

SERFF Tracking Number: STAN-126733692 State: Arkansas  
Filing Company: Standard Insurance Company State Tracking Number: 46333  
Company Tracking Number: SI 15306  
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other  
Product Name: Medical History Statement  
Project Name/Number: SI 15306/SI 15306

## Filing at a Glance

Company: Standard Insurance Company  
Product Name: Medical History Statement  
TOI: L04G Group Life - Term

SERFF Tr Num: STAN-126733692 State: Arkansas  
SERFF Status: Closed-Approved- State Tr Num: 46333  
Closed

Sub-TOI: L04G.500 Other  
Filing Type: Form

Co Tr Num: SI 15306 State Status: Approved-Closed  
Reviewer(s): Linda Bird  
Authors: Alan Smith, Gary Hublitz Disposition Date: 08/04/2010  
Date Submitted: 07/27/2010 Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval  
State Filing Description:

Implementation Date:

## General Information

Project Name: SI 15306  
Project Number: SI 15306  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:  
Filing Status Changed: 08/04/2010

Status of Filing in Domicile: Pending  
Date Approved in Domicile:  
Domicile Status Comments:  
Market Type: Group  
Group Market Size: Small and Large  
Group Market Type: Employer  
Explanation for Other Group Market Type:  
State Status Changed: 08/04/2010  
Created By: Alan Smith  
Corresponding Filing Tracking Number: SI  
15306

Deemer Date:  
Submitted By: Alan Smith

Filing Description:  
Dear Commissioner:

Standard Insurance Company is filing for your review and approval a new Group Medical History Statement form. Enclosed are duplicate copies of the Medical History Statement Form SI 15306. This form does not replace any previous Medical History Statement Form and is identical to our previously approved Medical History Statement Form SI 12970 on 7/22/2008 with the exception of shortened medical history statement questions. If the member answers the medical history statement questions as "No," any further Medical Underwriting will not be required. Answering a "Yes" to any one of the questions, the member will be directed to our currently approved Medical History Statement Form.

SERFF Tracking Number: STAN-126733692 State: Arkansas  
Filing Company: Standard Insurance Company State Tracking Number: 46333  
Company Tracking Number: SI 15306  
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other  
Product Name: Medical History Statement  
Project Name/Number: SI 15306/SI 15306

Enclosed are duplicate copies of the Medical History Statement Form SI 15306.

The top portion of this Medical History Statement Forms elicits generic enrollment information (name, address, social security number, etc.). It is bracketed as variable because we may find the layout could be improved and made more user friendly in the future. The signature block at the end of page 2 is also bracketed as variable since we may use either a manual or electronic signature depending on policyholder preference. When one signature type has been chosen by the policyholder, the other would be removed. Finally, the information practices notice on page 3 has been bracketed as variable in anticipation of further changes in privacy law requirements.

While the attached form is submitted on 8 ½ by 11 pages, we may also print the same text in a 8 by 14 inch format or on electronic media (e.g., CD-ROM, Internet) if requested by a policyholder. Also, if so requested, we may issue these forms in a foreign language, based upon a direct translation of the filed wording.

There is no deviation from generally accepted insurance practices.

This group insurance product is, and will continue to be, marketed through normal insurance channels (insurance brokers and representatives) to groups traditionally eligible for group insurance. The majority of group policies will be issued to employers to cover their employees.

The attached forms meet and exceed the requirements of the Arkansas Life and Disability Insurance Policy Language Simplification Act, when included within the base policy and certificate.

## Company and Contact

### Filing Contact Information

Gary Hublitz, Compliance Analyst ghublitz@standard.com  
900 SW 5th Ave 971-321-8114 [Phone]  
C14C 971-321-6407 [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

SERFF Tracking Number: STAN-126733692 State: Arkansas  
Filing Company: Standard Insurance Company State Tracking Number: 46333  
Company Tracking Number: SI 15306  
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other  
Product Name: Medical History Statement  
Project Name/Number: SI 15306/SI 15306

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? No  
Fee Explanation: The state of Arkansas charges fifty dollars per filing.  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Insurance Company	\$50.00	07/27/2010	38310581

SERFF Tracking Number: STAN-126733692 State: Arkansas  
Filing Company: Standard Insurance Company State Tracking Number: 46333  
Company Tracking Number: SI 15306  
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other  
Product Name: Medical History Statement  
Project Name/Number: SI 15306/SI 15306

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/04/2010	08/04/2010

*SERFF Tracking Number:* STAN-126733692      *State:* Arkansas  
*Filing Company:* Standard Insurance Company      *State Tracking Number:* 46333  
*Company Tracking Number:* SI 15306  
*TOI:* L04G Group Life - Term      *Sub-TOI:* L04G.500 Other  
*Product Name:* Medical History Statement  
*Project Name/Number:* SI 15306/SI 15306

## **Disposition**

Disposition Date: 08/04/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>STAN-126733692</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Standard Insurance Company</i>	<i>State Tracking Number:</i>	<i>46333</i>
<i>Company Tracking Number:</i>	<i>SI 15306</i>		
<i>TOI:</i>	<i>L04G Group Life - Term</i>	<i>Sub-TOI:</i>	<i>L04G.500 Other</i>
<i>Product Name:</i>	<i>Medical History Statement</i>		
<i>Project Name/Number:</i>	<i>SI 15306/SI 15306</i>		

<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification		Yes
<b>Supporting Document</b>	Application		No
<b>Form</b>	Medical History Statement		Yes

*SERFF Tracking Number:* STAN-126733692      *State:* Arkansas  
*Filing Company:* Standard Insurance Company      *State Tracking Number:* 46333  
*Company Tracking Number:* SI 15306  
*TOI:* L04G Group Life - Term      *Sub-TOI:* L04G.500 Other  
*Product Name:* Medical History Statement  
*Project Name/Number:* SI 15306/SI 15306

## Form Schedule

**Lead Form Number: SI 15306**

<b>Schedule Item Status</b>	<b>Form Number</b>	<b>Form Type Form Name</b>	<b>Action</b>	<b>Action Specific Data</b>	<b>Readability</b>	<b>Attachment</b>
	SI 15306	Application/Medical History Enrollment Statement Form	Initial		0.000	15306.pdf

**DIRECTIONS FOR APPLYING FOR COVERAGE**

*Read the Information Practices Notice(s) on page 3. A separate form must be submitted for each applicant (Employee/Member, Spouse and/or Child) when Evidence Of Insurability or Proof of Good Health is required to apply for coverage. Complete all items, date and sign in the space at the bottom of page 2. Keep a copy for your records, and send the original to Standard Insurance Company at the address given above.*

**MEMBER/EMPLOYEE INFORMATION**

Name of Group		Group Number	Check who is Applying (One per form) <input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
Member/Employee Name		Birthdate (Mo/Day/Year)	Date Hired (Mo/Day/Year)	
Occupation	Salary	Social Security Number	Member/Employee Identification No.	

**APPLICANT INFORMATION**

Applicant's Name (Person to be insured)			Email Address		
Street Address		City	State	Zip	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (Mo/Day/Year)	Birthplace	Social Security Number	Work Phone ( )	Home Phone ( )

**APPLICATION INFORMATION**

Type of Application (*check one*)  Initial  Increase in Coverage  Late Application

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

Short Term Disability

Long Term Disability  $\frac{\text{Current Amount In Force, if any}}{\text{Additional Amount Requested}} = \frac{\text{Total Amount Requested}}$

Life  $\frac{\text{Current Amount In Force, if any}}{\text{Additional Amount Requested}} = \frac{\text{Total Amount Requested}}$

Dependents Life  $\frac{\text{Current Amount In Force, if any}}{\text{Additional Amount Requested}} = \frac{\text{Total Amount Requested}}$

**MEDICAL HISTORY STATEMENT QUESTIONS**

**Check yes or no for each of these questions, and give details for any "yes" answers. Attach a separate sheet if necessary.**

- Has a medical professional ever prescribed medication or diagnosed you as having any of the following medical conditions, diseases or disorders: Cardiovascular, lung, GI (stomach, liver, gall bladder, intestinal tract), urinary (kidney or bladder), musculoskeletal (bone, muscle, or joint), endocrine (diabetes, thyroid, pituitary, adrenal, or reproductive), autoimmune (lupus or related conditions), blood, chronic infectious, neurologic, sensory, alcohol or substance abuse? .....  Yes  No
- In the past 5 years have you had any illness or injury not listed above which resulted in physician visits or the use of prescribed medication? .....  Yes  No
- Are you taking any prescribed medications or planning a visit to a doctor or practitioner for any pregnancy, operation, physical or mental condition, or injury? .....  Yes  No

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

V  
A  
R  
I  
A  
B  
L  
E

Applicant Name	Social Security Number
----------------	------------------------

**Describe any “yes” answers below. (Please provide the entire question number.)**

Question Number	Description of Injuries, Disorders and Operations	Month/Year	Duration	Final Result	Physicians Consulted, City & State

**ACKNOWLEDGMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION (Please read carefully.)**

- I represent that the statements contained herein, including those made in response to the Medical History Statement questions and any attachments, are true and complete, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, The Standard’s liability is limited to the return of any premium which may have been paid.
- To any health plan, physician, health care provider, hospital, clinic, laboratory, pharmacy, medical facility, insurance or reinsurance company, and the MIB, Inc. (MIB), I instruct you to disclose my entire medical record and any other protected health information concerning me to The Standard or its reinsurers. This includes information on any disorder of the immune system, including Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, and any communicable or sexually transmitted disease or disorder. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.
- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any of the above to release and disclose my entire medical records without restriction.
- I understand that The Standard will use information to determine my eligibility for group insurance coverage. I understand The Standard may release information it has about me to its reinsurers and to any person performing business or legal services for The Standard in connection with my application. I understand The Standard may release information it has about me to MIB for the purpose of reporting to the MIB information exchange and for MIB to audit The Standard’s reporting. I understand The Standard may release information it has about me to other insurance companies to which I have applied for insurance coverage or benefits.
- I understand that information disclosed to The Standard pursuant to authorization may be subject to redisclosure with my authorization or as otherwise permitted by law. Life and disability insurance coverages are not subject to the Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA), and therefore release of information to The Standard is not protected under the Act.
- I understand that I am entitled to receive a copy of this authorization. This authorization will remain valid six months from the date of the signature below. A photocopy or facsimile of this authorization shall be as valid as the original.
- I understand that I have the right to refuse to sign this authorization. I further understand that I have a right to revoke this authorization at any time by sending a written statement to The Standard, except to the extent it has been relied upon to disclose requested records. I understand that the revocation of the authorization, or the failure to sign the authorization, may impair The Standard’s ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.
- I understand that if my application is approved, premiums shall be paid in accordance with the provisions of the Group Policy(ies), and my coverage will be subject to all terms and conditions of the Group Policy(ies) and state limitations.
- For Member/Employee: If I currently have a Life and/or Trust Life beneficiary designation on file with my plan administrator, I understand the designation(s) on file will also apply to any approved amounts. If I have no beneficiary designation(s) on file or I wish to change the name of the current beneficiary(ies), I will contact my plan administrator.
- I understand that insurance on a Spouse or other Dependent, if any, is payable to the Member/Employee, if living, or as provided under the terms of the Group Policy(ies).
- I acknowledge that I have read and received the Information Practices Notice and I have kept a copy of this Medical History Statement.

<b>Signature of Applicant</b> (or Member/Employee for Dependent Child)	<b>Date</b>
<b>Electronic Signature</b> <input type="checkbox"/> I agree	<b>Date</b>

By clicking the box marked “I agree,” I acknowledge that I am signing this document electronically. I understand that this electronic signature shall be enforceable under the applicable state or federal law and is equivalent to a manual signature.

*Note: Declinations do not affect either Guarantee Issue Amounts not subject to Evidence Of Insurability or other coverages already in force with Standard Insurance Company.*

**V  
A  
R  
I  
A  
B  
L  
E**

Applicant Name	Social Security Number
----------------	------------------------

**INFORMATION PRACTICES NOTICE**

- To help us determine your eligibility for group insurance we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or MIB, Inc. (MIB), formerly known as Medical Information Bureau. We will use the authorization you signed on this form when we seek this information.
- MIB – Information regarding your insurability will be treated as confidential. Standard Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health (including short and long term disability) insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.  
 Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.  
 Standard Insurance Company may release information in its file to its reinsurers, and Standard Insurance Company, or its reinsurers, may release information in its file to other insurance companies to whom you may apply for life or health (including short and long term disability) insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.
- DISCLOSURE TO OTHERS – The information collected about you is confidential. We will not release any information about you without your authorization, except to the extent necessary to conduct our business or as required or permitted by law.
- YOUR RIGHTS – You have a right to know what information we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices please write to us at Medical Underwriting, Standard Insurance Company, 900 SW Fifth Avenue, Portland, Oregon 97204 or call 1-800-843-7979.

V  
A  
R  
I  
A  
B  
L  
E

**FRAUD NOTICE**

- FOR RESIDENTS OF ARKANSAS, LOUISIANA, OHIO, WASHINGTON: Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.
- FOR RESIDENTS OF COLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- FOR RESIDENTS OF DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- FOR RESIDENTS OF NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- FOR RESIDENTS OF PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

V  
A  
R  
I  
A  
B  
L  
E

SERFF Tracking Number: STAN-126733692

State: Arkansas

Filing Company: Standard Insurance Company

State Tracking Number: 46333

Company Tracking Number: SI 15306

TOI: L04G Group Life - Term

Sub-TOI: L04G.500 Other

Product Name: Medical History Statement

Project Name/Number: SI 15306/SI 15306

## Supporting Document Schedules

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachment:**

ar-mhs-read.pdf

# CERTIFICATION OF READABILITY

State of Arkansas

Form	Flesch
Number	Readability
SI 15306	Score
	50.2

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



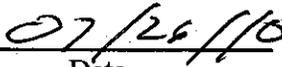
\_\_\_\_\_  
Signature

\_\_\_\_\_  
Larry S. Frank

Name

\_\_\_\_\_  
Assistant Vice President & Associate Counsel, ISG-Legal

Title



\_\_\_\_\_  
Date