment? If yes, list annual earned income, duties and percent of time spent at each duty. ☐YES ☐NO

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

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

QUESTION NUMBER:	

Proposed Insured (print):________________________________

Application for Disability Income Insurance

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

30. Complete questions a. and b. only if the amount of disability coverage currently in force plus amount applied for exceeds $4,000 per month:
   a. Does your annual unearned income exceed either $30,000 or 25% of your annual earned income? ☐YES ☐NO
   b. Is your net worth (assets less liabilities) more than $3,000,000? ☐YES ☐NO

31. When was your last previous application or medical examination for life or disability income insurance?
   MONTH__________ YEAR________ COMPANY__________________
   ☐ No prior applications or examinations

32. 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, rated up or canceled; or has renewal of any such policy been refused? If yes, please explain. ☐YES ☐NO

33. In the last 10 years have you 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

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

35. 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

36. 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

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

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

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

QUESTION NUMBER:	

Medical History

38. Height ____ FT. ____ IN.
39. Weight ____ LBS.
40. Weight Loss in Last Year ____ LBS.
41. Explain if more than 10 pounds
42. Name of Your Physician or Health Care Facility
43. Phone Number ( )
44. Address of Your Physician or Health Care Facility — City, State — Zip Code
45. Date Last Seen
46. Reason Seen
47. Results
48. Treatment or Medication Prescribed

49. In the last 10 years have you had, been told you had, been treated for or been diagnosed by a medical practitioner as having:
   a. Disorder of the eye, ear, nose or throat? ☐YES ☐NO
   b. Anxiety, depression, nervousness or stress; or other mental, emotional or psychiatric disorder? ☐YES ☐NO
   c. Stroke, dizziness, fainting, convulsion, recurrent headaches, paralysis or mental deficiency; or any other brain or nervous system disorder? ☐YES ☐NO
   d. Fibromyalgia, chronic fatigue, chronic fatigue syndrome or Epstein-Barr virus? ☐YES ☐NO
   e. Asthma, bronchitis, emphysema or pneumonia; or other lung or respiratory disorder? ☐YES ☐NO
   f. High blood pressure, chest pain or heart attack? ☐YES ☐NO
   g. Irregular heart beat, anemia or murmur; or other disorder of heart, blood or blood vessels? ☐YES ☐NO
   h. Colitis, bleeding or recurrent indigestion; or other disorder of liver, intestines, esophagus, stomach or pancreas? ☐YES ☐NO
   i. Diabetes; sugar, albumin, blood or pus in urine; or any unexplained fevers? ☐YES ☐NO
   j. Disorder of kidney, bladder, prostate, breasts, menstrual cycle or reproductive organs? ☐YES ☐NO
   k. Disorder of skin, lymph nodes or thyroid? ☐YES ☐NO
   l. Cyst, growth, polyp, tumor, leukemia or cancer? ☐YES ☐NO
   m. Any type of spinal, neck or back disorder or injury, including sprain, strain or disc disorder? ☐YES ☐NO
   n. Neuritis, rheumatism or arthritis; or other disorder or injury of muscle, nerve, bone or joint? ☐YES ☐NO
   o. Miscarriage, C-section or complication of pregnancy? ☐YES ☐NO

50. Are you currently pregnant? ☐YES ☐NO

51. 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 (not for HIV); 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

REMARKS AREA. PLEASE EXPLAIN ALL YES ANSWERS. GIVE DATE, REASON, DIAGNOSIS, DURATION, SEVERITY, TREATMENT, RESULTS AND NAMES AND ADDRESSES OF ALL PHYSICIANS AND MEDICAL FACILITIES.

QUESTION NUMBER:	

52. In the last 10 years have you:
    a. Had recommended any treatment, or received treatment for the use of a controlled substance, drug or alcohol? ☐YES ☐NO
    b. Been told you had, been treated for or been diagnosed as having: any sexually transmitted disease, HIV, AIDS, AIDS-Related Complex or immune system disorder? ☐YES ☐NO
    c. Had a positive (unfavorable) HIV or AIDS test which was taken in connection with an application for insurance? ☐YES ☐NO

53. Do you now take, or in the last 3 years have you taken any prescription medicine? ☐YES ☐NO

54. 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

55. In the last 3 years have you had any physical or mental condition or symptom that has not been treated or diagnosed? ☐YES ☐NO

56. In the last 10 years, have you:
    a. Used cocaine, barbiturates, amphetamines, narcotics, hallucinogens or any other controlled or illegal substance? ☐YES ☐NO
    b. Been cited or arrested for driving under the influence of a controlled substance, drug or alcohol? ☐YES ☐NO

57. Do you drink alcoholic beverages? If no, give month and year last used:_________. If yes, complete table: ☐YES ☐NO

		AMOUNT PER WEEK	
a.	WINE	______________	GLASSES
b.	BEER	______________	BOTTLES
c.	LIQUOR	______________	DRINKS

REMARKS AREA. PLEASE EXPLAIN ALL YES ANSWERS. GIVE DATE, REASON, DIAGNOSIS, DURATION, SEVERITY, TREATMENT, RESULTS AND NAMES AND ADDRESSES OF ALL PHYSICIANS AND MEDICAL FACILITIES.

QUESTION NUMBER:	

Agreement

I, THE UNDERSIGNED, AGREE TO THE FOLLOWING: This application includes pages 3 through 8 and all signed application supplements and amendments. I understand that Standard Insurance Company (Standard) will rely on the information I have provided in this application in considering the proposed insured's eligibility for insurance and for various premium rates. This application will not be effective unless signed and dated by the proposed insured and the owner, if different. In this application, "you" and "your" mean the proposed insured unless otherwise specified. No insurance will be in force until the date a policy has been issued and delivered to the owner and 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 and in connection with this application. In either case, premium will be calculated to begin on the policy's Effective Date. No sales person or medical examiner is authorized to judge insurability or change any of Standard's requirements. Any corrections or amendments under HOME OFFICE USE ONLY will be ratified when the policy is accepted. However, changes as to amount, classification, plan or benefit may not be made without written owner approval. We may require that any disability policy(s) listed in answer to Question 15 be permanently terminated or reduced. Standard will rely on the information in this answer in determining the amount, if any, of disability insurance it will issue. If such insurance is not terminated or reduced, any policy issued and accepted pursuant to this application may be rescinded and all premiums returned. If any insurance applied for is intended to replace other insurance in force with Standard, the Standard policy(s) being replaced will end the moment the insurance applied for becomes effective. I have read this application and I understand that any false statements or misrepresentations may result in loss of coverage. I DECLARE that all answers in this application are correctly recorded and are complete and true to the best of my knowledge and belief. Any and all answers I have provided verbally to a Standard agent or other Standard representative have also been recorded in this application.

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

_____ Signed at _____ on____/____/_____
Signature of Owner (If Other than Proposed Insured) City, State

_____ _____
Print Name and Title of Owner Owner's Tax ID Number (If Other than Proposed Insured)

_____ _____
Owner's Address City, State Zip Code Owner's Email Address

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

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.

HOME OFFICE USE ONLY – CORRECTIONS AND AMENDMENTS

Authorization & Acknowledgement

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health: any physician, medical practitioner, hospital, clinic, the Veteran's Administration, other medical or medically related facility, alcohol or drug treatment facility, insurance or reinsurance company, consumer reporting agency, the Medical Information Bureau (MIB) or my insurance agents, family members, friends, neighbors, associates or employers.

TO GIVE THIS INFORMATION: All medical information concerning me, including medical history, examination, diagnosis, prognosis and treatment of any physical or mental conditions, plus any nonmedical information requested about me. This includes but is not limited to information about occupation, avocations, driving record, aviation, finances, tobacco, drug or alcohol use or treatment, and general reputation.

TO THESE PERSONS: Standard Insurance Company (Standard), its reinsurers, and any consumer reporting agency with whom Standard does business. NOTE: The MIB may NOT disclose information to any consumer reporting agency.

I UNDERSTAND THAT: My medical records, including any alcohol or drug use information, may be protected by Federal regulations. I authorize Standard to get such information and I consent to its redisclosure as described in this form. Blood, urine, saliva or other tests may be required to underwrite the application. These tests may include and are not limited to tests for liver disorders, human immunodeficiency virus (HIV), nicotine, drugs or medications.

The information obtained will be used to determine my eligibility for disability insurance. Standard or its reinsurers may release this information to the MIB, to other insurers with whom I have or had insurance or may apply for insurance, and to any person performing business or legal services for Standard in connection with my application.

This authorization is valid for two and one half years from the date below. A photocopy is as valid as the original.

I may revoke at any time my authorization for Standard to obtain data protected by any Federal or State law or regulation which provides for such revocation. Any action taken before Standard receives my written revocation at its home office will be valid.

I understand that by obtaining and using information pursuant to this Authorization, Standard is not providing me with a medical opinion about my health. If I have any questions or concerns, I will not rely on any inquiry or decision by Standard about my insurability as a statement regarding or evaluation of my health.

I have received a copy of the Disclosure Notice.

_____ _____

Signature of Proposed Insured Date

YOU HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION ON REQUEST.

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

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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
1100 SW Sixth Avenue Portland OR 97204-1093

Authorization for Release of Health Information 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 all health information about me to Standard Insurance Company ("Standard") or an insurance support organization acting on behalf of Standard. This Authorization includes, but is not limited to, all information related to my medical history, examinations, diagnoses, prognoses, test results, consultations, prescriptions and treatments of any physical or mental conditions. **I specifically instruct the recipient of this Authorization to release a copy of my complete medical record without restriction and to refrain from providing a medical summary in lieu of releasing copies of the record.**

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 and disclosure of information related to my use of alcohol, drugs and tobacco; the diagnosis or treatment of Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and sexually transmitted diseases; and the diagnosis and treatment of psychological or mental illness (excluding psychotherapy notes).

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 to Standard pursuant to this Authorization may be subject to redisclosure as permitted or required by law and may no longer be protected by federal laws governing privacy and confidentiality of health information.

This Authorization will expire automatically twenty-four (24) months following the date of my signature below. I understand that I have the right to revoke this Authorization at any time by sending a written request for revocation to Standard Insurance Company, Attention: Individual Underwriting, 1100 SW Sixth Avenue, Portland, Oregon 97204-1093. Revocation of this Authorization, or failure to sign this Authorization, will impair Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage. I realize that if I do revoke this Authorization it will not affect any collection, use or disclosure of information prior to Standard's receipt of my revocation and any action taken before Standard receives my written revocation will be valid.

I acknowledge that I have read this Authorization and that I have the right to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization is as valid as the original.

Signature of (proposed) Insured/Patient _____ Date _____

Standard Insurance Company

Individual Disability Insurance
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 is part of the application for insurance on: 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 application MUST equal at least ONE MODAL PREMIUM.):

1. ☐ Disability Income (DI): Premium paid with application *: $_____.
2. ☐ Business Overhead Expense (BOE): Premium paid with 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 that application having the same proposed insured, owner and date(s) as this Receipt. This Receipt may NOT be used for Disability Buy-Out applications or Future Purchase Option applications.

CONDITIONS: Insurance coverage will be provided under this Receipt by any policy offered and accepted in connection with the application only if all of these Conditions are met:

1. You are insurable, as determined by our underwriters using our underwriting guidelines, on the day you sign this Receipt;
2. The initial 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, if any, starts on its Effective Date, but such coverage is subject to the COVERAGE TERMS AND LIMITATIONS below. No coverage is provided before the Effective Date. The Effective Date is:

a. This date, requested by the owner: ____/____/____(mm/dd/yy). (May not be more than 15 days before or after this Receipt is signed); OR
b. If the owner does not request a date in a, above: The date all of the above Conditions are met.

In either case, if the date indicated in a or b above is the 29th, 30th or 31st, the Effective Date will be the 1st of the following month.

COVERAGE TERMS AND LIMITATIONS:

1. If you become disabled under the terms of a policy subject to this Receipt, we will pay benefits for that disability, subject to the terms, conditions, limitations and exclusions of this Receipt and that policy. All benefits paid as a result of a disability incurred while this Receipt is in effect and before a policy is delivered to and accepted by the owner 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 the proposed insured and owner, if different, have signed this Receipt. We will return any premium paid for that policy.
3. This Receipt is not in effect for any policy, and any premium paid will be returned, if: (a) there is misrepresentation or fraud in the application or any application supplement; or (b) any check provided in connection with this Receipt is not honored when first presented for payment.
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 health and insurability as of the date you sign this Receipt. In underwriting your application we may rely on the results of medical tests and exams, and on other information, performed or obtained after the Effective Date. However, we will not consider any change in your health or insurability occurring after the date you sign this Receipt.
6. No one may change or waive anything in this Receipt.

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

This Conditional Receipt is part of the application for insurance on: 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 application MUST equal at least ONE MODAL PREMIUM.):

1. ☐ Disability Income (DI): Premium paid with application *: $_____.
2. ☐ Business Overhead Expense (BOE): Premium paid with 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 that application having the same proposed insured, owner and date(s) as this Receipt. This Receipt may NOT be used for Disability Buy-Out applications or Future Purchase Option applications.

CONDITIONS: Insurance coverage will be provided under this Receipt by any policy offered and accepted in connection with the application only if all of these Conditions are met:

1. You are insurable, as determined by our underwriters using our underwriting guidelines, on the day you sign this Receipt;
2. The initial 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, if any, starts on its Effective Date, but such coverage is subject to the COVERAGE TERMS AND LIMITATIONS below. No coverage is provided before the Effective Date. The Effective Date is:

a. This date, requested by the owner: ____/____/____(mm/dd/yy). (May not be more than 15 days before or after this Receipt is signed); OR
b. If the owner does not request a date in a, above: The date all of the above Conditions are met.

In either case, if the date indicated in a or b above is the 29th, 30th or 31st, the Effective Date will be the 1st of the following month.

COVERAGE TERMS AND LIMITATIONS:

1. If you become disabled under the terms of a policy subject to this Receipt, we will pay benefits for that disability, subject to the terms, conditions, limitations and exclusions of this Receipt and that policy. All benefits paid as a result of a disability incurred while this Receipt is in effect and before a policy is delivered to and accepted by the owner 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 the proposed insured and owner, if different, have signed this Receipt. We will return any premium paid for that policy.
3. This Receipt is not in effect for any policy, and any premium paid will be returned, if: (a) there is misrepresentation or fraud in the application or any application supplement; or (b) any check provided in connection with this Receipt is not honored when first presented for payment.
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 health and insurability as of the date you sign this Receipt. In underwriting your application we may rely on the results of medical tests and exams, and on other information, performed or obtained after the Effective Date. However, we will not consider any change in your health or insurability occurring 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.

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)

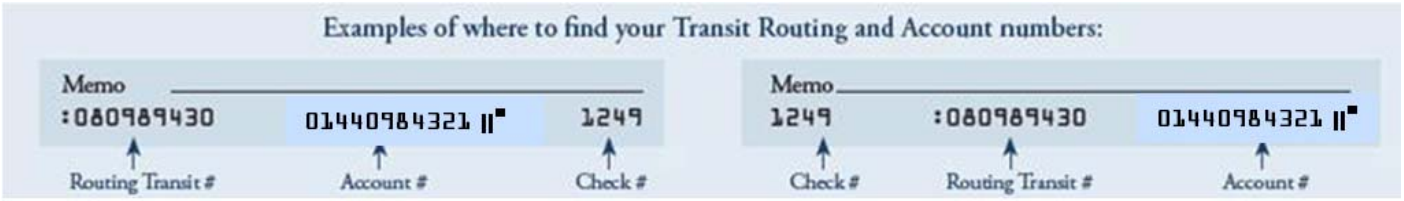
INSURED NAME	PHONE	FINANCIAL INSTITUTION NAME
NAME(S) ON ACCOUNT	ACCOUNT TYPE ☐ Checking ☐ Savings	TYPE OF FINANCIAL INSTITUTION ☐ Bank ☐ Credit Union ☐ Savings & Loan

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