

SERFF Tracking Number: ANTX-126174046 State: Arkansas
 Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 42583
 Company Tracking Number:
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
 Expense
 Product Name: DCA applications
 Project Name/Number: DCA applications/

Filing at a Glance

Company: Standard Life and Accident Insurance Company

Product Name: DCA applications

SERFF Tr Num: ANTX-126174046 State: ArkansasLH

TOI: H15G Group Health -

SERFF Status: Closed

State Tr Num: 42583

Hospital/Surgical/Medical Expense

Sub-TOI: H15G.002 Large Group Only

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: Deborah Biediger

Disposition Date: 06/09/2009

Date Submitted: 06/05/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: DCA applications

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile: 12/29/2008

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Overall Rate Impact:

Group Market Type: Association

Filing Status Changed: 06/09/2009

Explanation for Other Group Market Type:

State Status Changed: 06/09/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Attached for the Department's review are screen print-outs of the electronic versions of two applications that were approved by the Department on 5/15/09 under SERFF filing ANTX-125833329. These electronic versions of the approved paper forms will be used online.

The Applicant signs the electronic application form with an electronic signature.

SERFF Tracking Number: ANTX-126174046 State: Arkansas
 Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 42583
 Company Tracking Number:
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
 Expense
 Product Name: DCA applications
 Project Name/Number: DCA applications/

A sample of a completed electronic application is attached under Supporting Documentation.

Company and Contact

Filing Contact Information

Deborah Biediger, Sr Compliance deborah.biediger@anico.com
 One Moody Plaza 17th Floor (409) 766-6691 [Phone]
 Galveston, TX 77550 (409) 766-2024[FAX]

Filing Company Information

Standard Life and Accident Insurance Company CoCode: 86355 State of Domicile: Oklahoma
 One Moody Plaza 17th Floor Group Code: 408 Company Type: Health Insurance
 Galveston, TX 77550 Group Name: State ID Number:
 (409) 621-7779 ext. [Phone] FEIN Number: 73-0994234

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: 2 forms
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Life and Accident Insurance Company	\$50.00	06/05/2009	28398105

SERFF Tracking Number: ANTX-126174046 State: Arkansas
Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 42583
Company Tracking Number:
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
Expense
Product Name: DCA applications
Project Name/Number: DCA applications/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/09/2009	06/09/2009

SERFF Tracking Number: ANTX-126174046 State: Arkansas
Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 42583
Company Tracking Number:
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
Expense
Product Name: DCA applications
Project Name/Number: DCA applications/

Disposition

Disposition Date: 06/09/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ANTX-126174046 State: Arkansas
 Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 42583
 Company Tracking Number:
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
 Expense
 Product Name: DCA applications
 Project Name/Number: DCA applications/

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Enrollment Application	Approved-Closed	Yes
Form	EZ Enrollment Application	Approved-Closed	Yes

SERFF Tracking Number: ANTX-126174046 State: Arkansas
 Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 42583
 Company Tracking Number:
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
 Expense
 Product Name: DCA applications
 Project Name/Number: DCA applications/

Form Schedule

Lead Form Number: SLA-CAT08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	SLA-CAT08	Application/Enrollment	Enrollment Application Form	Initial			PrintableappB LANK_SLAI O_AllState[1].pdf
Approved-Closed	SLA-CAT08 (EZ)	Application/EZ Enrollment	Enrollment Application Form	Initial			PrintableappB LANK_SLAI O(EZ)_AllState[2].pdf



Application ID:

Policy ID:

Enrollment Application to
Standard Life and Accident Insurance Company (SLAICO) • Home Office • Galveston, Texas

Mail Certificate to Applicant:

SELECTED PLAN INFORMATION

Plan	Individual Deductible Amount	Family Deductible Amount
PPO Rider	PPO Selected	
Rate Of Payment	Stop-Loss Amount	Per Injury/Sickness Maximum

INITIAL MODAL PREMIUMS

Health Premium Amount	Life Premium Amount
-----------------------	---------------------

OPTIONAL BENEFITS

Accident Rider	Deductible Amount	Maximum Amount
OP Diagnostic Testing Rider	Deductible Amount	
OP Drug Rider	Individual Deductible Amount	Family Deductible Amount
OP Doctor Rider	Deductible Amount	Maximum Amount

CRITICAL ILLNESS BENEFICIARY

Name	Relationship
------	--------------

APPLICANT INFORMATION

Last Name	First Name	MI	
Number and Street or R.F.D	Social Security Number		
City	State	Zip Code	
Home Phone	Best Time to Call (AM/PM)	Cell Phone	Best Time to Call (AM/PM)
Work Phone	Best Time to Call (AM/PM)		
Email Address			
Date Of Birth	Age	Place Of Birth	
Gender	Marital Status	Height	Weight
Name Of Employer			
Full-Time (Y/N)	Duties/Title	Average Monthly Earnings Last 12 Months	

DEPENDENT INFORMATION			
Spouse	Last Name		First Name
			MI
	Social Security Number		Date Of Birth
			Age
			Gender
	Place of Birth		
	Marital Status		Height
			Weight
	Name of Employer		
Full-Time (Y/N)		Duties/Title	Average Monthly Earnings Last 12 Months

DEPENDENT INFORMATION			
Dependent	Last Name		First Name
			MI
	Social Security Number		Date Of Birth
			Age
			Gender
	Place of Birth		
	Height		Weight
	Relationship :		

EFFECTIVE DATE: SLAICO DOES NOT ASSIGN EFFECTIVE DATES ON THE 29TH, 30TH OR 31ST OF THE MONTH. APPLICATIONS APPROVAL MADE AFTER THE 28TH WILL HAVE AN EARLIEST DATE THE FIRST OF THE FOLLOWING MONTH.

Requested Effective Date :

EMPLOYMENT QUESTIONS

THE HEALTH INSURANCE COVERAGE THE AGENT HAS JUST DESCRIBED TO YOU IS NOT DESIGNED NOR INTENDED AS A HEALTH INSURANCE PLAN TO BE PROVIDED BY AN EMPLOYER FOR EMPLOYEES.

**CHANGES IN STATUS INDICATED BELOW MAY AFFECT FUTURE ELIGIBILITY FOR INSURANCE COVERAGE.
ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED.**

1. Is the Applicant or Spouse the owner of an incorporated business?

2. Is the Applicant or Spouse a sole proprietor or a partner in a partnership?

3. Is the Applicant or Spouse an employee of a business?
 - a. Will the Applicant's or Spouse's employer pay a portion of your health insurance premium?

 - b. Will the Applicant or Spouse be reimbursed by employer, through wage adjustments or otherwise, for any portion of the premium?

 - c. Will the Applicant's or Spouse's health insurance plan be treated by you or your employer as part of a plan or program for the purposes of Section 106, 125 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106, 125 or 162)?

ELIGIBILITY QUESTIONS

6. Is any Proposed Insured or household member (including students away at school, whether or not now applying for coverage) currently pregnant?

7. Has any Proposed Insured used any type of tobacco (including cigarettes, cigars, and/or smokeless tobacco) during the past 12 months?

8. Are all Proposed Insureds legal citizens of the United States?

9. Does any Proposed Insured intend to travel or reside outside the U.S.A.?

10. Are all your dependent children under the age of 26?
(Do not include on this application any of your children who are 26 years of age or older or any married children).

11. Has any Proposed Insured applying been covered under a health insurance plan including COBRA within the last 18 months?

a. Will requested coverage replace or change any existing medical insurance?

b. If Yes, give plan details below and provide reason for replacement such as carrier terminated coverage or lower rates, etc.

c. You should not cancel your existing medical insurance coverage until you receive written notification of acceptance from SLAICO. If accepted, do you agree to discontinue your current medical insurance?

12. Is any Proposed Insured applying for coverage under the federal HIPAA program?

13. Has any Proposed Insured applied for life, accident or health insurance, or reinstatement of such insurance, which was declined, restricted, postponed, rescinded, cancelled, withdrawn, or modified as to plan, amount, coverage, or rate?

14. Has any Proposed Insured made claim or received benefits for any injury or sickness in the last 12 months; or are they presently receiving any government aid such as Medicaid, Medicare, or SSDI?

15. Has any Proposed Insured ever taken part in: skydiving, hang gliding, parachuting, bungee jumping, rock or mountain climbing, scuba diving, racing (any type), motorcycle riding, professional sports, piloting an aircraft, or rodeo events?

ELIGIBILITY QUESTIONS (Continued...)

16. Has any Proposed Insured had a driver's license suspended, any traffic violations, DWI/DUI/OUI's or been arrested within the past 2 years?

17. Please list name and address of family/Primary Care Physician(s), reason and date last seen for each Proposed Insured:

MEDICAL HISTORY QUESTIONS

**THE FOLLOWING QUESTIONS ARE TO BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.
ANY MISSTATEMENTS MAY AFFECT YOUR COVERAGE**

18. Within the last 10 years, has any Proposed Insured had any indication of, diagnosis of, or treatment for:

- a. A respiratory or lung disorder, for example, allergies, sinusitis, reactive airway disease, asthma, bronchitis, tuberculosis, pneumonia, or emphysema;

- b. A circulatory or heart disorder, for example, high blood pressure, high cholesterol, heart attack, heart valve disorder, murmur angioplasty/bypass, chest pain, irregular heart rhythm, varicose veins, phlebitis or stroke;

- c. An immune, blood or spleen disorder, for example, anemia, leukemia, lymphoma, connective tissue disease, lupus, scleroderma, or clotting disorder;

- d. A digestive or gastrointestinal disorder, for example, ulcer, gastritis, reflux disorder, hepatitis, Crohn's Disease, ulcerative colitis, cirrhosis, irritable bowel, hemorrhoids, hernia or any disorder of the pancreas, liver, rectum or gallbladder;

- e. A nervous disorder, seizures, tremors, headaches, paralysis, palsy or injury of the brain, spinal cord, or nerves;

- f. A mental disorder, for example, emotional problems, eating disorder, attention deficit disorder, anxiety, depression, autism, sleep disorder, or received psychiatric treatment or counseling;

- g. An endocrine disorder, for example, diabetes mellitus or insipidus, low or high blood sugar, disorder of the thyroid, parathyroid, pituitary, or adrenal glands;

- h. A urinary tract disorder, for example, urinary tract stone, bladder or kidney infections, renal reflux, incontinence, or blood in the urine;

- i. A muscular or skeletal disorder, for example, arthritis, gout, fibromyalgia, bone, joint, muscle, back, spine disorder, disc disease, sciatica, or received chiropractic treatment or acupuncture;

- j. A facial bone or jaw disorder, for example, birth defect, congenital anomaly, malformation, temporomandibular joint disorder (TMJ), physical deformity, cleft palate or lip;

- k. Cancer in any form, tumor, cyst, polyp, or growth of any kind;

- l. An eye, ear, nose, throat disorder, for example, glaucoma, cataracts, ear infections, ear tubes, hearing impairment, enlarged tonsils/adenoids, vertigo, sleep apnea or deviated nasal septum;

- m. A skin or subcutaneous tissue disorder, for example, burns, scars or hemangioma;

- n. HIV, Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC);

- o. Mental or physical impairment or deformity; or congenital abnormality, mental retardation, developmental delay; or trait not previously disclosed;

MEDICAL HISTORY QUESTIONS (Continued...)

p. For Male Proposed Insureds Only:

A male reproductive disorder, for example, disorder, of the prostate, testicles, elevated PSA, or a sexually transmitted disease;

q. For Female Proposed Insureds (18+) Only:

I. Any disorder or condition of the female reproductive organs, for example, abnormal Pap Smear, irregular or excessive menstruation, endometriosis, infertility, pregnancy complications including Cesarean section delivery, cystocele, rectocele, pelvic relaxation, dysmenorrhea, chronic pelvic pain, or a sexually transmitted disease, or HPV (human papilloma virus);

II. Date of last Pap Smear

Results

III. Had instructions to have a repeat Pap Smear or any follow-up treatment or tests as a result of your last Pap Smear; or

IV. A breast disorder, disease, changes, or condition, lump(s) aspiration(s), calcifications, biopsies, removal or placement of breast implants, or mammoplasty?

19. Does any Proposed Insured have a prosthetic device present, for example, plates, screws, pins rods, implants, shunts, pacemakers, valve replacements or stents or fixation devices?

20. Within the past 5 years, has any Proposed Insured:

a. Had surgery, been hospital confined, or advised to undergo further testing, treatment, or surgery, including cosmetic or reconstructive surgery; or

b. Had a heart, bone, or blood study, MRI, x-ray, or ultrasound; or contacted or seen a physician, psychologist, chiropractor, counselor, therapist or any other person providing healthcare services?

21. Within the past 12 months, has any Proposed Insured experienced or been treated by a physician for a change in weight of more than 12 pounds?

22. Has any Proposed Insured ever been:

a. Treated or counseled for alcohol or drug use, or attended a drug or alcohol support group; or

b. Advised by a physician to seek treatment or discontinue or decrease alcohol or drug consumption; or

c. Under the influence of marijuana, narcotics, barbituates, amphetamines, hallucinogens, or used any other drugs not prescribed by a physician?

23. Within the last six months, has any Proposed Insured taken any prescription medication or are now taking any prescription medication or receiving treatment of any kind for any condition not listed in any of the previous questions?

APPLICATION DECLARATION & AGREEMENTS

I have personally completed this Enrollment Application and represent that all the answers and statements on this Enrollment Application are true, complete, and correctly recorded and agree they will be used to determine the eligibility for coverage applied for, for each Proposed Insured. I understand and agree that: 1) all statements and answers in this Enrollment Application, including any supplements, are complete and true; 2) I have personal knowledge of the medical history of each Proposed Insured; 3) any incorrect or incomplete information in this Enrollment Application may result in loss of coverage or claim denial; 4) no insurance coverage shall take effect unless the coverage applied for becomes effective or requested change is approved by SLAICO and the Certificate or requested change is delivered to the Applicant, and the first full premium paid during the lifetime and good health of all Proposed Insureds. I will notify and provide the Company with any evidence required by it to determine my future eligibility for coverage under the Group Policy. I acknowledge that I have received and read the material describing the rights of the Eligible Individual under the HIPAA mandate and understand its content.

Insurance Fraud: - Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I further understand and agree that:

1. A future change in my employment status may cause me to no longer be eligible for coverage under the Group Policy; and
2. Eligibility for coverage under the Group Policy does not constitute initial coverage under the Group Policy; and
3. Coverage under the Group Policy is subject to SLAICO's underwriting criteria.

Attention Applicant:

After this Enrollment Application has been completed, and before you sign it, read it carefully to be certain that all information has been properly recorded.

I agree that my electronic signature on this Enrollment Application serves as my original signature.

Applicant's Signature

First Name : Last Name: Date:

I agree that my electronic signature on this Enrollment Application serves as my original signature.

Spouse's Signature

First Name : Last Name: Date:

Agent Name

First Name : Last Name: Code/
Writing#

Fax# : Email:



AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE & ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency, or an independent administrator, including medical record retrieval services, pharmaceutical services, acting on behalf of STANDARD LIFE & ACCIDENT INSURANCE COMPANY or its reinsurers behalf, information concerning advice, care or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Proposed Insured(s). It is understood that STANDARD LIFE & ACCIDENT INSURANCE COMPANY underwriters, claims examiners, reinsurers, attorneys or the medical director may disclose such health information to the aforementioned parties for compliance, record clarification or explanation, or in response to litigation, summons or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations.

I understand that:

- (1) such information will be used by STANDARD LIFE & ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations.
- (2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage.
- (3) a picture copy or photocopy of this authorization shall be as valid as the original; and
- (4) any authorized representative of the Proposed Insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent those actions have been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE & ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

I agree that my electronic signature serves as my original signature.

Applicant's Signature

First Name :	<input type="text"/>	Last Name:	<input type="text"/>	Date:	<input type="text"/>
---------------------	----------------------	-------------------	----------------------	--------------	----------------------

I agree that my electronic signature serves as my original signature.

Spouse's Signature

First Name :	<input type="text"/>	Last Name:	<input type="text"/>	Date:	<input type="text"/>
---------------------	----------------------	-------------------	----------------------	--------------	----------------------

Personal Representative :	<input type="text"/>
----------------------------------	----------------------



Application ID:

Policy ID:

EZ Enrollment Application to
Standard Life and Accident Insurance Company (SLAICO) • Home Office • Galveston, Texas

Mail Certificate to Applicant:

SELECTED PLAN INFORMATION

Plan	Individual Deductible Amount	Family Deductible Amount
PPO Rider	PPO Selected	
Rate Of Payment	Stop-Loss Amount	Per Injury/Sickness Maximum

INITIAL MODAL PREMIUMS

Health Premium Amount	Life Premium Amount
-----------------------	---------------------

OPTIONAL BENEFITS

Accident Rider	Deductible Amount	Maximum Amount
OP Diagnostic Testing Rider	Deductible Amount	
OP Drug Rider	Individual Deductible Amount	Family Deductible Amount
OP Doctor Rider	Deductible Amount	Maximum Amount

CRITICAL ILLNESS BENEFICIARY

Name	Relationship
------	--------------

APPLICANT INFORMATION

Last Name	First Name	MI	
Number and Street or R.F.D	Social Security Number		
City	State	Zip Code	
Home Phone	Best Time to Call (AM/PM)	Cell Phone	Best Time to Call (AM/PM)
Work Phone	Best Time to Call (AM/PM)		
Email Address			
Date Of Birth	Age	Place Of Birth	
Gender	Marital Status	Height	Weight
Name Of Employer			
Full-Time (Y/N)	Duties/Title	Average Monthly Earnings Last 12 Months	

DEPENDENT INFORMATION			
Spouse	Last Name		First Name
			MI
	Social Security Number		Date Of Birth
			Age
			Gender
	Place of Birth		
	Marital Status		Height
			Weight
	Name of Employer		
Full-Time (Y/N)		Duties/Title	Average Monthly Earnings Last 12 Months

DEPENDENT INFORMATION			
Dependent	Last Name		First Name
			MI
	Social Security Number		Date Of Birth
			Age
			Gender
	Place of Birth		
	Height		Weight
	Relationship :		

<p>EFFECTIVE DATE: SLAICO DOES NOT ASSIGN EFFECTIVE DATES ON THE 29TH, 30TH OR 31ST OF THE MONTH. APPLICATIONS APPROVAL MADE AFTER THE 28TH WILL HAVE AN EARLIEST DATE THE FIRST OF THE FOLLOWING MONTH.</p>
Requested Effective Date :
Payment Mode :

ELIGIBILITY QUESTIONS

7. Has any Proposed Insured used tobacco or a tobacco based product within the past 12 months?

8. Has any Proposed Insured applied for life, accident or health insurance, or reinstatement of such insurance, which was declined, restricted, postponed, rescinded, cancelled, withdrawn, or modified as to plan, amount, coverage, or rate?

9. Are all dependent children under the age of 26 years?
(Do not include on this application any of your children who are 26 years of age or older or any married children).

10. Does any Proposed Insured plan to travel or reside outside the United States?

11. Does any Proposed Insured engage in hazardous occupations or sports?

12. Has any person applying been covered under a health insurance plan including COBRA within the last 18 months?

13. Are you applying for coverage under the federal HIPAA program?
(If yes, submit letter of creditable coverage.)

14. Will this insurance replace any existing insurance or insurance which has terminated with this company or any other company?
(If "yes" to questions 12, 13 or 14, provide details below for coverage in the last 24 months.)

15. You should not cancel your existing medical insurance coverage until you receive written notification of acceptance from SLAICO.

If accepted, do you agree to discontinue your current medical insurance?

EMPLOYMENT QUESTIONS

**CHANGES IN EMPLOYMENT STATUS INDICATED BELOW MAY AFFECT FUTURE ELIGIBILITY FOR INSURANCE COVERAGE.
ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED:**

16. Are you the owner of an incorporated business?

17. Are you a sole proprietor or a partner in a partnership?

18. Are you an employee of a business?

18a. Will your employer pay a portion of your health insurance premium?

18b. Will you be reimbursed by your employer, through wage adjustments or otherwise, for any portion of the premium?

18c. Will your health insurance plan be treated by you or your employer as part of a plan or program for the purposes of Section 106, 125 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106, 125 or 162)?

MEDICAL HISTORY QUESTIONS

19. Answer the following questions to determine if your client is eligible for health insurance coverage.

a. Does any Proposed Insured have history of Medical Conditions such as, but not limited to, AIDS/HIV, Internal Cancer, COPD, Connective Tissue Disorder, Crohn's Disease, Diabetes, Elevated Blood Sugar, Emphysema, Heart Attack, Heart Surgery, Heart Disease, Angioplasty, Hepatitis, Organ Transplant, Stroke, Stent Placement, Ulcerative Colitis or Melanoma?

b. Does any Proposed Insured have surgery or medical tests recommended or pending but not yet performed?

c. Does any Proposed Insured have a history of drug or alcohol abuse within the last 5 years, or had a driver's license suspended, received a DUI/DWI/OUI within the past 2 years?

d. Is any Proposed Insured or household family member (including students away at school whether applying or not applying for coverage) currently pregnant?

e. Has any Proposed Insured not resided in the United States 2 years or more?

If the answer is "Yes" to any of the above questions, do not apply for coverage on this individual. If a family member is pregnant, do not submit the application for any member.

APPLICATION DECLARATION & AGREEMENTS

I have personally completed this Enrollment Application and represent that all the answers and statements on this Enrollment Application are true, complete, and correctly recorded and agree they will be used to determine the eligibility for coverage applied for, for each Proposed Insured. I understand and agree that: 1) all statements and answers in this Enrollment Application, including any supplements, are complete and true; 2) I have personal knowledge of the medical history of each Proposed Insured; 3) any incorrect or incomplete information in this Enrollment Application may result in loss of coverage or claim denial; 4) no insurance coverage shall take effect unless the coverage applied for becomes effective or requested change is approved by SLAICO and the Certificate or requested change is delivered to the Applicant, and the first full premium paid during the lifetime and good health of all Proposed Insureds. I will notify and provide the Company with any evidence required by it to determine my future eligibility for coverage under the Group Policy. I acknowledge that I have received and read the material describing the rights of the Eligible Individual under the HIPAA mandate ,the Fair Credit Reporting Act Pre-Notification and the MIB Pre-Notification.

Insurance Fraud: - Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I further understand and agree that:

1. A future change in my employment status may cause me to no longer be eligible for coverage under the Group Policy; and
2. Eligibility for coverage under the Group Policy does not constitute initial coverage under the Group Policy; and
3. Coverage under the Group Policy is subject to SLAICO's underwriting criteria.

Attention Applicant:

After this Enrollment Application has been completed, and before you sign it, read it carefully to be certain that all information has been properly recorded.

I agree that my electronic signature on this Enrollment Application serves as my original signature.

Applicant's Signature

First Name : Last Name: Date:

I agree that my electronic signature on this Enrollment Application serves as my original signature.

Spouse's Signature

First Name : Last Name: Date:

Agent Name

First Name : Last Name: Code /Writing#:

Fax# : Email:



AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, MIB, Inc., the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency, or an independent administrator, including medical record retrieval services, pharmaceutical services, acting on behalf of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY or its reinsurers behalf, information concerning advice, care or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Proposed Insured(s). It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claims examiners, reinsurers, attorneys or the medical director may disclose such health information to the aforementioned parties for compliance, record clarification or explanation, or in response to litigation, summons or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations.

I understand that:

- (1) such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations.
- (2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage.
- (3) a picture copy or photocopy of this authorization shall be as valid as the original; and
- (4) any authorized representative of the Proposed Insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent those actions have been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

I agree that my electronic signature serves as my original signature.

Applicant's Signature

First Name : Last Name: Date:

I agree that my electronic signature serves as my original signature.

Spouse's Signature

First Name : Last Name: Date:

Personal Representative :

SERFF Tracking Number: ANTX-126174046 *State:* Arkansas
Filing Company: Standard Life and Accident Insurance Company *State Tracking Number:* 42583
Company Tracking Number:
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
Expense
Product Name: DCA applications
Project Name/Number: DCA applications/

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: ANTX-126174046 State: Arkansas
Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 42583
Company Tracking Number:
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
Expense
Product Name: DCA applications
Project Name/Number: DCA applications/

Supporting Document Schedules

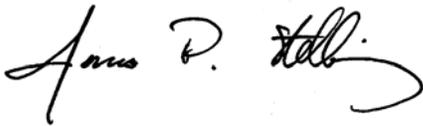
Satisfied -Name: Flesch Certification **Review Status:** Approved-Closed 06/09/2009
Comments:
certification
Attachment:
COMPLIANCE CERTIFICATION.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 06/09/2009
Comments:
Applications attached under Form Schedule and the ones attached here are "john doe" versions.
Attachments:
PrintableappYES_SLAICO1_AllState[1].pdf
PrintableappYES_SLAICO(EZ)_AllState[1].pdf

COMPLIANCE CERTIFICATION

We, Standard Life and Accident Insurance Company, certify that we are in compliance with the following:

- 019 Rule and Regulation 19 - Unfair Sex Discrimination in the Sale of Insurance
- 049 Rule and Regulation 49 - Life and Health Insurance Guaranty Association Notices –The notice is contained in all certificates issued to citizens of the state of Arkansas
- Minimum standards. All forms submitted in this filing achieve a minimum score of forty (40) on the Flesch reading ease test
- 23-79-138. Information to accompany policies – form SLA-CIN (AR) is contained in all certificates issued to residents of the state of Arkansas

A handwritten signature in black ink, appearing to read "James P. Stelling". The signature is written in a cursive style with a large, sweeping flourish at the end.

James P. Stelling
Vice President

Dated: June 5, 2009



Application ID:

Policy ID:

Enrollment Application to
Standard Life and Accident Insurance Company (SLAICO) • Home Office • Galveston, Texas

Mail Certificate to Applicant : YES

SELECTED PLAN INFORMATION		
Plan	Individual Deductible Amount	Family Deductible Amount
Option B	N/A	\$10,000
PPO Rider	PPO Selected	
N/A	N/A	
Rate Of Payment	Stop-Loss Amount	Per Injury/Sickness Maximum
100%	N/A	\$2,000,000

INITIAL MODAL PREMIUMS	
Health Premium Amount	Life Premium Amount
\$1,000	\$1,000

OPTIONAL BENEFITS		
Accident Rider	Deductible Amount	Maximum Amount
Yes	\$250	\$1,000
OP Diagnostic Testing Rider	Deductible Amount	
No	N/A	
OP Drug Rider	Individual Deductible Amount	Family Deductible Amount
Yes	\$1,000	\$2,000
OP Doctor Rider	Deductible Amount	Maximum Amount
Yes	\$1,000	\$25,000

CRITICAL ILLNESS BENEFICIARY	
Name	Relationship
Walt Disney	Father

APPLICANT INFORMATION			
Last Name	First Name	MI	
Duck	Donald	N/A	
Number and Street or R.F.D.			Social Security Number
123 South Main Street			123-45-6789
City	State	Zip Code	
Disneyland	CA	55555	
Home Phone	Best Time to Call (AM/PM)	Cell Phone	Best Time to Call (AM/PM)
(876)354-0012	AM	(333)444-5555	PM
Work Phone	Best Time to Call (AM/PM)		
(999)999-9999	AM		
Email Address			
dduck@disney.com			
Date Of Birth	Age	Place Of Birth	
03/20/68	40	Orlando,FL	
Gender	Marital Status	Height	Weight
Male	Married	6'1"	190 lb
Name Of Employer			
Disney Inc.			
Full-Time (Y/N)	Duties/Title	Average Monthly Earnings Last 12 Months	
Yes	Senior Imagineer	\$26,000	

DEPENDENT INFORMATION				
Spouse	Last Name	First Name	MI	
	Duck	Daisy	N/A	
	Social Security Number	Date Of Birth	Age	Gender
	987-65-4321	02/14/1969	39	Female
	Place of Birth			
	Orlando, FL			
	Marital Status	Height	Weight	
	Married	5'6"	145	
	Name of Employer			
	Disney Inc.			
Full-Time (Y/N)	Duties/Title	Average Monthly Earnings Last 12 Months		
Yes	Character	\$6,000		

DEPENDENT INFORMATION				
Dependent	Last Name	First Name	MI	
	Duck	Dewey	N/A	
	Social Security Number	Date Of Birth	Age	Gender
	333-44-5555	11/01/92	16	Male
	Place of Birth			
	Orlando, FL			
	Height	Weight		
	5'8"	136 lb		
Relationship : Child				

DEPENDENT INFORMATION				
Dependent	Last Name	First Name	MI	
	Duck	Huey	N/A	
	Social Security Number	Date Of Birth	Age	Gender
	777-88-9999	12/03/95	13	Male
	Place of Birth			
	Orlando, FL			
	Height	Weight		
	5'1"	100 lb		
Relationship : Child				

EFFECTIVE DATE: SLAICO DOES NOT ASSIGN EFFECTIVE DATES ON THE 29TH, 30TH OR 31ST OF THE MONTH. APPLICATIONS APPROVAL MADE AFTER THE 28TH WILL HAVE AN EARLIEST DATE THE FIRST OF THE FOLLOWING MONTH.

Requested Effective Date : 11/01/2008

EMPLOYMENT QUESTIONS

THE HEALTH INSURANCE COVERAGE THE AGENT HAS JUST DESCRIBED TO YOU IS NOT DESIGNED NOR INTENDED AS A HEALTH INSURANCE PLAN TO BE PROVIDED BY AN EMPLOYER FOR EMPLOYEES.

CHANGES IN STATUS INDICATED BELOW MAY AFFECT FUTURE ELIGIBILITY FOR INSURANCE COVERAGE.
ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED:

- | | |
|---|-----|
| 1. Is the Applicant or Spouse the owner of an incorporated business? | YES |
| <hr/> | |
| 2. Is the Applicant or Spouse a sole proprietor or a partner in a partnership? | YES |
| <hr/> | |
| 3. Is the Applicant or Spouse an employee of a business? | YES |
| <hr/> | |
| a. Will the Applicant's or Spouse's employer pay a portion of your health insurance premium? | YES |
| <hr/> | |
| b. Will the Applicant or Spouse be reimbursed by employer, through wage adjustments or otherwise, for any portion of the premium? | YES |
| <hr/> | |
| c. Will the Applicant's or Spouse's health insurance plan be treated by you or your employer as part of a plan or program for the purposes of Section 106, 125 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106, 125 or 162)? | YES |
| <hr/> | |

ELIGIBILITY QUESTIONS

6. Is any Proposed Insured or household member (including students away at school, whether or not now applying for coverage) currently pregnant? YES
Daisy Duck
-
7. Has any Proposed Insured used any type of tobacco (including cigarettes, cigars, and/or smokeless tobacco) during the past 12 months? YES
Daisy Duck
-
8. Are all Proposed Insureds legal citizens of the United States? YES
-
9. Does any Proposed Insured intend to travel or reside outside the U.S.A.? YES
Dewey Duck Studying in England
-
10. Are all your dependent children under the age of 26?
(Do not include on this application any of your children who are 26 years of age or older or any married children). YES
-
11. Has any Proposed Insured applying been covered under a health insurance plan including COBRA within the last 18 months? YES
- a. Will requested coverage replace or change any existing medical insurance? YES
-
- b. If Yes, give plan details below and provide reason for replacement such as carrier terminated coverage or lower rates, etc.
- | | |
|--------------------------------------|------------------|
| Name of Company and Policy #: | Care one 3691003 |
| Plan Type (Grp. or Ind.): | Ind. |
| Medical Insurance: | Yes |
| Reason For Termination: | New Job |
| Effective Date(mm-yy): | 01/07 |
| Termination Date: | 11/07 |
-
- c. You should not cancel your existing medical insurance coverage until you receive written notification of acceptance from SLAICO. If accepted, do you agree to discontinue your current medical insurance? YES
-
12. Is any Proposed Insured applying for coverage under the federal HIPAA program? YES
-
13. Has any Proposed Insured applied for life, accident or health insurance, or reinstatement of such insurance, which was declined, restricted, postponed, rescinded, cancelled, withdrawn, or modified as to plan, amount, coverage, or rate? YES
Donald Duck health insurance plan and coverage was modified
-
14. Has any Proposed Insured made claim or received benefits for any injury or sickness in the last 12 months; or are they presently receiving any government aid such as Medicaid, Medicare, or SSDI? YES
Donald Duck received Medicare in 12/07
-
15. Has any Proposed Insured ever taken part in: skydiving, hang gliding, parachuting, bungy jumping, rock or mountain climbing, scuba diving, racing (any type), motorcycle riding, professional sports, piloting an aircraft, or rodeo events? YES
Huey Duck Scuba Diving
-

ELIGIBILITY QUESTIONS (Continued...)

16. Has any Proposed Insured had a driver's license suspended, any traffic violations, DWI/DUI/OUI's or been arrested within the past 2 years? YES
Donald Duck - DWI

17. Please list name and address of family/Primary Care Physician(s), reason and date last seen for each Proposed Insured:

Proposed Insured:	Donald Duck
Condition, injury, symptoms, diagnosis and treatment:	Broken Wrist
Onset Date:	03/08
Date of last treatment:	04/08
Results/Degree of recovery:	Complete Recovery
Physician :	Dr. Lester Pane, 123 Main Steet Disneyland, CA 55555

MEDICAL HISTORY QUESTIONS

**THE FOLLOWING QUESTIONS ARE TO BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.
ANY MISSTATEMENTS MAY AFFECT YOUR COVERAGE**

18. Within the last 10 years, has any Proposed Insured had any indication of, diagnosis of, or treatment for:

- a. A respiratory or lung disorder, for example, allergies, sinusitis, reactive airway disease, asthma, bronchitis, tuberculosis, pneumonia, or emphysema; YES

Dewey Duck

Date of treatment From :	02/06
Date of treatment To :	Present
Reason for Check-up, Diagnosis, illness or Frequency of Attacks:	Difficulty breathing while running or in gym, Activity related Asthma, Attacks
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery :	Inhaler, Condition Ongoing
Name and Address of Each Physician, Practitioner, and Medical Facility :	Dr. Lesler Pane, 456 Queen Street, Disneyland , CA 55555

- b. A circulatory or heart disorder, for example, high blood pressure, high cholesterol, heart attack, heart valve disorder, murmur angioplasty/bypass, chest pain, irregular heart rhythm, varicose veins, phlebitis or stroke; YES

Dewey Duck

Date of treatment From :	01/93
Date of treatment To :	Present
Reason for Check-up, Diagnosis, illness or Frequency of Attacks:	Routine check up; heart murmur
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery :	Frequent doctor visit recommended for 1 year
Name and Address of Each Physician, Practitioner, and Medical Facility :	Dr. Lesler Pane, 456 Queen Street, Disneyland , CA 55555

- c. An immune, blood or spleen disorder, for example, anemia, leukemia, lymphoma, connective tissue disease, lupus, scleroderma, or clotting disorder; YES

Daisy Duck

Date of treatment From :	12/85
Date of treatment To :	Present
Reason for Check-up, Diagnosis, illness or Frequency of Attacks:	Weakness & Fatigue, diagnosed with Anemia
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery :	Diet changes instructed
Name and Address of Each Physician, Practitioner, and Medical Facility :	Dr. Lesler Pane, 456 Queen Street, Disneyland , CA 55555

MEDICAL HISTORY QUESTIONS (Continued...)

- d. A digestive or gastrointestinal disorder, for example, ulcer, gastritis, reflux disorder, hepatitis, Crohn's Disease, ulcerative colitis, cirrhosis, irritable bowel, hemorrhoids, hernia or any disorder of the pancreas, liver, rectum or gallbladder; YES

Donald Duck

Date of treatment From : 03/98
Date of treatment To : 06/98
Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Increasing pain in abdomen, Gall Stones found
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Surgery performed; Complete recovery
Name and Address of Each Physician, Practitioner, and Medical Facility : Dr. Lesler Pane, 456 Queen Street, DisneyLand , CA 55555

- e. A nervous disorder, seizures, tremors, headaches, paralysis, palsy or injury of the brain, spinal cord, or nerves; YES

Daisy Duck

Date of treatment From : 11/03
Date of treatment To : Present
Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Headaches, sensitivity to light and noise; diagnosed with migraines
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Medication prescribed; continued treatment
Name and Address of Each Physician, Practitioner, and Medical Facility : Dr. Lesler Pane, 456 Queen Street, DisneyLand , CA 55555

- f. A mental disorder, for example, emotional problems, eating disorder, attention deficit disorder, anxiety, depression, autism, sleep disorder, or received psychiatric treatment or counseling; YES

Huey Duck

Date of treatment From : 06/00
Date of treatment To : Present
Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Lack of attention, hyperactive, Attention Deficit Disorder Daily
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Medication prescribed, condition ongoing
Name and Address of Each Physician, Practitioner, and Medical Facility : Dr. Lesler Pane, 456 Queen Street, DisneyLand , CA 55555

MEDICAL HISTORY QUESTIONS (Continued...)

g. An endocrine disorder, for example, diabetes mellitus or insipidus, low or high blood sugar, disorder of the thyroid, parathyroid, pituitary, or adrenal glands; YES

Daisy Duck

Date of treatment From : 05/88
Date of treatment To : Present
Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Yearly Physical

Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Diabetes, Medication and Diet change, condition ongoing

Name and Address of Each Physician, Practitioner, and Medical Facility : Dr. Lesler Pane, 456 Queen Street, DisneyLand , CA 55555

h. A urinary tract disorder, for example, urinary tract stone, bladder or kidney infections, renal reflux, incontinence, or blood in the urine; YES

Daisy Duck

Date of treatment From : 01/84
Date of treatment To : 01/84
Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Frequent urination along with the feeling of having to urinate

Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Antibiotics prescribed

Name and Address of Each Physician, Practitioner, and Medical Facility : Dr. Lesler Pane, 456 Queen Street, DisneyLand , CA 55555

i. A muscular or skeletal disorder, for example, arthritis, gout, fibromyalgia, bone, joint, muscle, back, spine disorder, disc disease, sciatica, or received chiropractic treatment or acupuncture; YES

Donald Duck

Date of treatment From : 12/06
Date of treatment To : 03/07
Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Soreness in foot, unable to put pressure on foot

Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Gout, medication, Complete Recovery

Name and Address of Each Physician, Practitioner, and Medical Facility : Dr. Lesler Pane, 456 Queen Street, DisneyLand , CA 55555

MEDICAL HISTORY QUESTIONS (Continued...)

- j. A facial bone or jaw disorder, for example, birth defect, congenital anomaly, malformation, temporomandibular joint disorder (TMJ), physical deformity, cleft palate or lip; YES

Daisy Duck

Date of treatment From :	05/99
Date of treatment To :	Present
Reason for Check-up, Diagnosis, illness or Frequency of Attacks:	Increased jaw and ear pain; TMJ diagnosed
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery :	Pain Killers prescribed; Dentist visits every 3 months to watch progress
Name and Address of Each Physician, Practitioner, and Medical Facility :	Dr. Lesler Pane, 456 Queen Street, Disneyland , CA 55555

- k. Cancer in any form, tumor, cyst, polyp, or growth of any kind; YES

Donald Duck

Date of treatment From :	10/89
Date of treatment To :	02/90
Reason for Check-up, Diagnosis, illness or Frequency of Attacks:	Yearly Physical, Testicular Cancer found
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery :	Surgery and Radiation administered, Hospitalization for 2 days , Complete Recovery
Name and Address of Each Physician, Practitioner, and Medical Facility :	Dr. Lesler Pane, 456 Queen Street, Disneyland , CA 55555

- l. An eye, ear, nose, throat disorder, for example, glaucoma, cataracts, ear infections, ear tubes, hearing impairment, enlarged tonsils/adenoids, vertigo, sleep apnea or deviated nasal septum; YES

Huey Duck

Date of treatment From :	06/02
Date of treatment To :	08/02
Reason for Check-up, Diagnosis, illness or Frequency of Attacks:	Soar ears; consistent ear ache; Swimmers ear diagnosed
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery :	Ear drops prescribed; instructed not to put head under water
Name and Address of Each Physician, Practitioner, and Medical Facility:	Dr. Lester Pane, 456 Queen Street, Disneyland, CA 55555

MEDICAL HISTORY QUESTIONS (Continued...)

m. A skin or subcutaneous tissue disorder, for example, burns, scars or hemangioma; YES

Dewey Duck

Date of treatment From : 08/03
Date of treatment To : 08/03
Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Fell off bike, scar on leg
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Antibiotics prescribed
Name and Address of Each Physician, Practitioner, and Medical Facility: Dr. Lesler Pane, 456 Queen Street, Disneyland , CA 55555

n. HIV, Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC); YES

Daisy Duck

Date of treatment From : 10/90
Date of treatment To : Present
Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Yearly Checkup; concern of fatigue and night sweats; Blood test confirmed HIV
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Medication prescribed; Frequent doctor visit recommended to monitor
Name and Address of Each Physician, Practitioner, and Medical Facility: Dr. Lester Pane, 456 Queen Street, Disneyland, CA 55555

o. Mental or physical impairment or deformity; or congenital abnormality, mental retardation, developmental delay; or trait not previously disclosed; YES

Huey Duck

Date of treatment From : 03/97
Date of treatment To : Present
Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Not talking; diagnosed with Autism.
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Diet Change and medication prescribed
Name and Address of Each Physician, Practitioner, and Medical Facility: Dr. Lester Pane, 456 Queen Street, Disneyland, CA 55555

MEDICAL HISTORY QUESTIONS (Continued...)

p. For Male Proposed Insureds Only:

A male reproductive disorder, for example, disorder, of the prostate, testicles, elevated PSA, or a sexually transmitted disease; YES

Donald Duck

Date of treatment From : 10/89
Date of treatment To : 02/90
Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Yearly Physical; Testicular Cancer found
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Surgery and radiation administered; Hospitalization for 2 days, Complete
Name and Address of Each Physician, Practitioner, and Medical Facility: Disney Medical Center; 333 Health one Way, Disneyland, CA 55555

q. For Female Proposed Insureds (18+) Only:

I. Any disorder or condition of the female reproductive organs, for example, abnormal Pap Smear, irregular or excessive menstruation, endometriosis, infertility, pregnancy complications including Cesarean section delivery, cystocele, rectocele, pelvic relaxation, dysmenorrhea, chronic pelvic pain, or a sexually transmitted disease, or HPV (human papilloma virus); YES

Daisy Duck

Date of treatment From : 12/97
Date of treatment To : Present
Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Abnormal Pap Smear
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Repeat Pap Smear every 6 months
Name and Address of Each Physician, Practitioner, and Medical Facility: Dr. Lesler Pane, 456 Queen Street, Disneyland , CA 55555

II. Date of last Pap Smear 05/12/2008
 Results OK

III. Had instructions to have a repeat Pap Smear or any follow-up treatment or tests as a result of your last Pap Smear; or YES

Daisy Duck

Date of treatment From : 12/97
Date of treatment To : Present
Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Abnormal Pap Smear
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Repeat Pap Smear every 6 months
Name and Address of Each Physician, Practitioner, and Medical Facility: Dr. Lesler Pane, 456 Queen Street, Disneyland , CA 55555

MEDICAL HISTORY QUESTIONS (Continued...)

IV. A breast disorder, disease, changes, or condition, lump(s) aspiration(s), calcifications, biopsies, removal or placement of breast implants, or mammoplasty? YES

Daisy Duck

Date of treatment From : 03/06
Date of treatment To : 03/06
Reason for Check-up, Diagnosis, illness or Frequency of Attacks: 6 Month exam found calcifications
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Biopsy and ultrasound performed; continuing 6 month visits
Name and Address of Each Physician, Practitioner, and Medical Facility: Dr. Lesler Pane, 456 Queen Street, DisneyLand , CA 55555

19. Does any Proposed Insured have a prosthetic device present, for example, plates, screws, pins rods, implants, shunts, pacemakers, valve replacements or stents or fixation devices? YES

Dewey Duck

Date of treatment From : 09/03
Date of treatment To : 09/03
Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Broken arm; Screws used to fix
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Hospitalization for 4 days; 6 months of Physical Therapy; Pain and antibiotic medication prescribed
Name and Address of Each Physician, Practitioner, and Medical Facility: Disney Medical Center; 333 Health one Way, Disneyland, CA 55555

20. Within the past 5 years, has any Proposed Insured:
a. Had surgery, been hospital confined, or advised to undergo further testing, treatment, or surgery, including cosmetic or reconstructive surgery; or YES

Dewey Duck

Date of treatment From : 09/00
Date of treatment To : 09/00
Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Broken Leg; Screws used to fix
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Hospitalization for 4 days; 6 months of Physical Therapy; Pain and antibiotic medication prescribed
Name and Address of Each Physician, Practitioner, and Medical Facility: Disney Medical Center; 333 Health one Way, Disneyland, CA 55555

MEDICAL HISTORY QUESTIONS (Continued...)

b. Had a heart, bone, or blood study, MRI, x-ray, or ultrasound; or contacted or seen a physician, psychologist, chiropractor, counselor, therapist or any other person providing healthcare services? YES

Daisy Duck

Date of treatment From :	03/06
Date of treatment To :	03/06
Reason for Check-up, Diagnosis, illness or Frequency of Attacks:	6 Month exam found calcifications
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery :	Biopsy and ultrasound performed
Name and Address of Each Physician, Practitioner, and Medical Facility:	Disney Medical Center; 333 Health one Way, Disneyland, CA 55555

21. Within the past 12 months, has any Proposed Insured experienced or been treated by a physician for a change in weight of more than 12 pounds? YES

Donald Duck

Date of treatment From :	01/08
Date of treatment To :	Present
Reason for Check-up, Diagnosis, illness or Frequency of Attacks:	Yearly Physical; increased weight gain
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery :	Diet change discussed
Name and Address of Each Physician, Practitioner, and Medical Facility:	Dr. Lesler Pane, 456 Queen Street, DisneyLand , CA 55555

22. Has any Proposed Insured ever been:

a. Treated or counseled for alcohol or drug use, or attended a drug or alcohol support group; or YES

Donald Duck

Date of treatment From :	02/01
Date of treatment To :	02/02
Reason for Check-up, Diagnosis, illness or Frequency of Attacks:	Yearly Physical discussed alcohol dependence with doctor
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery :	Visited Licensed Therapist and Attended alcohol support group
Name and Address of Each Physician, Practitioner, and Medical Facility:	Dr. Lesler Pane, 456 Queen Street, DisneyLand , CA 55555

MEDICAL HISTORY QUESTIONS (Continued...)

b. Advised by a physician to seek treatment or discontinue or decrease alcohol or drug consumption; YES
or

Donald Duck

Date of treatment From : 02/01
Date of treatment To : 02/02
Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Yearly Physical; advised to seek treatment for alcohol dependence
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Visited Licensed Therapist and Attended alcohol support group
Name and Address of Each Physician, Practitioner, and Medical Facility: Dr. Lesler Pane, 456 Queen Street, Disneyland , CA 55555

c. Under the influence of marijuana, narcotics, barbituates, amphetamines, hallucinogens, or used any other drugs not prescribed by a physician? YES

Donald Duck

Date of treatment From : 07/86
Date of treatment To : 08/88
Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Frequent marijuana use
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : N/A
Name and Address of Each Physician, Practitioner, and Medical Facility: N/A

23. Within the last six months, has any Proposed Insured taken any prescription medication or are now taking any prescription medication or receiving treatment of any kind for any condition not listed in any of the previous questions? YES

Donald Duck

Date of treatment From : 08/08
Date of treatment To : Present
Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Tremors, loss of balance; Diagnosed with Parkinson's
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Taking doctor prescribed medication to offset symptoms
Name and Address of Each Physician, Practitioner, and Medical Facility: Dr. Lesler Pane, 456 Queen Street, Disneyland , CA 55555

APPLICATION DECLARATION & AGREEMENTS

I have personally completed this Enrollment Application and represent that all the answers and statements on this Enrollment Application are true, complete, and correctly recorded and agree they will be used to determine the eligibility for coverage applied for, for each Proposed Insured. I understand and agree that: 1) all statements and answers in this Enrollment Application, including any supplements, are complete and true; 2) I have personal knowledge of the medical history of each Proposed Insured; 3) any incorrect or incomplete information in this Enrollment Application may result in loss of coverage or claim denial; 4) no insurance coverage shall take effect unless the coverage applied for becomes effective or requested change is approved by SLAICO and the Certificate or requested change is delivered to the Applicant, and the first full premium paid during the lifetime and good health of all Proposed Insureds. I will notify and provide the Company with any evidence required by it to determine my future eligibility for coverage under the Group Policy. I acknowledge that I have received and read the material describing the rights of the Eligible Individual under the HIPAA mandate and understand its content.

Insurance Fraud: - Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I further understand and agree that:

1. A future change in my employment status may cause me to no longer be eligible for coverage under the Group Policy; and
2. Eligibility for coverage under the Group Policy does not constitute initial coverage under the Group Policy; and
3. Coverage under the Group Policy is subject to SLAICO's underwriting criteria.

Attention Applicant:

After this Enrollment Application has been completed, and before you sign it, read it carefully to be certain that all information has been properly recorded.

I agree that my electronic signature on this Enrollment Application serves as my original signature.

Applicant's Signature

First Name : Last Name: Date:

I agree that my electronic signature on this Enrollment Application serves as my original signature.

Spouse's Signature

First Name : Last Name: Date:

Agent Name

First Name : Last Name: Code /Writing# :

Fax# : Email:



AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE & ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency, or an independent administrator, including medical record retrieval services, pharmaceutical services, acting on behalf of STANDARD LIFE & ACCIDENT INSURANCE COMPANY or its reinsurers behalf, information concerning advice, care or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Proposed Insured(s). It is understood that STANDARD LIFE & ACCIDENT INSURANCE COMPANY underwriters, claims examiners, reinsurers, attorneys or the medical director may disclose such health information to the aforementioned parties for compliance, record clarification or explanation, or in response to litigation, summons or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations.

I understand that:

- (1) such information will be used by STANDARD LIFE & ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations.
- (2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage.
- (3) a picture copy or photocopy of this authorization shall be as valid as the original; and
- (4) any authorized representative of the Proposed Insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent those actions have been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE & ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

I agree that my electronic signature serves as my original signature.

Applicant's Signature

First Name : **Last Name:** **Date:**

I agree that my electronic signature serves as my original signature.

Spouse's Signature

First Name : **Last Name:** **Date:**

Personal Representative :



Application ID:

Policy ID:

EZ Enrollment Application to
Standard Life and Accident Insurance Company (SLAICO) • Home Office • Galveston, Texas

Mail Certificate to Applicant : YES

SELECTED PLAN INFORMATION		
Plan	Individual Deductible Amount	Family Deductible Amount
Option B	N/A	\$10,000
PPO Rider	PPO Selected	
N/A	N/A	
Rate Of Payment	Stop-Loss Amount	Per Injury/Sickness Maximum
100%	N/A	\$2,000,000

INITIAL MODAL PREMIUMS	
Health Premium Amount	Life Premium Amount
\$1,000	\$1,000

OPTIONAL BENEFITS		
Accident Rider	Deductible Amount	Maximum Amount
Yes	\$250	\$1,000
OP Diagnostic Testing Rider	Deductible Amount	
No	N/A	
OP Drug Rider	Individual Deductible Amount	Family Deductible Amount
Yes	\$1,000	\$2,000
OP Doctor Rider	Deductible Amount	Maximum Amount
Yes	\$1,000	\$25,000

CRITICAL ILLNESS BENEFICIARY	
Name	Relationship
Walt Disney	Father

APPLICANT INFORMATION			
Last Name	First Name	MI	
Duck	Donald	N/A	
Number and Street or R.F.D.			Social Security Number
123 South Main Street			123-45-6789
City	State	Zip Code	
Disneyland	CA	55555	
Home Phone	Best Time to Call (AM/PM)	Cell Phone	Best Time to Call (AM/PM)
(876)354-0012	AM	(333)444-5555	PM
Work Phone	Best Time to Call (AM/PM)		
(999)999-9999	AM		
Email Address			
dduck@disney.com			
Date Of Birth	Age	Place Of Birth	
03/20/68	40	Orlando, FL	
Gender	Marital Status	Height	Weight
Male	Married	6'1"	190 lb
Name Of Employer			
Disney Inc.			
Full-Time (Y/N)	Duties/Title	Average Monthly Earnings Last 12 Months	
Yes	Senior Imagineer	\$26,000	

DEPENDENT INFORMATION				
Spouse	Last Name	First Name	MI	
	Duck	Daisy	N/A	
	Social Security Number	Date Of Birth	Age	Gender
	987-65-4321	02/14/1969	39	Female
	Place of Birth			
	Orlando,FL			
	Marital Status	Height	Weight	
	Married	5'6"	145	
	Name of Employer			
	Disney Inc.			
Full-Time (Y/N)	Duties/Title	Average Monthly Earnings Last 12 Months		
Yes	Character	\$6,000		

DEPENDENT INFORMATION				
Dependent	Last Name	First Name	MI	
	Duck	Dewey	N/A	
	Social Security Number	Date Of Birth	Age	Gender
	333-44-5555	11/01/92	16	Male
	Place of Birth			
	Orlando, FL			
	Height	Weight		
	5'8"	136 lb		
Relationship : Child				

DEPENDENT INFORMATION				
Dependent	Last Name	First Name	MI	
	Duck	Huey	N/A	
	Social Security Number	Date Of Birth	Age	Gender
	777-88-9999	12/03/95	13	Male
	Place of Birth			
	Orlando, FL			
	Height	Weight		
	5'1"	100 lb		
Relationship : Child				

EFFECTIVE DATE: SLAICO DOES NOT ASSIGN EFFECTIVE DATES ON THE 29TH, 30TH OR 31ST OF THE MONTH.	
APPLICATIONS APPROVAL MADE AFTER THE 28TH WILL HAVE AN EARLIEST DATE THE FIRST OF THE FOLLOWING MONTH.	
Requested Effective Date :	11/01/2008
Payment Mode :	Annual

ELIGIBILITY QUESTIONS

7. Has any Proposed Insured used tobacco or a tobacco based product within the past 12 months? YES

Daisy Duck

8. Has any Proposed Insured applied for life, accident or health insurance, or reinstatement of such insurance, which was declined, restricted, postponed, rescinded, cancelled, withdrawn, or modified as to plan, amount, coverage, or rate? YES

Daisy Duck

9. Are all dependent children under the age of 26 years? YES
(Do not include on this application any of your children who are 26 years of age or older or any married children).

10. Does any Proposed Insured plan to travel or reside outside the United States? YES

Dewey Duck Studying in England

11. Does any Proposed Insured engage in hazardous occupations or sports? YES

Huey Duck Scuba Diving

12. Has any person applying been covered under a health insurance plan including COBRA within the last 18 months? YES

13. Are you applying for coverage under the federal HIPAA program? YES
(If yes, submit letter of creditable coverage.)

14. Will this insurance replace any existing insurance or insurance which has terminated with this company or any other company? YES

(If "yes" to questions 12, 13 or 14, provide details below for coverage in the last 24 months.)

Name of Company and Policy #:	Care one 3691003
Plan Type (Grp. or Ind.):	Ind.
Medical Insurance:	Yes
Reason For Termination:	New Job
Effective Date(mm-yy):	01/07
Termination Date:	11/07

15. You should not cancel your existing medical insurance coverage until you receive written notification of acceptance from SLAICO.

If accepted, do you agree to discontinue your current medical insurance? YES

EMPLOYMENT QUESTIONS

**CHANGES IN EMPLOYMENT STATUS INDICATED BELOW MAY AFFECT FUTURE ELIGIBILITY FOR INSURANCE COVERAGE.
ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED:**

- | | |
|--|-----|
| 16. Are you the owner of an incorporated business? | YES |
| <hr/> | |
| 17. Are you a sole proprietor or a partner in a partnership? | YES |
| <hr/> | |
| 18. Are you an employee of a business? | YES |
| 18a. Will your employer pay a portion of your health insurance premium? | YES |
| <hr/> | |
| 18b. Will you be reimbursed by your employer, through wage adjustments or otherwise, for any portion of the premium? | YES |
| <hr/> | |
| 18c. Will your health insurance plan be treated by you or your employer as part of a plan or program for the purposes of Section 106, 125 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106, 125 or 162)? | YES |
| <hr/> | |

MEDICAL HISTORY QUESTIONS

19. Answer the following questions to determine if your client is eligible for health insurance coverage.

- a. Does any Proposed Insured have history of Medical Conditions such as, but not limited to, AIDS/HIV, YES Internal Cancer, COPD, Connective Tissue Disorder, Crohn’s Disease, Diabetes, Elevated Blood Sugar, Emphysema, Heart Attack, Heart Surgery, Heart Disease, Angioplasty, Hepatitis, Organ Transplant, Stroke, Stent Placement, Ulcerative Colitis or Melanoma?

Daisy Duck

Date of treatment From : 02/06

Date of treatment To : Present

Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Difficulty breathing while running or in gym, Activity related Asthma, Attacks

Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Inhaler, Condition Ongoing

Name and Address of Each Physician, Practitioner, and Medical Facility : Dr. Lesler Pane, 456 Queen Street, Disneyland , CA 55555

- b. Does any Proposed Insured have surgery or medical tests recommended or pending but not yet performed? YES

Dewey Duck

Date of treatment From : 01/93

Date of treatment To : Present

Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Routine check up; heart murmur

Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Frequent doctor visit recommended for 1 year

Name and Address of Each Physician, Practitioner, and Medical Facility : Dr. Lesler Pane, 456 Queen Street, Disneyland , CA 55555

- c. Does any Proposed Insured have a history of drug or alcohol abuse within the last 5 years, or had a driver’s license suspended, received a DUI/DWI/OUI within the past 2 years? YES

Daisy Duck

Date of treatment From : 12/85

Date of treatment To : Present

Reason for Check-up, Diagnosis, illness or Frequency of Attacks: Weakness & Fatigue, diagnosed with Anemia

Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery : Diet changes instructed

Name and Address of Each Physician, Practitioner, and Medical Facility : Dr. Lesler Pane, 456 Queen Street, Disneyland , CA 55555

MEDICAL HISTORY QUESTIONS (Continued...)

- d. Is any Proposed Insured or household family member (including students away at school whether applying or not applying for coverage) currently pregnant? YES

Donald Duck

Date of treatment From :	03/98
Date of treatment To :	06/98
Reason for Check-up, Diagnosis, illness or Frequency of Attacks:	Increasing pain in abdomen, Gall Stones found
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery :	Surgery performed; Complete recovery
Name and Address of Each Physician, Practitioner, and Medical Facility :	Dr. Lesler Pane, 456 Queen Street, Disneyland , CA 55555

- e. Has any Proposed Insured not resided in the United States 2 years or more? YES

Daisy Duck

Date of treatment From :	11/03
Date of treatment To :	Present
Reason for Check-up, Diagnosis, illness or Frequency of Attacks:	Headaches, sensitivity to light and noise; diagnosed with migraines
Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery :	Medication prescribed; continued treatment
Name and Address of Each Physician, Practitioner, and Medical Facility :	Dr. Lesler Pane, 456 Queen Street, Disneyland , CA 55555

If the answer is "Yes" to any of the above questions, do not apply for coverage on this individual. If a family member is pregnant, do not submit the application for any member.

APPLICATION DECLARATION & AGREEMENTS

I have personally completed this Enrollment Application and represent that all the answers and statements on this Enrollment Application are true, complete, and correctly recorded and agree they will be used to determine the eligibility for coverage applied for, for each Proposed Insured. I understand and agree that: 1) all statements and answers in this Enrollment Application, including any supplements, are complete and true; 2) I have personal knowledge of the medical history of each Proposed Insured; 3) any incorrect or incomplete information in this Enrollment Application may result in loss of coverage or claim denial; 4) no insurance coverage shall take effect unless the coverage applied for becomes effective or requested change is approved by SLAICO and the Certificate or requested change is delivered to the Applicant, and the first full premium paid during the lifetime and good health of all Proposed Insureds. I will notify and provide the Company with any evidence required by it to determine my future eligibility for coverage under the Group Policy. I acknowledge that I have received and read the material describing the rights of the Eligible Individual under the HIPAA mandate, the Fair Credit Reporting Act Pre-Notification and the MIB Pre-Notification.

Insurance Fraud: - Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I further understand and agree that:

1. A future change in my employment status may cause me to no longer be eligible for coverage under the Group Policy; and
2. Eligibility for coverage under the Group Policy does not constitute initial coverage under the Group Policy; and
3. Coverage under the Group Policy is subject to SLAICO's underwriting criteria.

Attention Applicant:

After this Enrollment Application has been completed, and before you sign it, read it carefully to be certain that all information has been properly recorded.

I agree that my electronic signature on this Enrollment Application serves as my original signature.

Applicant's Signature

First Name : Last Name: Date:

I agree that my electronic signature on this Enrollment Application serves as my original signature.

Spouse's Signature

First Name : Last Name: Date:

Agent Name

First Name : Last Name: Code /Writing#:

Fax# : Email:



AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, MIB, Inc., the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency, or an independent administrator, including medical record retrieval services, pharmaceutical services, acting on behalf of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY or its reinsurers behalf, information concerning advice, care or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Proposed Insured(s). It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claims examiners, reinsurers, attorneys or the medical director may disclose such health information to the aforementioned parties for compliance, record clarification or explanation, or in response to litigation, summons or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations.

I understand that:

- (1) such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations.
- (2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage.
- (3) a picture copy or photocopy of this authorization shall be as valid as the original; and
- (4) any authorized representative of the Proposed Insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent those actions have been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

I agree that my electronic signature serves as my original signature.

Applicant's Signature

First Name : **Last Name:** **Date:**

I agree that my electronic signature serves as my original signature.

Spouse's Signature

First Name : **Last Name:** **Date:**

Personal Representative :