

SERFF Tracking Number: STAN-126704349 State: Arkansas
Filing Company: Standard Insurance Company State Tracking Number: 46147
Company Tracking Number: DPACCR
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
Product Name: Policy Acceptances
Project Name/Number: Policy Acceptances/PolAcc A

Filing at a Glance

Company: Standard Insurance Company

Product Name: Policy Acceptances

TOI: H111 Individual Health - Disability Income

Sub-TOI: H111.004 Other

Filing Type: Form

SERFF Tr Num: STAN-126704349 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 46147

Co Tr Num: DPACCR

Author: Christine Starnes

Date Submitted: 07/07/2010

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 07/14/2010

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: Policy Acceptances

Project Number: PolAcc A

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 07/14/2010

Deemer Date:

Submitted By: Christine Starnes

Filing Description:

RE: Standard Insurance Company - New Form Approval Filing

Individual Disability Insurance Applications

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Filed

simultaneously in Oregon, our state of domicile

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 07/14/2010

Created By: Christine Starnes

Corresponding Filing Tracking Number:

DPACCR(6/10)AR Disability Policy Acceptance and Application Supplement CR

DPACA(6/10)AR Disability Policy Acceptance and Application Supplement A

DPACB(6/10)AR Disability Policy Acceptance and Application Supplement B

DPAMEND(6/10)AR Disability Policy and Application Amendment

DPACGI(6/10)AR Disability Policy Acceptance and Application Supplement GI

SERFF Tracking Number: STAN-126704349 State: Arkansas
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Dear Mr. Musgrove:

Enclosed for your filing and approval are the above referenced policy acceptance forms to be used in the application process for our individual disability insurance products. The first three are revised forms that will replace forms currently in use, while two are new forms, as indicated in the description of each form shown below. These forms will be used in conjunction with our basic Application for Disability Insurance or Short Form Application for Guarantee Issue, both previously filed/approved by your office.

The following are our current products for which the enclosed forms will be used:

Base Policy Form Number Title/Description Approval/Filing

B152(5/05)AR Disability Income Insurance, approved on June 24, 2005

B123.3(2/99)AR Business Overhead Expense Disability Insurance, approved on Nov. 12, 1998

B128.3(11/03)AR Disability Policy for Business Buy-Out Expense, approved on Dec. 10, 2003

We may also use these application supplement forms for individual disability insurance products we develop in the future as they are filed/approved by your office.

A brief description of each form follows:

Disability Policy Acceptance and Application Supplement CR, DPACCR(6/10)AR

As previously filed/approved, the purpose for this form is to obtain the policyowner's written acceptance of the policy and is for cases where an initial premium has been paid with the Application for Disability Insurance and a conditional receipt has been issued. As in the previous version, Section A provides the information for the effective dates selected by the policyowner. The significant revision to this form was the removal of Section C, addressing any amendments or changes in the application or coverage applied for. The amendments section is now included in a new form, DPAMEND, described below. This policy acceptance form was also revised to remove the REQUIRED QUESTIONS section (D), which is now revised and discussed in section B. There are also miscellaneous wording and formatting changes. A marked-up sample of the generic version of this form is included for your reference, reflecting the significant changes. Upon your filing/approval, this form will replace form DPACCR(2/08)AR, filed/approved by your office on February 20, 2008.

Disability Policy Acceptance and Application Supplement A, DPACA(6/10)AR

As previously filed/approved, the purpose for this form is to also to obtain the policyowner's written acceptance of the policy and is for non-conditional receipt cases. As before, Section A provides the information for the effective dates selected by the policyowner. As with DPACCR (above), the significant revision to this form was the removal of Section

SERFF Tracking Number: STAN-126704349 State: Arkansas
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Company Tracking Number: DPACCR
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Product Name: Policy Acceptances
Project Name/Number: Policy Acceptances/PolAcc A

C addressing any amendments or changes in the application or coverage applied for. The amendments section is now included in a new form, DPAMEND, described below. The form was also revised to remove the REQUIRED QUESTIONS section (D), which is now revised and discussed in section B. There are also miscellaneous wording and formatting revisions throughout the new version. A marked-up sample of the generic version of this form is included for your reference, reflecting the significant changes.

Upon your filing/approval, this form will replace form DPACA(2/08)AR, filed/approved by your office on February 20, 2008

Disability Policy Acceptance and Application Supplement B, DPACB(6/10)AR

As previously filed/approved, this general policy acceptance form continues to be used in cases where the policyowner has chosen to exercise their future purchase option and provides for written acceptance of that increase policy. The policy effective date is already established. As with the two forms discussed above, this acceptance has been revised to remove the section addressing any amendments or changes in the application or coverage applied for, which are now addressed in DPAMEND (below). Other minor wording and formatting changes were also made, as shown in the attached mark-up example.

Upon your filing/approval, this form will replace form DPACB(5/04)AR, filed/approved by your office on June 10, 2004.

Disability Policy and Application Amendment, DPAMEND(6/10)AR

This is a new form, and as mentioned above, will be used to list any amendments or changes in the application or coverage applied for, as signed for and accepted by the policyowner/insured. If applicable, this form will be used in conjunction with Disability Policy Acceptance and Application Supplements A, B and CR, listed above.

Disability Policy Acceptance and Application Supplement GI, DPACGI(6/10)AR

This is a new policy acceptance form, yet is substantially similar to our previous Disability Policy Acceptance and Application Supplement B form. This form will be used in conjunction with delivery of our guarantee issue policies to obtain the policyowner's written acceptance of the policy, including acceptance of any amendments or changes to the application or coverage applied for. Amendments or changes are reflected under Section C, some of which may be as small as a correction of an address or a "yes/no" answer on the Short Form Application for Insurance, (previously approved by your office); or they may be more substantive amendments such as the addition of a rider.

To complete this filing, a certificate of readability is enclosed. A \$50 filing fee is also include through EFT. Please note there is no filing fee in Oregon, our state of domicile

The submitted forms are in final print format, but may be printed in other formats or through electronic media (e.g. CD, internet or intranet). While we may employ type style, paper sizes or a layout different from the enclosed forms, we certify and agree that the content of the forms will not change without prior approval from your department. We also certify that any type style change will be in compliance with your readability requirements.

SERFF Tracking Number: STAN-126704349 State: Arkansas
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Company Tracking Number: DPACCR
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
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If you have any questions or require any additional information, please feel free to call me at 800-378-2313, or email chris.starnes@standard.com.

Thank you for your assistance with this filing.

Sincerely,

Christine Starnes
Senior Compliance Analyst
Individual Disability Insurance

Company and Contact

Filing Contact Information

Chris Starnes, Senior Compliance Analyst cstarnes@standard.com
1100 SW Sixth Avenue 971-321-8936 [Phone]
P6D 971-321-7805 [FAX]
Portland, OR 97204

Filing Company Information

Standard Insurance Company CoCode: 69019 State of Domicile: Oregon
1100 SW 6th Avenue Group Code: 1348 Company Type: Life Insurance
Portland, OR 97204 Group Name: SIC State ID Number:
(971) 321-6823 ext. [Phone] FEIN Number: 93-0242990

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? Yes
Fee Explanation: \$50 per filing. There is no filing fee in Oregon our state of domicile
Per Company: No

SERFF Tracking Number: STAN-126704349 State: Arkansas
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TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
Product Name: Policy Acceptances
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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Insurance Company	\$50.00	07/07/2010	37792440

SERFF Tracking Number: STAN-126704349 State: Arkansas
Filing Company: Standard Insurance Company State Tracking Number: 46147
Company Tracking Number: DPACCR
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/14/2010	07/14/2010

SERFF Tracking Number: STAN-126704349 *State:* Arkansas
Filing Company: Standard Insurance Company *State Tracking Number:* 46147
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TOI: H111 Individual Health - Disability Income *Sub-TOI:* H111.004 Other
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Disposition

Disposition Date: 07/14/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: STAN-126704349 State: Arkansas
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 Company Tracking Number: DPACCR
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Mark ups of current forms being revised	Approved-Closed	Yes
Form	Disability Policy Acceptance and Application Supplement CR	Approved-Closed	Yes
Form	Disability Policy Acceptance and Application Supplement A	Approved-Closed	Yes
Form	Disability Policy Acceptance and Application Supplement B	Approved-Closed	Yes
Form	Disability Policy and Application Amendment	Approved-Closed	Yes
Form	Disability Policy Acceptance and Application Supplement GI	Approved-Closed	Yes

SERFF Tracking Number: STAN-126704349 State: Arkansas
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 Company Tracking Number: DPACCR
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
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 Project Name/Number: Policy Acceptances/PolAcc A

Form Schedule

Lead Form Number: DPACCR(6/10)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/14/2010	DPACCR(6/10)AR	Enrollment Form	Application/Disability Policy Acceptance and Application Supplement CR	Initial		51.300	DPACCR_0610 AR.pdf
Approved-Closed 07/14/2010	DPACA(6/10)AR	Enrollment Form	Application/Disability Policy Acceptance and Application Supplement A	Initial		50.300	DPACA_0610 AR.pdf
Approved-Closed 07/14/2010	DPACB(6/10)AR	Enrollment Form	Application/Disability Policy Acceptance and Application Supplement B	Initial		58.200	DPACB_0610 AR.pdf
Approved-Closed 07/14/2010	DPAMEND(6/10)AR	Enrollment Form	Application/Disability Policy and Application Amendment	Initial		50.700	DPAMEND_0610 AR.pdf
Approved-Closed 07/14/2010	DPACGI(6/10)AR	Enrollment Form	Application/Disability Policy Acceptance and Application Supplement GI	Initial		50.700	DPACGI_0610 AR.pdf

Standard Insurance Company

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

**Disability Insurance Policy Acceptance and
Application Supplement CR**

This form is part of the application for insurance with Standard Insurance Company on:

Proposed Insured: _____ **Policy Number:** _____

A. I ELECT A POLICY EFFECTIVE DATE AS PROVIDED BELOW:

1. I elect a Policy Effective Date of ___/___/___ (mm/dd/yy). (May not be a date before [the date of my application for the policy, <<Application Date>>, / 30 days prior to the date of my application for the policy, <<Date 30 Prior to Application Date>>], or after the date the owner signs this form); OR

2. If a Policy Effective Date is not elected in item 1, above, or if the date elected is outside the time period described in item 1, I understand and agree the Policy Effective Date elected will be the date of the Conditional Receipt, <<Date of Conditional Receipt>>.

In either 1 or 2, above, if the Policy Effective Date falls on the 29th, 30th or 31st of the month, I understand and agree that the Policy Effective Date will be changed to the 1st of the following month. I also understand and agree that premiums will be charged for coverage under the policy from the Policy Effective Date elected.

B. I UNDERSTAND AND AGREE THAT:

1. I have read the questions and answers in the application for insurance (including any application supplement) which is attached to the policy and all answers recorded in the application are true and complete as of the date of the application. If I was asked questions in a telephone interview as part of the application, I have reviewed the answers I provided in the telephone interview and have confirmed those answers have been accurately recorded in the application and are true and complete as of the time of the telephone interview and as of the date of the application.

2. **If I have elected a Policy Effective Date after the date of the application,** I have not, since the date of the application: (1) consulted with or been treated by a physician or other medical practitioner, other than to comply with Standard's underwriting requirements; (2) experienced any sickness, injury or change in health; or (3) changed occupation or employer. **I understand that if any of this information has changed since the date of the application, I should notify the sales producer of the change(s) and should not sign this form and not accept delivery of the policy.**

3. Coverage will not take effect under the policy unless this form is signed by me and the policyowner, if different, the first full premium is paid, and there has been no change in my health and status of employment or occupation as stated in the application.

NOTE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The signature below certifies the accuracy of the declarations that I have made above and acknowledges that I have reviewed, accepted and received the policy offered by Standard on the date shown below. Once signed, I understand that this form will be attached to, and become part of, the policy.

Signature of Proposed Insured Signed on ___/___/___
Date

Signature of Policyowner (if other than Proposed Insured) Signed on ___/___/___
If a company is policyowner, signature of authorized representative. Date

Print Name of Policyowner (If other than Proposed Insured)
If a company is policyowner, also print title of authorized representative and company name.

Standard Insurance Company

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

**Disability Insurance Policy Acceptance and
Application Supplement A**

This form is part of the application for insurance with Standard Insurance Company on:

Proposed Insured: _____ **Policy Number:** _____

A. I ELECT A POLICY EFFECTIVE DATE AS PROVIDED BELOW:

1. I elect a Policy Effective Date of ___/___/___ (mm/dd/yy). (May not be a date before [the date of my application for the policy, <<Application Date>>, / 30 days prior to the date of my application for the policy, <<Date 30 Prior to Application Date>>], or after the date the policyowner signs this form); OR

2. If a Policy Effective Date is not elected in item 1, above, or if the date elected is outside the time period described in item 1, I understand and agree the Policy Effective Date elected will be the date when this form is signed.

In either 1 or 2, above, if the Policy Effective Date falls on the 29th, 30th or 31st of the month, I understand and agree that the Policy Effective Date will be changed to the 1st of the following month. I also understand and agree that premiums will be charged for coverage under the policy from the Policy Effective Date elected.

B. I UNDERSTAND AND AGREE THAT:

1. I have read the questions and answers in the application for insurance (including any application supplement) which is attached to the policy and all answers recorded in the application are true and complete as of the date of the application. If I was asked questions in a telephone interview as part of the application, I have reviewed the answers I provided in the telephone interview and have confirmed those answers have been accurately recorded in the application and are true and complete as of the time of the telephone interview and as of the date of the application.

2. Since the date of the application, I have not: (1) consulted with or been treated by a physician or other medical practitioner, other than to comply with Standard's underwriting requirements; (2) experienced any sickness, injury or change in health; or (3) changed occupation or employer. **I understand that if any of this information has changed since the date of the application, I should notify the sales producer of the change(s) and should not sign this form and not accept delivery of the policy.**

3. Coverage will not take effect under the policy unless this form is signed by me and the policyowner, if different, the first full premium is paid, and there has been no change in my health and status of employment or occupation as stated in the application.

NOTE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The signature below certifies the accuracy of the declarations that I have made above and acknowledges that I have reviewed, accepted and received the policy offered by Standard on the date shown below. Once signed, I understand that this form will be attached to, and become part of, the policy.

Signature of Proposed Insured Signed on ___/___/___
Date

Signature of Policyowner (if other than Proposed Insured)
If a company is policyowner, signature of authorized representative. Signed on ___/___/___
Date

Print Name of Policyowner (If other than Proposed Insured)
If a company is policyowner, also print title of authorized representative and company name.

This form is part of the application for insurance with Standard Insurance Company on:

Proposed Insured: _____ **Policy Number:** _____

A. POLICY EFFECTIVE DATE:

B. I UNDERSTAND AND AGREE THAT:

1. I have read the questions and answers in the application for insurance (including any application supplement) which is attached to the policy and all answers recorded in the application are true and complete as of the date of the application. **I understand that if any answer has changed since the date of the application, I should notify the sales producer of the change(s) and should not sign this form and not accept delivery of the policy.**
2. Coverage will not take effect under the policy unless this form is signed by me and the policyowner, if different, the first full premium is paid, and there has been no change in the answers I provided in the application.

NOTE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The signature below certifies the accuracy of the declarations that I have made above and acknowledges that I have reviewed, accepted and received the policy offered by Standard on the date shown below. Once signed, I understand that this form will be attached to, and become part of, the policy.

Signature of Proposed Insured

Signed on ____/____/____
Date

Signature of Policyowner (if other than Proposed Insured)
If a company is policyowner, signature of authorized representative.

Signed on ____/____/____
Date

Print Name of Policyowner (If other than Proposed Insured)
If a company is policyowner, also print title of authorized representative and company name.

This form is part of the application for insurance with Standard Insurance Company on:

Proposed Insured: _____ **Policy Number:** _____

A. AMENDMENT: The policy is issued by Standard and accepted by the policyowner subject to the following terms, provisions or amendments:

B. I UNDERSTAND AND AGREE THAT:

1. I have read the questions and answers in the application for insurance (including any application supplement) and the amendments to the policy or application listed above. All answers recorded in the application and in this amendment remain true and complete as of the date this form is signed.
2. Since the date of the application, there has been no change in the information provided in the application, except those amendment(s) specifically listed above. **I understand that if there are any other amendments to be made to the application, I should notify the sales producer of the amendment(s) and should not sign this form and not accept delivery of the policy.**
3. Coverage will not take effect under the policy unless this form is signed by me and the policyowner, if different, the first full premium is paid, and there are no amendments in the answers I have provided in the application other than those listed above.

NOTE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The signature below certifies the accuracy of the declarations that I have made above. Once signed, I understand that any amendments to the policy or application listed above will be attached to, and become part of, the policy.

Signature of Proposed Insured

Signed on ____/____/____
Date

Signature of Policyowner (if other than Proposed Insured)
If a company is policyowner, signature of authorized representative.

Signed on ____/____/____
Date

Print Name of Policyowner (If other than Proposed Insured)
If a company is policyowner, also print title of authorized representative and company name.

This form is part of the application for insurance with Standard Insurance Company on:

Proposed Insured: _____ **Policy Number:** _____

A. POLICY EFFECTIVE DATE:

B. AMENDMENT(S): The policy is issued by Standard and accepted by the policyowner subject to the following terms or amendments:

B. I UNDERSTAND AND AGREE THAT:

1. I have read the questions and answers in the application for insurance (including any application supplement) and the amendments to the policy or application listed above. All answers recorded in the application and this amendment remain true and complete as of the date this form is signed.
2. Since the date of the application, there has been no change in the information provided in the application, except those amendment(s) specifically listed above. **I understand that if there are any other amendments to be made to the application, I should notify the sales producer of the amendment(s) and should not sign this form and not accept delivery of the policy.**
3. Coverage will not take effect under the policy unless this form is signed by me and the policyowner, if different, the first full premium is paid, and there are no amendments in the answers I provided in the application other than those listed above.

NOTE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The signature below certifies the accuracy of the declarations that I have made above and acknowledges that I have reviewed, accepted and received the policy offered by Standard on the date shown below. Once signed, I understand that this form will be attached to, and become part of, the policy.

Signature of Proposed Insured Signed on ___/___/___
Date

Signature of Policyowner (if other than Proposed Insured) Signed on ___/___/___
If a company is policyowner, signature of authorized representative. Date

Print Name of Policyowner (If other than Proposed Insured)
If a company is policyowner, also print title of authorized representative and company name.

SERFF Tracking Number: STAN-126704349 State: Arkansas
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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	07/14/2010
Comments:			
Attachment:			
ar-read.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	07/14/2010
Bypass Reason:	No policy is being filed. New application supplements are being filed.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	07/14/2010
Bypass Reason:	No rates are included in this filing. This section is N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	07/14/2010
Bypass Reason:	This is an application-only filing. No policy form is included. This section is N/A		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Mark ups of current forms being revised	Approved-Closed	07/14/2010
Comments:	the attached forms reflect changes to three forms revised in this filing. The other two forms are new, therefore no markup is available.		

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Attachments:

DPACA markup.pdf
DPACB markup.pdf
DPACCR markup.pdf

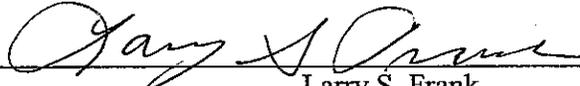
CERTIFICATION OF READABILITY

State of Arkansas

Form Number	Flesch Readability Score
DPACA(6/10)AR	50.3
DPACCR(6/10)AR	51.3
DPACB(6/10)AR	58.2
DPAMEND(6/10)AR	50.7
DPACGI(6/10)AR	50.7

I certify that to the best of my knowledge and belief, the above-referenced form(s) meet or exceed the readability, legibility, and format requirements of any applicable laws and regulations in the state of Arkansas.

Standard Insurance Company


Larry S. Frank

Assistant Vice President & Associate Counsel, ISG-Legal

07/02/2010
Date

Standard Insurance Company

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

Disability Insurance Policy Acceptance and
Application Supplement A

~~A. GENERAL INFORMATION: 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.~~

~~All references to "Standard" mean "Standard Insurance Company." All references to "the policy" mean the policy with the Policy Number shown below.~~

This form is part of the application for insurance with Standard Insurance Company on:

Proposed Insured: _____ Policy Number: _____

~~B. POLICY EFFECTIVE DATE: I elect a Policy Effective Date as provided for below. I understand that premiums will be charged for coverage under the policy from the Policy Effective Date elected. (Moved to paragraph below)~~

A. I ELECT A POLICY EFFECTIVE DATE AS PROVIDED BELOW:

1. I elect a Policy Effective Date of ___/___/___(mm/dd/yy). (May not be a date before [the date of my application for the policy, <<Application Date>>, / 30 days prior to the date of my application for the policy, <<Date 30 Prior to Application Date>>], or after the date the owner signs this form); OR
2. If a Policy Effective Date is not elected in item 1, above, or if the date elected is outside the time period described in item 1, I understand and agree the Policy Effective Date elected will be the date the proposed insured signs this Application Supplement.

In either 1 or 2, above, if the Policy Effective Date falls on the 29th, 30th or 31st of the month, I understand and agree that the Policy Effective Date will be changed to the 1st of the following month. I also understand and agree that premiums will be charged for coverage under the policy from the Policy Effective Date elected.

~~C. REQUIRED QUESTIONS: Since the date of the application for the policy, has the proposed insured:~~

- ~~1. Consulted with or been treated or examined by any physician or chiropractor; or _____ Yes _____ No other medical practitioner; or counselor, psychiatrist or therapist? _____~~
- ~~2. Had any illness, injury or change in health? _____~~
- ~~3. Become aware of any current physical or mental condition or symptom that has not previously been diagnosed, treated, or disclosed to Standard? _____~~
- ~~4. Changed occupation or employer; or had a material change in job duties? _____~~
- ~~5. Applied for any other disability or life insurance policy; or had any such policy rated up, modified or declined? _____~~

~~***NOTE -- Questions 1, 2, and 3 are condensed and referenced in section B2 below****~~

~~REMARKS: Explain any YES answer below. Give details of any medical consultations where applicable. Include the following: practitioner's name and address; date, reason, and diagnosis; and severity, treatment and results.~~

~~IMPORTANT: If any of the above Required Questions is answered "yes" or left blank: The policy is NOT IN FORCE; and there is no coverage under it. The policy, and this completed and signed form, must be returned immediately to Standard. The only exception is the soliciting producer's signed statement, as follows:~~

~~I have discussed the "yes" answer(s) above with a Standard home office underwriter. He/she has approved the policy for delivery as issued.~~

Signature of Soliciting Producer Date Auth. Code

Proposed Insured: _____

Policy Number: _____

~~D. POLICY CHANGES: I accept, ratify and acknowledge the changes made by Standard to my application, including: any benefit, endorsement or agreement added to or deleted from the policy. These changes are shown below:~~

This section was completely deleted from this form and is now available on DPAMEND.

~~E. I REPRESENT THAT: All answers to the REQUIRED QUESTIONS on this Application Supplement are correctly recorded, complete and true.~~

~~I FURTHER REPRESENT that I have read all of the questions, and the answers recorded in response to those questions, in the application attached to the policy; and I CONFIRM that the answers provided by the proposed insured to the questions in the application were complete, true and accurate at the time of the application.~~

~~Note: If any answers on the application were not accurate, complete and true: Do not sign this form and do not accept delivery of the policy. Instead, inform sales producer. (Producer, contact the Underwriter in this event.)~~

~~I AGREE THAT: This Application Supplement shall become part of any contract of insurance based on such application.~~

~~I UNDERSTAND AND AGREE THAT: There can be no coverage under the policy prior to the Policy Effective Date, and there is no coverage under the policy unless this Application Supplement is signed by the proposed insured, and the owner if different, and the required premium is paid.~~

~~PROVIDED all REQUIRED QUESTIONS on this form are answered NO (unless otherwise authorized by the underwriter as noted on the previous page): I ACCEPT and acknowledge receipt of the policy offered by Standard, including any policy changes made by Standard shown on this form. I signed this form in the city and state and on the date shown below. This section was removed and replaced with similar language below :~~

B. I UNDERSTAND AND AGREE THAT:

1. I have read the questions and answers in the application for insurance (including any application supplement) which is attached to the policy and all answers recorded in the application are true and complete as of the date of the application. If I was asked questions in a telephone interview as part of the application, I have reviewed the answers I provided in the telephone interview and have confirmed those answers have been accurately recorded in the application and are true and complete as of the time of the telephone interview and as of the date of the application.

2. Since the date of the application, I have not: (1) consulted with or been treated by a physician or other medical practitioner, other than to comply with Standard's underwriting requirements; (2) experienced any sickness, injury or change in health; or (3) changed occupation or employer. I understand that if any of this information has changed since the date of the application, I should notify the sales producer of the change(s) and should not sign this form and not accept delivery of the policy.

3. Coverage will not take effect under the policy unless this form is signed by me and the policyowner, if different, the first full premium is paid, and there has been no change in my health and status of employment or occupation as stated in the application.

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

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

Print Name of Policyowner (If other than Proposed Insured)
If a company is policyowner, also print title of authorized representative and company name.

~~I declare and affirm that: No changes, additions or alterations of any kind have been made to this form after it was signed by the proposed insured and owner if different. If this form has been sent to Standard electronically, the copy of this form sent to Standard is a true and exact copy of the original.~~

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

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 Division
1100 SW Sixth Avenue Portland OR 97204-1093

Disability Insurance Policy Acceptance and
Application Supplement B

~~A. GENERAL INFORMATION:~~ This form is part of the application for insurance with Standard Insurance Company on:

Proposed Insured: _____ Policy Number: _____

All ~~references to "Standard" mean Standard Insurance Company.~~

~~BA. POLICY EFFECTIVE DATE:~~

~~C. POLICY CHANGES:~~ I accept, ratify and acknowledge the changes made by Standard to my application or policy change request; including: any benefit, endorsement or agreement added to or deleted from the policy. These changes are shown below:

This section has been moved to form DPAMEND, which is solely used as a policy amendment form.

~~D. [I REPRESENT THAT: I have read questions 18 through 59, and the answers recorded in response to those questions, in the Application attached to this policy; and I confirm that those answers are true, and they accurately and completely reflect the information I gave in the telephone interview. I understand and agree that those questions and answers are part of the application and this policy.~~

~~—Note: If any answers are not accurate, complete or true: Do not sign this form and do not accept delivery of the policy. Instead, inform sales producer. (Producer, contact the Underwriter in this event.)]~~

~~I AGREE THAT: This application supplement shall become part of any contract of insurance based on such application. I signed this form in the city and state and on the date shown below.~~

B. I UNDERSTAND AND AGREE THAT:

1. I have read the questions and answers in the application for insurance (including any application supplement) which is attached to the policy and all answers recorded in the application are true and complete as of the date of the application. I understand that if any answer has changed since the date of the application, I should notify the sales producer of the change(s) and should not sign this form and not accept delivery of the policy.

2. Coverage will not take effect under the policy unless this form is signed by me and the policyowner, if different, the first full premium is paid, and there has been no change in the answers I provided in the application.

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

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

Print Name of Policyowner (If Other than Proposed Insured)
If a company is policyowner, also print title of authorized representative and company name.

~~I declare and affirm that: No changes, additions or alterations of any kind have been made to this form after it was signed by the proposed insured and the owner if different. If this form has been sent to Standard electronically, the copy of this form sent to Standard is a true and exact copy of the original.~~

Signature Soliciting Producer Signed at _____ City _____ State on ____/____/____
Date

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

Disability Insurance Policy Acceptance and
Application Supplement CR

~~A. GENERAL INFORMATION: 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.~~

~~All references to "Standard" mean "Standard Insurance Company." All references to "the policy" mean the policy with the Policy Number shown below.~~

This form is part of the application for insurance with Standard Insurance Company on:

Proposed Insured: _____ Policy Number: _____

~~B. POLICY EFFECTIVE DATE: A. I elect a Policy Effective Date as provided for below: I understand that premiums will be charged for coverage under the policy from the Policy Effective Date elected.~~

- 1. I elect a Policy Effective Date of ___/___/___(mm/dd/yy). (May not be a date before [the date of my application for the policy, <<Application Date>>, / 30 days prior to the date of my application for the policy, <<Date 30 Prior to Application Date>>], or after the date the owner signs this form); OR
- 2. If a Policy Effective Date is not elected in item 1, above, or if the date elected is outside the time period described in item 1, I understand and agree the Policy Effective Date elected will be the date of the Conditional Receipt, <<Date of Conditional Receipt>>.

In either 1 or 2, above, if the Policy Effective Date falls on the 29th, 30th or 31st of the month, I understand and agree that the Policy Effective Date will be changed to the 1st of the following month. I also understand and agree that premiums will be charged for coverage under the policy from the Policy Effective Date elected.

~~If the Policy Effective Date elected above is any date after <<Application Date>>, the proposed insured must complete the Required Questions in C, below. If the Policy Effective Date elected above is the same as [or earlier than] <<Application Date>>, skip section C and proceed to section D on the next page.~~

~~C. REQUIRED QUESTIONS: Since the date of the application for the policy has the proposed insured:~~

- ~~1. Consulted with or been treated or examined by any physician or chiropractor; or _____ Yes _____ No other medical practitioner; or counselor, psychiatrist or therapist? _____~~
- ~~2. Had any illness, injury or change in health? _____~~
- ~~3. Become aware of any current physical or mental condition or symptom that has not previously been diagnosed, treated, or disclosed to Standard? _____~~
- ~~4. Changed occupation or employer; or had a material change in job duties? _____~~
- ~~5. Applied for any other disability or life insurance policy; or had any such policy rated up, modified or declined? _____~~

Note – questions 1, 2, and 4 were modified and now included as acceptance statements in section B below.

~~REMARKS: Explain any YES or NO answers to the above questions. If a question is not applicable, include "not applicable." Include the following: practitioner's name, address, phone number, and date of examination, statement and results.~~

~~IMPORTANT: If any of the above Required Questions is answered "yes" or left blank: The policy is NOT IN FORCE; and there is no coverage under it. The policy, and this completed and signed form, must be returned immediately to Standard. The only exception is the soliciting producer's signed statement, as follows:~~

~~I have discussed the "yes" answer(s) above with a Standard home office underwriter. He/she has approved the policy for delivery as issued.~~

Signature of Soliciting Producer Date Auth. Code

~~I declare and affirm that: No changes, additions or alterations of any kind have been made to this form after it was signed by the proposed insured and owner if different. If this form has been sent to Standard electronically, the copy of this form sent to Standard is a true and exact copy of the original.~~

Signature Soliciting Producer

Signed at _____, _____ on ____/____/____
City State Date

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.