

SERFF Tracking Number: STAN-128259525 State: Arkansas
Filing Company: Standard Insurance Company State Tracking Number:
Company Tracking Number: SI 16119
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
Product Name: Medical History Statement
Project Name/Number: AMU EEOI MHS/SI 16119

Filing at a Glance

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

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

SERFF Tr Num: STAN-128259525 State: Arkansas
SERFF Status: Closed-Approved- State Tr Num:
Closed

Co Tr Num: SI 16119

State Status: Approved-Closed
Reviewer(s): Linda Bird
Disposition Date: 04/30/2012

Authors: Alan Smith, Lena
Forrester, Gary Hublitz

Date Submitted: 04/24/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval
State Filing Description:

Implementation Date:

General Information

Project Name: AMU EEOI MHS
Project Number: SI 16119
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission

Group Market Type: Employer, Association, Discretionary, Trust, Other

Overall Rate Impact:

Deemer Date:
Submitted By: Lena Forrester
Filing Description:

Standard Insurance Company is submitting the above referenced forms for review and approval. We are submitting these forms, which are used with our group insurance products, to elicit information from applicants when evidence of insurability is required, such as for amounts over "guarantee issue" and for late enrollments. These forms will be used with two different electronic systems, as explained below.

Electronic Portal System:

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Filing
simultaneously.

Market Type: Group

Group Market Size: Small and Large

Explanation for Other Group Market Type:
union

Filing Status Changed: 04/30/2012

State Status Changed: 04/30/2012

Created By: Lena Forrester

Corresponding Filing Tracking Number:

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Medical History Statement SI 16090 and Medical History Statement SI 16070 are new forms used with the electronic portal system. SI 16090 is the longer version of the Medical History Statement; the SI 16070 is the shorter version.

Medical History Statements SI 16090 and SI 16070 will be used when a group insurance client wishes to allow their applicants to submit evidence of insurability via our electronic portal system. There are no restrictions on the size or types of groups that can have access to this service. Once a group has negotiated for this system, the applicant will access the form through their group's website portal, and complete the form online, with actual submission to the Medical Underwriting Department. With our electronic portal system we have included some clarifying fields that elicit underlying details related to an affirmative answer. Logic will be built into the system to allow only the applicable information and relevant fields to appear. Therefore, because the need for underlying details will only be triggered by an affirmative answer, these additional fields are marked as variable because they will not appear for every applicant. (However, for those applicants who prefer to submit via a paper form, their version will necessarily show all additional fields.) For example, if an applicant suffers from ulcers and is prescribed medication to treat this condition, they would answer "yes" to question 2A. Electronically, this would trigger additional fillable fields relating to diagnosis, type of treatment, current status and the physician's name and address. For an applicant who did not suffer from ulcers, this subset of fields would not appear. Finally, this electronic portal system utilizes the same security features as described below.

Electronic Evidence Of Insurability (EEOI) System:

The Medical History Statement SI 12970, approved on 7/22/2008, will be replaced upon approval by Medical History Statement SI 16119. The Medical History Statement SI 15306, approved via SERFF on 8/4/2010, State Tr. # 46333 will be replaced upon approval by Medical History Statement SI 16140. The SI 16119 is the longer version of the Medical History Statement; the SI 16140 is the shorter version.

Medical History Statements SI 16119 and SI 16140 will be used when a group insurance client wishes to allow their applicants to submit evidence of insurability via our EEOI system. The EEOI process utilizes a web-based application to assist in collecting required information that is presented on a Medical History Statement form for submission purposes. There are no restrictions on the size or types of groups that can have access to this service. Once a group has negotiated for this application system, the group will be given a secure URL ("https") for distribution to the applicant. Applicants submit their form online via a secure internet host socket (https) and the data is immediately available to the Medical Underwriting Department upon submission. Unlike the SI 16090 and SI 16070 versions, there are no additional fillable fields present on the SI 16119 and SI 16140 versions.

*HTTPS (Hyper Text Transfer Protocol Secure) is a secure version of the Hyper Text Transfer Protocol (http). "Secure" means the manner of transferring data using "https" protocol in the World Wide Web, like other secure ecommerce transactions such as online banking transactions and other transactions which require encryption for security. In other words, "https" encrypts the session with a digital certificate i.e., "https" over SSL (Secure Sockets Layer), which can be used by Web browsers and https-capable client programs. HTTPS Protocol works with a combination of programs,

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including browser programs such as Internet Explorer or Mozilla Firefox, which takes care of the encryption/decryption routines that exist on Web hosting servers.

All the forms submitted today do contain variability. The top portion of the 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 Acknowledgment and Authorization for Release of Information section is bracketed as variable to accommodate any future MIB changes or changes in state law. The signature block following the Acknowledgment and Authorization for Release of Information section is also bracketed as variable since we may use either a manual or electronic signature in the future depending on the group. When one signature type has been chosen by the group, the other would be removed. The Information Practices Notice following the signature block has been bracketed as variable in anticipation of further changes in privacy law requirements and to accommodate address/phone number changes. Finally, the fraud notices on the back of the form are also marked as variable in anticipation of additional states adopting a fraud notice requirement for their forms and we would like the flexibility to update this language as required without having to re-file.

While the attached form is submitted on 8 ½ by 11 pages, we may also print the same text in an 8 ½ by 14 inch format or on electronic media (e.g. CD-ROM, Internet) if requested by a group. These forms are being submitted in final print format; however, when information is inputted to the computer system by the applicant, it may result in non-material formatting changes due to the amount of information received; i.e. the size of open narrative sections will vary based on the information supplied by the applicant. Printing is subject to changes in fonts, layout, ink, paper stock, formatting, margins and positioning. Also, if so requested, we may issue this form in a foreign language, based upon a direct translation of the filed wording.

The underlying 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. Although the majority of group policies will be issued to employers to cover their employees, we will on occasion issue to other groups as allowed by state law. There is no deviation from generally accepted insurance practices.

There is no rate impact with this filing.

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.

State Narrative:

Company and Contact

Filing Contact Information

Lena Forrester, Senior Compliance Analyst lforrest@standard.com

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900 SW Fifth Avenue 971-321-7824 [Phone]
 Portland, OR 97204 971-321-8369 [FAX]

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: \$200.00
 Retaliatory? No
 Fee Explanation: The state of Arkansas charges \$50 per form. We file four forms.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Insurance Company	\$200.00	04/24/2012	58518458

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/30/2012	04/30/2012

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Disposition

Disposition Date: 04/30/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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

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Form Schedule

Lead Form Number: SI 16119

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	SI 16119	Application/Medical History Enrollment Statement Form	Initial		50.000	16119(option al_variable).pdf
	SI 16140	Application/Medical History Enrollment Statement Form	Initial		50.000	16140(option al_variable).pdf
	SI 16090	Application/Medical History Enrollment Statement Form	Initial		50.000	16090(option al_variable) (2).pdf
	SI 16070	Application/Medical History Enrollment Statement Form	Initial		50.000	16070(option al_variable).pdf

DIRECTIONS FOR APPLYING FOR COVERAGE

Read the Information Practices Notice(s) on page 4. 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 3. 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		Birth Date (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/Province	ZIP/Postal Code
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date (Mo/Day/Year)	Birthplace	Social Security Number	Work Phone () Home Phone ()

APPLICATION INFORMATION

Type of Application (<i>check one</i>) <input type="checkbox"/> Initial <input type="checkbox"/> Increase in Coverage <input type="checkbox"/> Late Application				
Check the type and provide details on the amount of coverage you are requesting.				
<input type="checkbox"/> Short Term Disability				
<input type="checkbox"/> Long Term Disability	_____	+	_____	= _____
	Current Amount In Force, if any		Additional Amount Requested	Total Amount Requested
<input type="checkbox"/> Life	_____	+	_____	= _____
	Current Amount In Force, if any		Additional Amount Requested	Total Amount Requested
<input type="checkbox"/> Dependents Life	_____	+	_____	= _____
	Current Amount In Force, if any		Additional Amount Requested	Total Amount Requested

PHYSICIAN INFORMATION (*Physician name or medical facility with Applicant's complete medical records—provide name and full mailing address*)

Doctor First Name		Doctor Last Name		
Clinic Name			Doctor Phone	
Doctor Address		City	State/Province	ZIP/Postal Code
Date Last Consulted				
Reason Last Consulted				

V A R I A B L E

Applicant Name	Social Security Number
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MEDICAL HISTORY STATEMENT QUESTIONS

Height	Weight
Check yes or no for each of these questions, and give details for any "yes" answers. Attach a separate sheet if necessary.	
<p>1. Have you been absent from work for a period of 5 or more consecutive days during the last 2 years due to any sickness, surgery, injury, mental or emotional condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:</p> <p style="padding-left: 20px;">A. Disease of the liver, pancreas, kidney, ulcers, stomach, intestinal disorder, or digestive system disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">B. Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, deafness, or another neurological or muscle disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">C. Cancer (malignancy or growth), leukemia, lymphoma, chronic anemia, or blood clotting (thrombophlebitis, pulmonary embolism)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">D. Cardiovascular disease, heart ailment, arteriosclerosis, chest pain, high blood pressure, heart murmur, valve, circulatory or vascular disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">E. Emphysema, asthma, chronic bronchitis, sleep apnea, or other lung disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">F. Lupus, scleroderma, vasculitis, connective tissue disease, or other immune system disorder not related to Human Immunodeficiency Virus (HIV)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">G. Osteoarthritis, rheumatoid arthritis, osteoporosis, pain in the joints, amputations, or other disease or disorder of the bones, joints, back or spine, or arthritic conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">H. Endocrine (including thyroid or adrenal), diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">I. Drug, alcohol or nicotine use or abuse, or have you used drugs, alcohol or nicotine in a manner that resulted in you having to obtain advice, counseling or treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">J. Psychiatric or mental condition, depression, adjustment disorder, affective disorder, or obsessive-compulsive disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Has a medical professional ever diagnosed you as having or prescribed medication to you for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or HIV antibodies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. During the past five years have you been in a hospital or other institution for observation, rest, diagnosis, or treatment of any disease, disorder, condition or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you plan any operation or visit to a doctor or practitioner for an existing physical or mental condition, illness, injury, surgery or pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Do you currently have any disorder, condition or disease, or are you currently taking medication prescribed by a medical or other practitioner for any disorder, condition (including pregnancy) or disease other than cold or allergies not disclosed above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

DETAILS OF ANY "YES" ANSWERS ABOVE

<i>Include diagnosis, start and end dates, duration, type and frequency of treatment, hospitalization, physician visits, cause, location of disorder, residuals, acute or chronic status, work loss, and operations.</i>				
Question #	Diagnosis/Description	Month/Year	Details/Current Status	Physicians Consulted, City and State

Applicant Name	Social Security Number
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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 supplemental information, are true and complete to the best of my knowledge and belief, 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 authorize The Standard to 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 Fraud Notice (if applicable), and I have made a copy of this Medical History Statement.

OPTIONAL & VARIABLE

OPTIONAL & VARIABLE

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

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.

Applicant Name	Social Security Number
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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.

FRAUD NOTICE

- ARKANSAS, MAINE, OHIO: 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.
- 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.
- 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.
- KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
- LOUISIANA, MARYLAND, NEW MEXICO, RHODE ISLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- 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.
- 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.
- PUERTO RICO: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or any other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.
- TENNESSEE, WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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DIRECTIONS FOR APPLYING FOR COVERAGE

Read the Information Practices Notice(s) on page 4. 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 3. 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		Birth Date (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/Province	ZIP/Postal Code
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date (Mo/Day/Year)	Birthplace	Social Security Number	Work Phone () Home Phone ()

APPLICATION INFORMATION

Type of Application (<i>check one</i>) <input type="checkbox"/> Initial <input type="checkbox"/> Increase in Coverage <input type="checkbox"/> Late Application				
Check the type and provide details on the amount of coverage you are requesting.				
<input type="checkbox"/> Short Term Disability				
<input type="checkbox"/> Long Term Disability	_____ + _____ = _____ Current Amount In Force, if any Additional Amount Requested Total Amount Requested			
<input type="checkbox"/> Life	_____ + _____ = _____ Current Amount In Force, if any Additional Amount Requested Total Amount Requested			
<input type="checkbox"/> Dependents Life	_____ + _____ = _____ Current Amount In Force, if any Additional Amount Requested Total Amount Requested			

PHYSICIAN INFORMATION (*Physician name or medical facility with Applicant's complete medical records—provide name and full mailing address*)

Doctor First Name		Doctor Last Name		
Clinic Name			Doctor Phone	
Doctor Address		City	State/Province	ZIP/Postal Code
Date Last Consulted				
Reason Last Consulted				
Height		Weight		

V A R I A B L E

Applicant Name	Social Security Number
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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.

FRAUD NOTICE

- ARKANSAS, MAINE, OHIO: 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.
- 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.
- 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.
- KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
- LOUISIANA, MARYLAND, NEW MEXICO, RHODE ISLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- 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.
- 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.
- PUERTO RICO: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or any other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.
- TENNESSEE, WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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DIRECTIONS FOR APPLYING FOR COVERAGE

Read the Information Practices Notice(s) on page 10. 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 9. 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		Birth Date (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/Province	ZIP/Postal Code
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date (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 _____ + _____ = _____
 Current Amount In Force, if any Additional Amount Requested Total Amount Requested

Life _____ + _____ = _____
 Current Amount In Force, if any Additional Amount Requested Total Amount Requested

Dependents Life _____ + _____ = _____
 Current Amount In Force, if any Additional Amount Requested Total Amount Requested

PHYSICIAN INFORMATION (*Physician name or medical facility with Applicant's complete medical records—provide name and full mailing address*)

Doctor First Name		Doctor Last Name		
Clinic Name			Doctor Phone	
Doctor Address		City	State/Province	ZIP/Postal Code
Date Last Consulted				
Reason Last Consulted				

V A R I A B L E

Applicant Name	Social Security Number
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MEDICAL HISTORY STATEMENT QUESTIONS

Height	Weight
<p>Check yes or no for each of these questions, and give details for any "yes" answers. Attach a separate sheet if necessary.</p>	
<p>1. Have you been absent from work for a period of 5 or more consecutive days during the last 2 years due to any sickness, surgery, injury, mental or emotional condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Description of Reasons</i> _____</p> <p><i>Limitations</i> _____</p> <p><i>Diagnosis</i> _____</p> <p><i>Current Status</i> _____</p> <p><i>Physician's Name and Address</i> _____</p>	
<p>2. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:</p>	
<p>2A. Disease of the liver, pancreas, kidney, ulcers, stomach, intestinal disorder, or digestive system disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>2A.1 Liver Chronic: <input type="checkbox"/> Yes (go to question 2A.2) Acute: <input type="checkbox"/> Yes (provide details below)</p> <p><i>Diagnosis</i> _____ <i>Date Diagnosed</i> _____</p> <p><i>Frequency and Type of Treatment</i> _____</p> <p><i>Current Status</i> _____</p> <p><i>Physician's Name and Address</i> _____</p>	
<p>2A.2 Pancreas Chronic: <input type="checkbox"/> Yes (go to question 2A.3) Acute: <input type="checkbox"/> Yes (provide details below)</p> <p><i>Diagnosis</i> _____ <i>Date Diagnosed</i> _____</p> <p><i>Frequency and Type of Treatment</i> _____</p> <p><i>Current Status</i> _____</p> <p><i>Physician's Name and Address</i> _____</p>	
<p>2A.3 Kidney <input type="checkbox"/> Yes</p> <p><i>Diagnosis</i> _____ <i>Date Diagnosed</i> _____</p> <p><i>Frequency and Type of Treatment</i> _____</p> <p><i>Current Status</i> _____</p> <p><i>Physician's Name and Address</i> _____</p>	
<p>2A.4 Ulcers <input type="checkbox"/> Yes</p> <p><i>Diagnosis</i> _____ <i>Date Diagnosed</i> _____</p> <p><i>Frequency and Type of Treatment</i> _____</p> <p><i>Current Status</i> _____</p> <p><i>Physician's Name and Address</i> _____</p>	
<p>2A.5 Stomach <input type="checkbox"/> Yes</p> <p><i>Diagnosis</i> _____ <i>Date Diagnosed</i> _____</p> <p><i>Frequency and Type of Treatment</i> _____</p> <p><i>Current Status</i> _____</p> <p><i>Physician's Name and Address</i> _____</p>	
<p>2A.6 Intestinal Disorder <input type="checkbox"/> Yes</p> <p><i>Diagnosis</i> _____ <i>Date Diagnosed</i> _____</p> <p><i>Frequency and Type of Treatment</i> _____</p> <p><i>Current Status</i> _____</p> <p><i>Physician's Name and Address</i> _____</p>	
<p>2A.7 Digestive System Disorder <input type="checkbox"/> Yes</p> <p><i>Diagnosis</i> _____ <i>Date Diagnosed</i> _____</p> <p><i>Frequency and Type of Treatment</i> _____</p> <p><i>Current Status</i> _____</p> <p><i>Physician's Name and Address</i> _____</p>	

OPTIONAL & VARIABLE

OPTIONAL & VARIABLE

Applicant Name	Social Security Number
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2B. Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, deafness, or another neurological or muscle disorder? Yes No

2B.1 Multiple Sclerosis Yes

2B.2 Epilepsy Yes

Frequency _____ Date of Last Seizure _____

Type _____ Type of Treatment _____

Current Status _____

Physician's Name and Address _____

2B.3 Stroke Yes

2B.4 Paralysis Yes

Description _____

Cause _____

Frequency and Type of Treatment _____ Date Diagnosed _____

Current Status _____

Physician's Name and Address _____

2B.5 Numbness. Yes

Diagnosis _____ Date Diagnosed _____

Duration _____ Frequency and Type of Treatment _____

Current Status _____

Physician's Name and Address _____

2B.6 Visual Disturbance Yes

Diagnosis _____ Date Diagnosed _____

Duration _____ Any Double Vision _____ Loss of Vision _____

Frequency and Type of Treatment _____

Current Status _____

Physician's Name and Address _____

2B.7 Deafness. Yes

Diagnosis _____ Date Diagnosed _____

Frequency and Type of Treatment _____

Current Status _____

Physician's Name and Address _____

2B.8 Neurological Disorder Yes

Diagnosis _____ Date Diagnosed _____

Frequency and Type of Treatment _____

Current Status _____

Physician's Name and Address _____

2B.9 Muscle Disorder Yes

Diagnosis _____ Date Diagnosed _____

Duration _____ Frequency and Type of Treatment _____

Current Status _____

Physician's Name and Address _____

2C. Cancer (malignancy or growth), leukemia, lymphoma, chronic anemia, or blood clotting (thrombophlebitis or pulmonary embolism)? Yes No

2C.1 Cancer (Malignancy or Growth) Yes

Diagnosis _____ Date Diagnosed _____

Frequency and Type of Treatment _____

Current Status _____

Physician's Name and Address _____

2C.2 Leukemia Yes

2C.3 Lymphoma Yes

OPTIONAL & VARIABLE

OPTIONAL & VARIABLE

Applicant Name	Social Security Number
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2C.4	Chronic Anemia	☐ Yes	OPTIONAL & VARIABLE
	Diagnosis _____ Date Diagnosed _____		
	Frequency and Type of Treatment _____		
	Current Status _____ Physician's Name and Address _____		
2C.5	Blood Clotting (thrombophlebitis or pulmonary embolism)	☐ Yes	OPTIONAL & VARIABLE
	Diagnosis _____ Date Diagnosed _____		
	Frequency and Type of Treatment _____		
	Current Status _____ Physician's Name and Address _____		
2D.	Cardiovascular disease, heart ailment, arteriosclerosis, chest pain, high blood pressure, heart murmur, valve, circulatory or vascular disorder?	☐ Yes ☐ No	OPTIONAL & VARIABLE
2D.1	Cardiovascular Disease	☐ Yes	
2D.2	Heart Ailment	☐ Yes	
2D.3	Arteriosclerosis	☐ Yes	
2D.4	Chest Pain	☐ Yes	
	Duration _____ Frequency and Type of Treatment _____		
	Current Status _____ Date Diagnosed _____		
	Physician's Name and Address _____		
2D.5	High Blood Pressure	☐ Yes	
	Physician's Name and Address _____		
2D.6	Heart Murmur	☐ Yes	
	Diagnosis _____ Date Diagnosed _____		
	Frequency and Type of Treatment _____		
	Current Status _____ Physician's Name and Address _____		
2D.7	Valve Disorder	☐ Yes	
	Diagnosis _____ Date Diagnosed _____		
	Frequency and Type of Treatment _____		
	Current Status _____ Physician's Name and Address _____		
2D.8	Circulatory Disorder	☐ Yes	
	Diagnosis _____ Date Diagnosed _____		
	Frequency and Type of Treatment _____		
	Current Status _____ Physician's Name and Address _____		
2D.9	Vascular Disorder	☐ Yes	
	Diagnosis _____ Date Diagnosed _____		
	Frequency and Type of Treatment _____		
	Current Status _____ Physician's Name and Address _____		
2E.	Emphysema, asthma, chronic bronchitis, sleep apnea, or other lung disease?	☐ Yes ☐ No	OPTIONAL & VARIABLE
2E.1	Emphysema	☐ Yes	
2E.2	Asthma	☐ Yes	
	Type of Treatment _____		
	Work Loss _____ Frequency of Attacks _____ Date Diagnosed _____		
	Physician's Name and Address _____		

Applicant Name _____	Social Security Number _____
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2E.3	Chronic Bronchitis. <input type="checkbox"/> Yes	OPTIONAL & VARIABLE
	Type of Treatment _____	
	Work Loss _____	
	Frequency of Attacks _____ Date Diagnosed _____	
	Physician's Name and Address _____	
2E.4	Sleep Apnea. <input type="checkbox"/> Yes	OPTIONAL & VARIABLE
	Type of Treatment _____	
	Current Status _____ Date Diagnosed _____	
	Physician's Name and Address _____	
2E.5	Lung Disease. <input type="checkbox"/> Yes	OPTIONAL & VARIABLE
	Diagnosis _____ Date Diagnosed _____	
	Frequency and Type of Treatment _____	
	Work Loss _____	
	Current Status _____	
2F.	Lupus, scleroderma, vasculitis, connective tissue disease, or other immune system disorder not related to Human Immunodeficiency Virus (HIV)? <input type="checkbox"/> Yes <input type="checkbox"/> No	OPTIONAL & VARIABLE
2F.1	Lupus. <input type="checkbox"/> Yes	
	Type _____ Frequency and Type of Treatment _____	
	Current Status _____ Date Diagnosed _____	
	Physician's Name and Address _____	
2F.2	Scleroderma. <input type="checkbox"/> Yes	
2F.3	Vasculitis. <input type="checkbox"/> Yes	
	Type _____ Frequency and Type of Treatment _____	
	Current Status _____ Date Diagnosed _____	
	Physician's Name and Address _____	
2F.4	Connective Tissue Disease. <input type="checkbox"/> Yes	
2F.5	Immune System Disorder Not Related to Human Immunodeficiency Virus (HIV)? <input type="checkbox"/> Yes	
	Diagnosis _____ Date Diagnosed _____	
	Frequency and Type of Treatment _____	
	Current Status _____	
	Physician's Name and Address _____	
2G.	Osteoarthritis, rheumatoid arthritis, osteoporosis, amputations, or other disease or disorder of the bones, joints, back or spine, or arthritic conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No	OPTIONAL & VARIABLE
2G.1	Osteoarthritis. <input type="checkbox"/> Yes	
	Frequency and Type of Treatment _____ Date Diagnosed _____	
	Physician's Name and Address _____	
2G.2	Rheumatoid Arthritis. <input type="checkbox"/> Yes	
	Frequency and Type of Treatment _____ Date Diagnosed _____	
	Physician's Name and Address _____	
2G.3	Osteoporosis. <input type="checkbox"/> Yes	
	Frequency and Type of Treatment _____ Date Diagnosed _____	
	Physician's Name and Address _____	
2G.4	Amputations. <input type="checkbox"/> Yes	
	Cause _____ Date Diagnosed _____	
	Current Status _____	
	Physician's Name and Address _____	

Applicant Name	Social Security Number
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2G.5	Disease or Disorder of the Bones, Joints, Back or Spine <input type="checkbox"/> Yes	OPTIONAL & VARIABLE	
	Description _____		
	Diagnosis _____ Date Diagnosed _____		
	Frequency and Type of Treatment _____		
	Current Status _____		
	Physician's Name and Address _____		
2G.6	Arthritic Conditions <input type="checkbox"/> Yes		
	Description _____		
	Frequency and Type of Treatment _____ Date Diagnosed _____		
	Current Status _____		
	Physician's Name and Address _____		
2H.	Endocrine (including thyroid or adrenal), diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No	OPTIONAL & VARIABLE	
2H.1	Endocrine (including thyroid or adrenal) <input type="checkbox"/> Yes		
	Diagnosis _____ Date Diagnosed _____		
	Frequency and Type of Treatment _____		
	Current Status _____		
	Physician's Name and Address _____		
2H.2	Diabetes <input type="checkbox"/> Yes		
	Type of Treatment _____		
2I.	Drug, alcohol or nicotine use or abuse, or have you used drugs, alcohol or nicotine in a manner that resulted in you having to obtain advice, counseling or treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	OPTIONAL & VARIABLE	
	Duration _____ Frequency and Type of Treatment _____		
	Current Status _____		
	Physician's Name and Address _____		
	Physician's Name and Address _____		
2J.	Psychiatric or mental condition, depression, adjustment disorder, affective disorder, or obsessive-compulsive disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	OPTIONAL & VARIABLE	
2J.1	Psychiatric Condition <input type="checkbox"/> Yes		
	Diagnosis _____ Date Diagnosed _____		
	Frequency and Type of Treatment _____		
	Duration _____ Work Loss _____		
	Current Status _____		
	Physician's Name and Address _____		
2J.2	Mental Condition <input type="checkbox"/> Yes		
	Diagnosis _____ Date Diagnosed _____		
	Frequency and Type of Treatment _____		
	Duration _____ Work Loss _____		
	Current Status _____		
	Physician's Name and Address _____		
2J.3	Depression <input type="checkbox"/> Yes		
	Diagnosis _____ Date Diagnosed _____		
	Frequency and Type of Treatment _____		
	Duration _____ Work Loss _____		
	Current Status _____		
	Physician's Name and Address _____		
2J.4	Adjustment Disorder <input type="checkbox"/> Yes		
	Diagnosis _____ Date Diagnosed _____		
	Frequency and Type of Treatment _____		
	Duration _____ Work Loss _____		
	Current Status _____		
	Physician's Name and Address _____		

Applicant Name _____	Social Security Number _____
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2J.5 Affective Disorder Yes
Diagnosis _____ *Date Diagnosed* _____
Frequency and Type of Treatment _____
Duration _____ *Work Loss* _____
Current Status _____
Physician's Name and Address _____

2J.6 Obsessive Compulsive Disorder Yes
Diagnosis _____ *Date Diagnosed* _____
Frequency and Type of Treatment _____
Duration _____ *Work Loss* _____
Current Status _____
Physician's Name and Address _____

3. Has a medical professional ever diagnosed you as having or prescribed medication to you for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or HIV antibodies? Yes No

3A. Acquired Immune Deficiency Syndrome (AIDS) Yes
3B. AIDS Related Complex (ARC) Yes
3C. HIV Antibodies Yes

4. During the past five years have you been in a hospital or other institution for observation, rest, diagnosis, or treatment of any disease, disorder, medical condition, or injury? Yes No

Diagnosis _____ *Date Diagnosed* _____
Duration _____ *Frequency and Type of Treatment* _____
Current Status _____
Physician's Name and Address _____

Diagnosis _____ *Date Diagnosed* _____
Duration _____ *Frequency and Type of Treatment* _____
Current Status _____
Physician's Name and Address _____

5. Do you plan any operation or visit to a doctor or practitioner for an existing physical or mental condition, illness, injury, surgery, or pregnancy? Yes No

5A. Physical Condition Yes
Description _____ *Date Diagnosed* _____
Physician's Name and Address _____

5B. Mental Condition Yes
Description _____ *Date Diagnosed* _____
Physician's Name and Address _____

5C. Illness Yes
Description _____ *Date Diagnosed* _____
Physician's Name and Address _____

5D. Injury Yes
Description _____ *Date Diagnosed* _____
Physician's Name and Address _____

5E. Surgery Yes
Type _____ *Date* _____
Physician's Name and Address _____

5F. Pregnancy Yes
Expected Date of Delivery _____

6. Do you currently have any disorder, condition or disease, or are you currently taking medication prescribed by a medical or other practitioner for any disorder, condition (including pregnancy) or disease other than cold or allergies not disclosed above? . . . Yes No

Description _____ *Type of Medication* _____
Current Status _____
Physician's Name and Address _____

OPTIONAL & VARIABLE

Applicant Name	Social Security Number
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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 supplemental information, are true and complete to the best of my knowledge and belief, 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 authorize The Standard to 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 Fraud Notice (if applicable), and I have made a copy of this Medical History Statement.

OPTIONAL & VARIABLE

OPTIONAL & VARIABLE

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

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.

Applicant Name	Social Security Number
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INFORMATION PRACTICES NOTICE

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- 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.

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- 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.
- 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.
- KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
- LOUISIANA, MARYLAND, NEW MEXICO, RHODE ISLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- 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.
- 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.
- PUERTO RICO: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or any other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.
- TENNESSEE, WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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DIRECTIONS FOR APPLYING FOR COVERAGE

Read the Information Practices Notice(s) on page 7. 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 6. 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		Birth Date (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/Province	ZIP/Postal Code
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date (Mo/Day/Year)	Birthplace	Social Security Number	Work Phone () Home Phone ()

APPLICATION INFORMATION

Type of Application (<i>check one</i>) <input type="checkbox"/> Initial <input type="checkbox"/> Increase in Coverage <input type="checkbox"/> Late Application				
Check the type and provide details on the amount of coverage you are requesting.				
<input type="checkbox"/> Short Term Disability				
<input type="checkbox"/> Long Term Disability	_____	+	_____	= _____
	Current Amount In Force, if any		Additional Amount Requested	Total Amount Requested
<input type="checkbox"/> Life	_____	+	_____	= _____
	Current Amount In Force, if any		Additional Amount Requested	Total Amount Requested
<input type="checkbox"/> Dependents Life	_____	+	_____	= _____
	Current Amount In Force, if any		Additional Amount Requested	Total Amount Requested

PHYSICIAN INFORMATION (*Physician name or medical facility with Applicant's complete medical records—provide name and full mailing address*)

Doctor First Name		Doctor Last Name		
Clinic Name			Doctor Phone	
Doctor Address		City	State/Province	ZIP/Postal Code
Date Last Consulted				
Reason Last Consulted				

VARIABLE

Applicant Name	Social Security Number
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MEDICAL HISTORY STATEMENT QUESTIONS

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

1. In the last five years, have you been treated for or had any trouble with any of the following:
 Heart, chest pain, lung (respiratory), GI (stomach, intestinal tract, liver, pancreas), genitourinary (bladder, kidney), musculoskeletal (bone, muscle, joint), endocrine (diabetes, pituitary, adrenal, reproductive), immune or autoimmune disease, disorder of the blood, chronic infections, neurologic (including mental or emotional), cancer, drug, alcohol or nicotine use or abuse, or have you used drugs, alcohol or nicotine in a manner that resulted in your having to obtain advice, counseling or treatment? Yes No
 - 1A. Heart Yes
 Diagnosis _____ Date Diagnosed _____
 Frequency and Type of Treatment _____
 Current Status _____
 Physician's Name and Address _____
 - 1B. Chest Pain Yes
 Diagnosis _____ Date Diagnosed _____
 Frequency and Type of Treatment _____
 Current Status _____
 Physician's Name and Address _____
 - 1C. Lung (Respiratory) Yes
 Diagnosis _____ Date Diagnosed _____
 Frequency and Type of Treatment _____
 Current Status _____
 Work Loss _____
 Physician's Name and Address _____
 - 1D. GI (Stomach, Intestinal Tract, Liver, Pancreas) Yes
 Diagnosis _____ Date Diagnosed _____
 Frequency and Type of Treatment _____
 Current Status _____
 Physician's Name and Address _____
 - 1E. Genitourinary (Bladder, Kidney) Yes
 Diagnosis _____ Date Diagnosed _____
 Frequency and Type of Treatment _____
 Current Status _____
 Physician's Name and Address _____
 - 1F. Musculoskeletal (Bone, Muscle, or Joint) Yes
 Diagnosis _____ Date Diagnosed _____
 Frequency and Type of Treatment _____
 Current Status _____
 Physician's Name and Address _____
 - 1G. Endocrine (Diabetes, Pituitary, Adrenal, Reproductive) Yes
 Diagnosis _____ Date Diagnosed _____
 Frequency and Type of Treatment _____
 Current Status _____
 Physician's Name and Address _____

OPTIONAL & VARIABLE

Applicant Name	Social Security Number
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1H. Immune or Autoimmune Disease. Yes
Diagnosis _____ *Date Diagnosed* _____
Frequency and Type of Treatment _____
Current Status _____
Physician's Name and Address _____

1I. Disorder of the Blood. Yes
Diagnosis _____ *Date Diagnosed* _____
Frequency and Type of Treatment _____
Current Status _____
Physician's Name and Address _____

1J. Chronic Infections. Yes
Diagnosis _____ *Date Diagnosed* _____
Frequency and Type of Treatment _____
Current Status _____
Physician's Name and Address _____

1K. Neurologic (Including Mental or Emotional). Yes
Diagnosis _____ *Date Diagnosed* _____
Frequency and Type of Treatment _____
Current Status _____
Physician's Name and Address _____

1L. Cancer. Yes
Diagnosis _____ *Date Diagnosed* _____
Frequency and Type of Treatment _____
Current Status _____
Physician's Name and Address _____

1M. Alcohol Abuse. Yes
Description _____
Duration _____ *Frequency and Type of Treatment* _____
Current Status _____
Physician's Name and Address _____

1N. Drug Abuse. Yes
Description _____
Duration _____ *Frequency and Type of Treatment* _____
Current Status _____
Physician's Name and Address _____

2. During the past five years, have you been in a hospital or other institution for observation, rest, surgery or treatment? Yes No

2A. Observation. Yes
Diagnosis _____ *Date Diagnosed* _____
Duration _____ *Frequency and Type of Treatment* _____
Current Status _____
Physician's Name and Address _____

OPTIONAL & VARIABLE

OPTIONAL & VARIABLE

Applicant Name _____	Social Security Number _____
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2B. Rest Yes
Diagnosis _____
Duration _____ *Frequency and Type of Treatment* _____
Current Status _____
Physician's Name and Address _____

2D. Surgery Yes
Type _____ *Date* _____
Physician's Name and Address _____

2E. Treatment Yes
Diagnosis _____
Duration _____ *Frequency and Type of Treatment* _____
Current Status _____
Physician's Name and Address _____

3. Do you currently have any disorder, condition or disease, or are you currently taking medication prescribed by a medical or other practitioner for any disorder, condition (including pregnancy) or disease other than a cold or allergies? Yes No

3A. Disorder Yes
Diagnosis _____ *Date Diagnosed* _____
Frequency and Type of Treatment _____
Current Status _____
Physician's Name and Address _____

3B. Condition Yes
Diagnosis _____ *Date Diagnosed* _____
Frequency and Type of Treatment _____
Current Status _____
Physician's Name and Address _____

3C. Disease Yes
Diagnosis _____ *Date Diagnosed* _____
Frequency and Type of Treatment _____
Current Status _____
Physician's Name and Address _____

3D. Pregnancy Yes
Expected Date of Delivery _____

OPTIONAL & VARIABLE

OPTIONAL & VARIABLE

Applicant Name	Social Security Number
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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.

FRAUD NOTICE

- ARKANSAS, MAINE, OHIO: 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.
- 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 kindly 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.
- 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.
- KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
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- NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
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VARIABLE

SERFF Tracking Number: STAN-128259525 State: Arkansas
Filing Company: Standard Insurance Company State Tracking Number:
Company Tracking Number: SI 16119
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
Product Name: Medical History Statement
Project Name/Number: AMU EEOI MHS/SI 16119

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: AR Readability.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: This is not a policy filing; rather it is an application filing. Comments:		

STANDARD INSURANCE COMPANY
1100 SW SIXTH AVENUE
PORTLAND, OREGON 97204

CERTIFICATION OF READABILITY

State of Arkansas

<u>Form Number</u>	<u>Flesch Reading Ease Score</u>
SI 16119	50
SI 16140	50
SI 16090	50
SI 16070	50

I hereby certify that to the best of my knowledge and belief, the above-referenced form(s) meet or exceed the minimum reading ease score and all other readability requirements of any applicable insurance laws and regulations in the State of Arkansas.



C. Elizabeth Sloan

4-23-12

Date

2nd VP & Associate Counsel, ISG-Legal