Application Tips

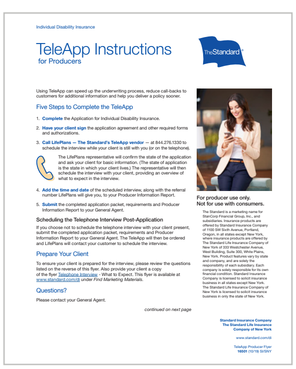
For producer use only. Not for use with consumers.

At The Standard, we strive to complete the application and underwriting process in a timely manner. This allows you to provide your clients income protection as quickly as possible. However, incomplete paperwork can impede an application's progress.

You can help reduce underwriting delays by ensuring all questions are answered completely and accurately.

TeleApp — in which medical, income and employment information is collected during a telephone interview — is quicker and easier for both you and your clients. You can further jumpstart the application and underwriting process by using the point-of-sale service to schedule the TeleApp interview.

Please reference these TeleApp resources to learn more about this streamlined application process.

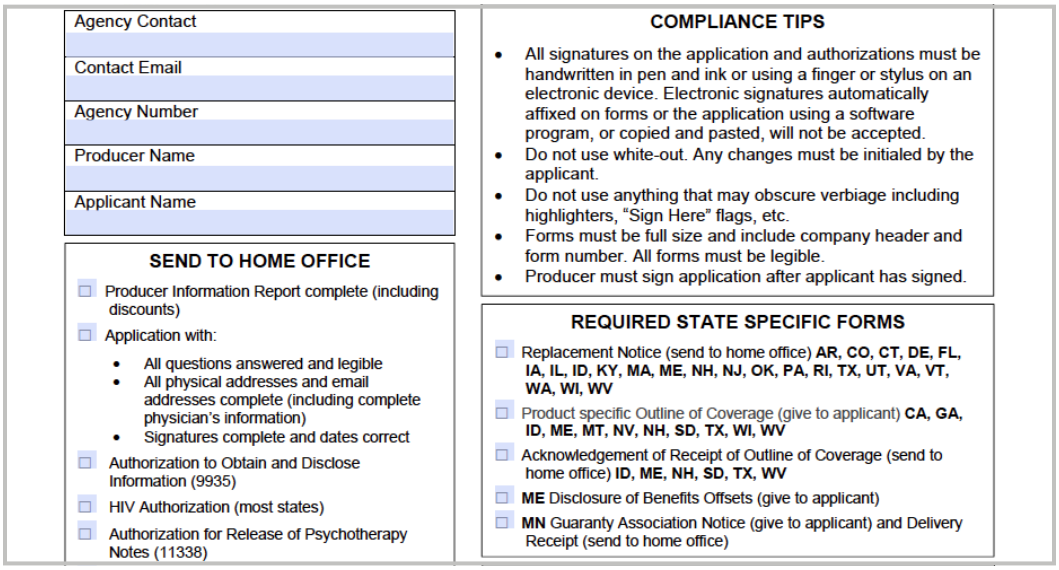


TeleApp - Instructions Flyer

TeleApp - What to Expect Flyer

Contact your General Agent for the appropriate state-specific application.

continued on next page



Agency Contact

Contact Email

Agency Number

Producer Name

Applicant Name

SEND TO HOME OFFICE

- ☐ Producer Information Report complete (including discounts)
- ☐ Application with:
  - All questions answered and legible
  - All physical addresses and email addresses complete (including complete physician's information)
  - Signatures complete and dates correct
- ☐ Authorization to Obtain and Disclose Information (9935)
- ☐ HIV Authorization (most states)
- ☐ Authorization for Release of Psychotherapy Notes (11338)

COMPLIANCE TIPS

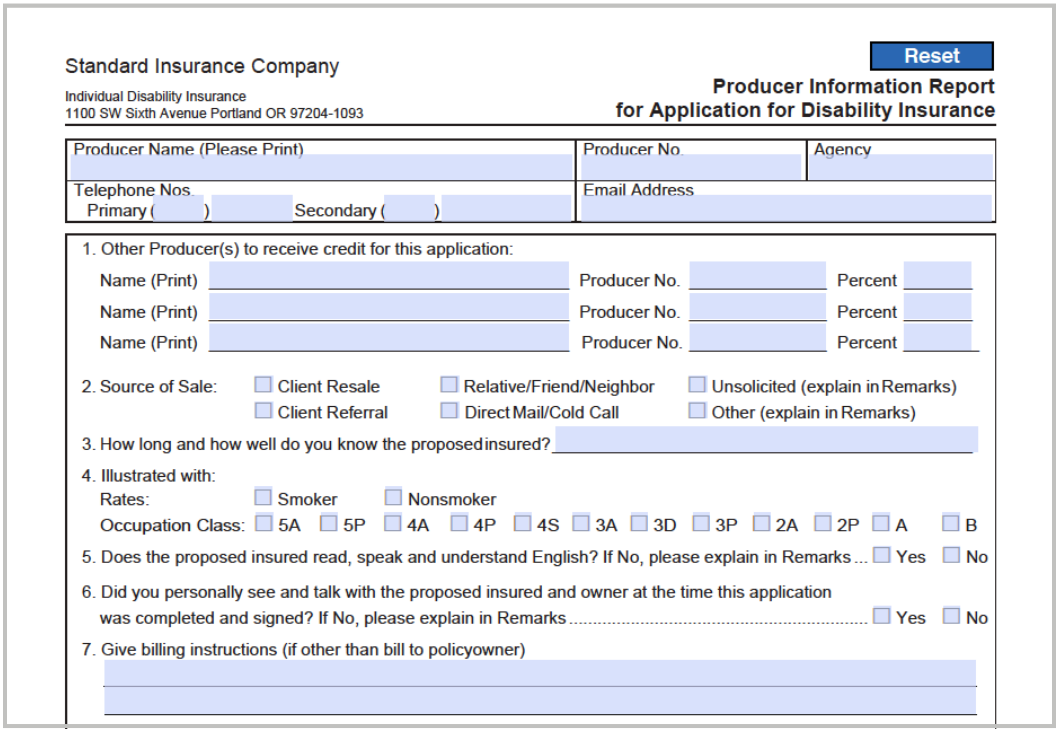
- All signatures on the application and authorizations must be handwritten in pen and ink or using a finger or stylus on an electronic device. Electronic signatures automatically affixed on forms or the application using a software program, or copied and pasted, will not be accepted.
- Do not use white-out. Any changes must be initialed by the applicant.
- Do not use anything that may obscure verbiage including highlighters, "Sign Here" flags, etc.
- Forms must be full size and include company header and form number. All forms must be legible.
- Producer must sign application after applicant has signed.

REQUIRED STATE SPECIFIC FORMS

- ☐ Replacement Notice (send to home office) **AR, CO, CT, DE, FL, IA, IL, ID, KY, MA, ME, NH, NJ, OK, PA, RI, TX, UT, VA, VT, WA, WI, WV**
- ☐ Product specific Outline of Coverage (give to applicant) **CA, GA, ID, ME, MT, NV, NH, SD, TX, WI, WV**
- ☐ Acknowledgement of Receipt of Outline of Coverage (send to home office) **ID, ME, NH, SD, TX, WV**
- ☐ **ME** Disclosure of Benefits Offsets (give to applicant)
- ☐ **MN** Guaranty Association Notice (give to applicant) and Delivery Receipt (send to home office)

The [Application Checklist and Cover Sheet,] with helpful compliance tips, guides you through the required forms.

It may also be used as a cover memo when submitting the application!



Standard Insurance Company

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

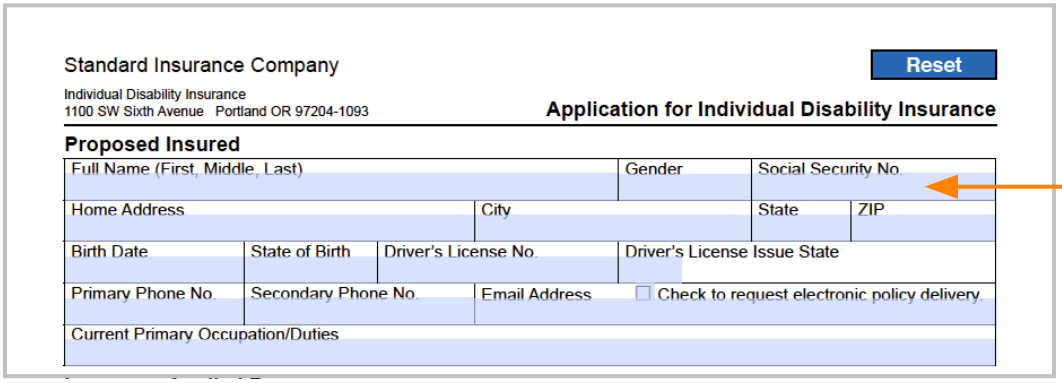
Reset

Producer Information Report for Application for Disability Insurance

Producer Name (Please Print)	Producer No.	Agency
Telephone Nos. Primary ( ) Secondary ( )	Email Address	

1. Other Producer(s) to receive credit for this application:
   - Name (Print) _____ Producer No. _____ Percent _____
   - Name (Print) _____ Producer No. _____ Percent _____
   - Name (Print) _____ Producer No. _____ Percent _____
2. Source of Sale: ☐ Client Resale ☐ Relative/Friend/Neighbor ☐ Unsolicited (explain in Remarks) ☐ Client Referral ☐ Direct Mail/Cold Call ☐ Other (explain in Remarks)
3. How long and how well do you know the proposed insured? _____
4. Illustrated with:
   - Rates: ☐ Smoker ☐ Nonsmoker
   - Occupation Class: ☐ 5A ☐ 5P ☐ 4A ☐ 4P ☐ 4S ☐ 3A ☐ 3D ☐ 3P ☐ 2A ☐ 2P ☐ A ☐ B
5. Does the proposed insured read, speak and understand English? If No, please explain in Remarks ... ☐ Yes ☐ No
6. Did you personally see and talk with the proposed insured and owner at the time this application was completed and signed? If No, please explain in Remarks ..... ☐ Yes ☐ No
7. Give billing instructions (if other than bill to policyowner)

The writing producer must complete the [Producer Information Report] for each application.



Standard Insurance Company

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

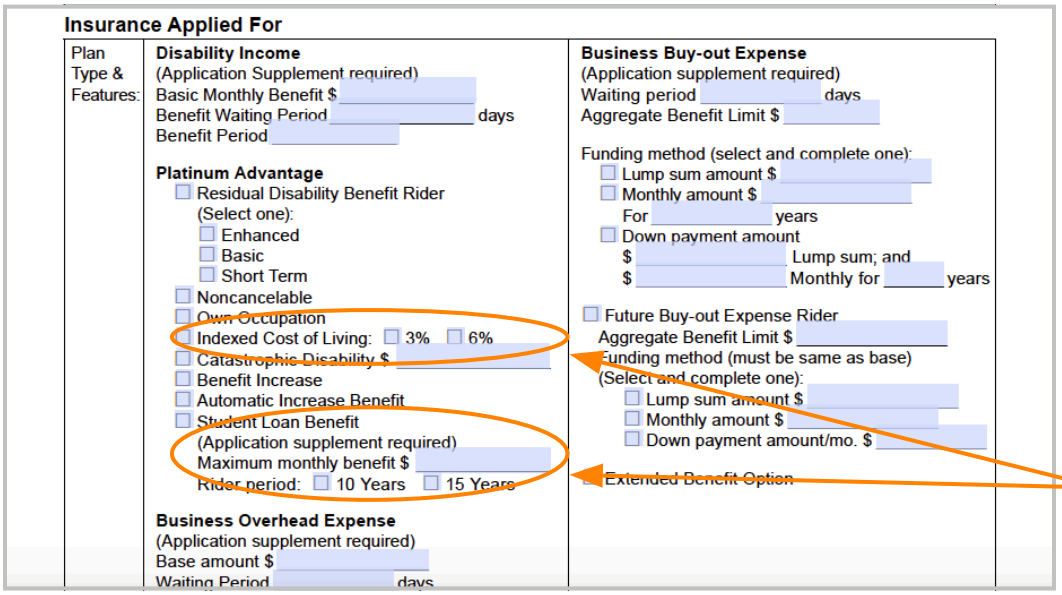
Reset

Application for Individual Disability Insurance

Proposed Insured

Full Name (First, Middle, Last)			Gender	Social Security No.	
Home Address		City		State	ZIP
Birth Date	State of Birth	Driver's License No.	Driver's License Issue State		
Primary Phone No.	Secondary Phone No.	Email Address	☐ Check to request electronic policy delivery		
Current Primary Occupation/Duties					

On the TeleApp IDI Application, a Social Security number is used for electronic delivery of the policy.



Insurance Applied For

Plan Type & Features:

Disability Income
(Application Supplement required)
Basic Monthly Benefit $ _____
Benefit Waiting Period _____ days
Benefit Period _____

Platinum Advantage
- ☐ Residual Disability Benefit Rider
  (Select one):
  - ☐ Enhanced
  - ☐ Basic
  - ☐ Short Term
- ☐ Noncancelable
- ☐ Own Occupation
- ☐ Indexed Cost of Living: ☐ 3% ☐ 6%
- ☐ Catastrophic Disability $ _____
- ☐ Benefit Increase
- ☐ Automatic Increase Benefit
- ☐ Student Loan Benefit
  (Application supplement required)
  Maximum monthly benefit $ _____
  Rider period: ☐ 10 Years ☐ 15 Years

Business Overhead Expense
(Application supplement required)
Base amount $ _____
Waiting Period _____ days

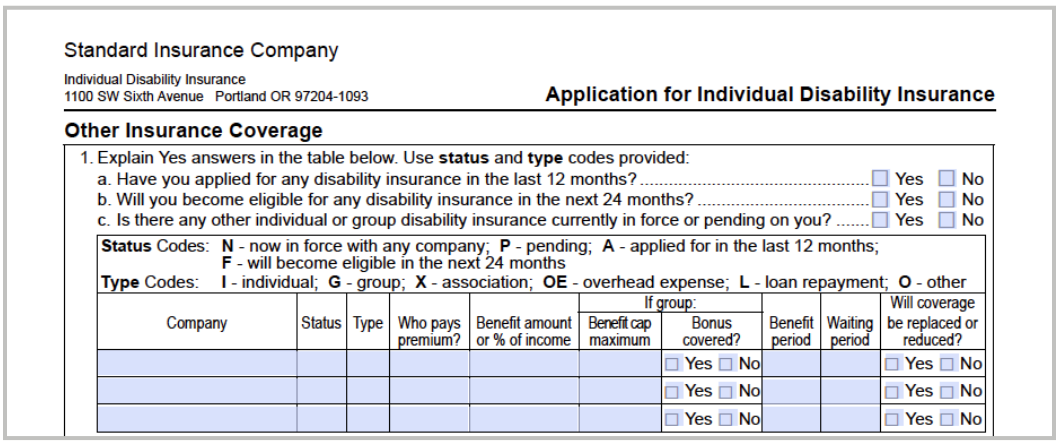
Business Buy-out Expense
(Application supplement required)
Waiting period _____ days
Aggregate Benefit Limit $ _____

Funding method (select and complete one):
- ☐ Lump sum amount $ _____
- ☐ Monthly amount $ _____
  For _____ years
- ☐ Down payment amount
  $ _____ Lump sum; and
  $ _____ Monthly for _____ years

- ☐ Future Buy-out Expense Rider
  Aggregate Benefit Limit $ _____
  Funding method (must be same as base)
  (Select and complete one):
  - ☐ Lump sum amount $ _____
  - ☐ Monthly amount $ _____
  - ☐ Down payment amount/mo. $ _____
- ☐ Extended Benefit Option

Please provide complete details about the desired policy. It is helpful for the prepared illustration to match.

Don't overlook these boxes!



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

Application for Individual Disability Insurance

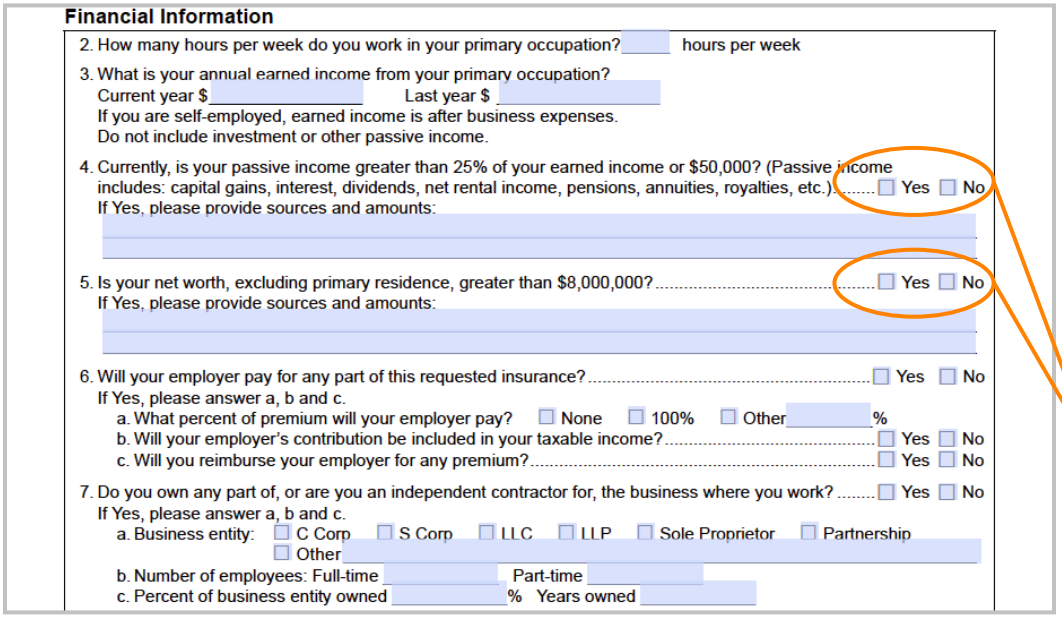
Other Insurance Coverage

1. Explain Yes answers in the table below. Use **status** and **type** codes provided:
   a. Have you applied for any disability insurance in the last 12 months? ☐ Yes ☐ No
   b. Will you become eligible for any disability insurance in the next 24 months? ☐ Yes ☐ No
   c. Is there any other individual or group disability insurance currently in force or pending on you? ☐ Yes ☐ No

Status Codes: **N** - now in force with any company; **P** - pending; **A** - applied for in the last 12 months; **F** - will become eligible in the next 24 months
Type Codes: **I** - individual; **G** - group; **X** - association; **OE** - overhead expense; **L** - loan repayment; **O** - other

Company	Status	Type	Who pays premium?	Benefit amount or % of income	If group: Benefit cap maximum	If group: Bonus covered?	Benefit period	Waiting period	Will coverage be replaced or reduced?
						☐ Yes ☐ No			☐ Yes ☐ No
						☐ Yes ☐ No			☐ Yes ☐ No
						☐ Yes ☐ No			☐ Yes ☐ No

Please collect detailed information about pending or in-force coverage on your client. This ensures we offer an accurate benefit amount.



Financial Information

2. How many hours per week do you work in your primary occupation? _____ hours per week
3. What is your annual earned income from your primary occupation?
   Current year $ _____ Last year $ _____
   If you are self-employed, earned income is after business expenses.
   Do not include investment or other passive income.
4. Currently, is your passive income greater than 25% of your earned income or $50,000? (Passive income includes: capital gains, interest, dividends, net rental income, pensions, annuities, royalties, etc.) ☐ Yes ☐ No
   If Yes, please provide sources and amounts:
5. Is your net worth, excluding primary residence, greater than $8,000,000? ☐ Yes ☐ No
   If Yes, please provide sources and amounts:
6. Will your employer pay for any part of this requested insurance? ☐ Yes ☐ No
   If Yes, please answer a, b and c.
   a. What percent of premium will your employer pay? ☐ None ☐ 100% ☐ Other _____ %
   b. Will your employer's contribution be included in your taxable income? ☐ Yes ☐ No
   c. Will you reimburse your employer for any premium? ☐ Yes ☐ No
7. Do you own any part of, or are you an independent contractor for, the business where you work? ☐ Yes ☐ No
   If Yes, please answer a, b and c.
   a. Business entity: ☐ C Corp ☐ S Corp ☐ LLC ☐ LLP ☐ Sole Proprietor ☐ Partnership ☐ Other _____
   b. Number of employees: Full-time _____ Part-time _____
   c. Percent of business entity owned _____ % Years owned _____

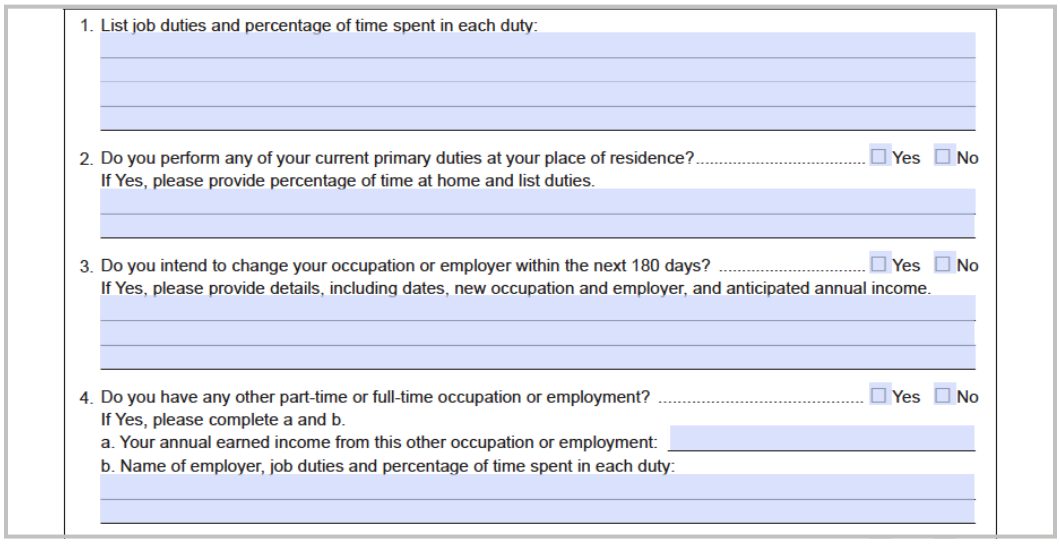
Even though income documentation is submitted with the application, complete and accurate answers are needed.

Please reference the Income Documentation Requirements Flyer to determine proof of income needed based on entity and product.

If **Yes** is marked, please include requested details.

Helpful Tips for Completing the Full Underwriting Application Supplement

(if the TeleApp version is not used)



1. List job duties and percentage of time spent in each duty:

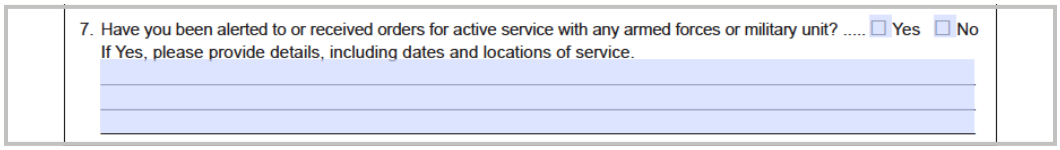
2. Do you perform any of your current primary duties at your place of residence? ☐ Yes ☐ No
   If Yes, please provide percentage of time at home and list duties.

3. Do you intend to change your occupation or employer within the next 180 days? ☐ Yes ☐ No
   If Yes, please provide details, including dates, new occupation and employer, and anticipated annual income.

4. Do you have any other part-time or full-time occupation or employment? ☐ Yes ☐ No
   If Yes, please complete a and b.
   a. Your annual earned income from this other occupation or employment:
   b. Name of employer, job duties and percentage of time spent in each duty:

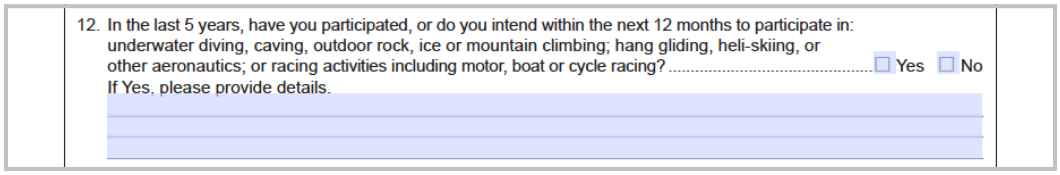
Complete details about job duties help determine occupation class.

Additional information may be provided with the Occupation Duties Questionnaire.



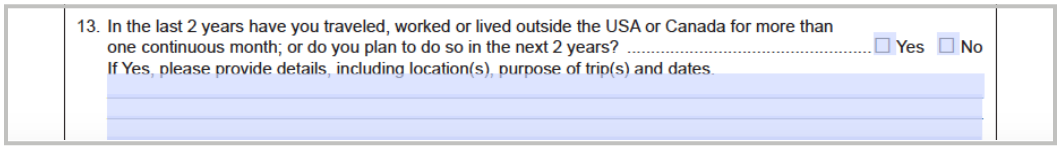
7. Have you been alerted to or received orders for active service with any armed forces or military unit? ☐ Yes ☐ No
   If Yes, please provide details, including dates and locations of service.

Please see the Income Protection and the Military FAQ Flyer. It explains eligibility for individuals in the military.



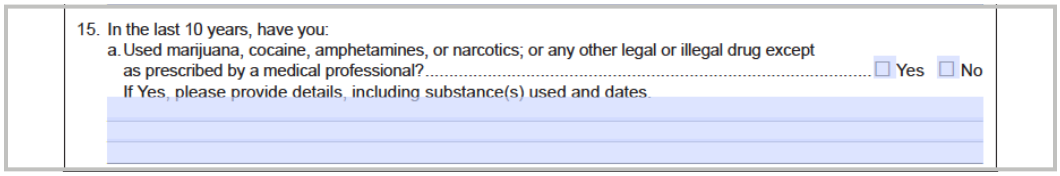
12. In the last 5 years, have you participated, or do you intend within the next 12 months to participate in: underwater diving, caving, outdoor rock, ice or mountain climbing; hang gliding, heli-skiing, or other aeronautics; or racing activities including motor, boat or cycle racing? ☐ Yes ☐ No
    If Yes, please provide details.

Please include details and complete the Hazardous Sports Questionnaire if the answer is **Yes**.



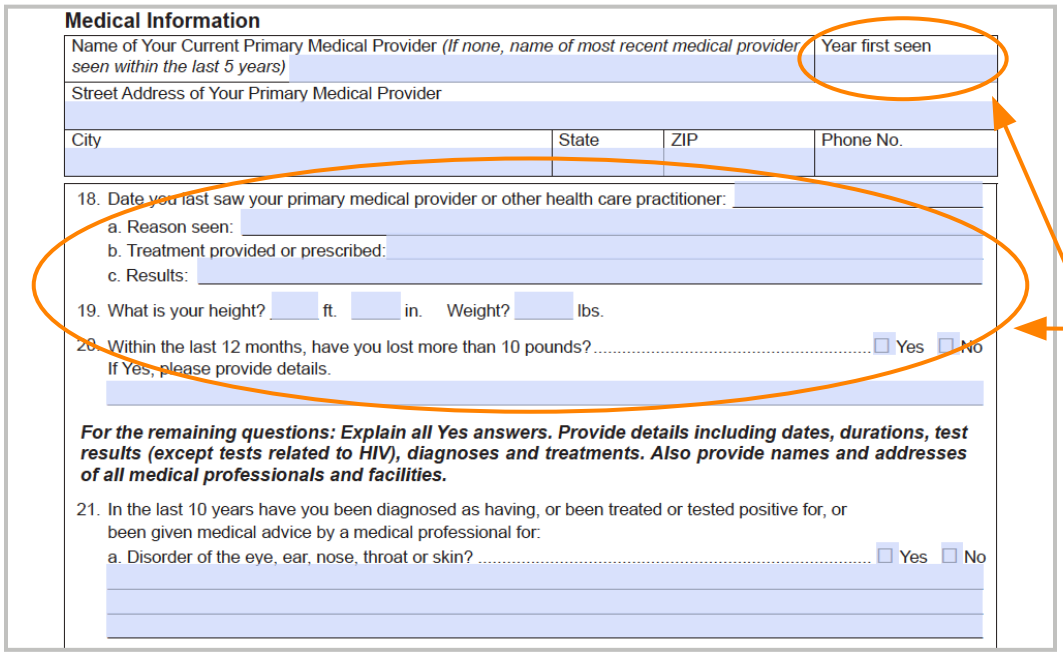
13. In the last 2 years have you traveled, worked or lived outside the USA or Canada for more than one continuous month; or do you plan to do so in the next 2 years? ☐ Yes ☐ No
    If Yes, please provide details, including location(s), purpose of trip(s) and dates.

Please include details and complete the Foreign Travel, Work or Residence Questionnaire if the answer is **Yes**.



15. In the last 10 years, have you:
    a. Used marijuana, cocaine, amphetamines, or narcotics; or any other legal or illegal drug except as prescribed by a medical professional? ☐ Yes ☐ No
       If Yes, please provide details, including substance(s) used and dates.

Please specify frequency of use if the answer is **Yes**.



Medical Information

Name of Your Current Primary Medical Provider *(If none, name of most recent medical provider seen within the last 5 years)* | Year first seen

Street Address of Your Primary Medical Provider

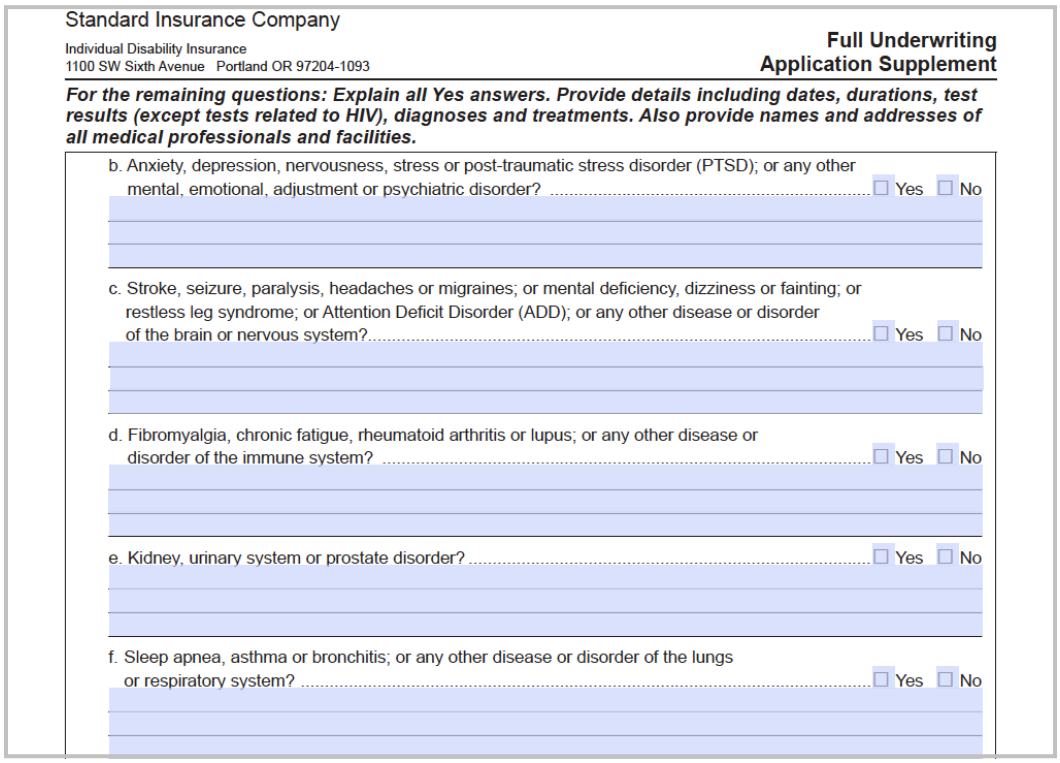
City | State | ZIP | Phone No.

18. Date you last saw your primary medical provider or other health care practitioner:
    a. Reason seen:
    b. Treatment provided or prescribed:
    c. Results:
19. What is your height? ft. in. Weight? lbs.
20. Within the last 12 months, have you lost more than 10 pounds? ☐ Yes ☐ No
    If Yes, please provide details.

For the remaining questions: Explain all Yes answers. Provide details including dates, durations, test results (except tests related to HIV), diagnoses and treatments. Also provide names and addresses of all medical professionals and facilities.

21. In the last 10 years have you been diagnosed as having, or been treated or tested positive for, or been given medical advice by a medical professional for:
    a. Disorder of the eye, ear, nose, throat or skin? ☐ Yes ☐ No

These sections are often missed. Be sure to complete them!



Standard Insurance Company

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

Full Underwriting Application Supplement

For the remaining questions: Explain all Yes answers. Provide details including dates, durations, test results (except tests related to HIV), diagnoses and treatments. Also provide names and addresses of all medical professionals and facilities.

b. Anxiety, depression, nervousness, stress or post-traumatic stress disorder (PTSD); or any other mental, emotional, adjustment or psychiatric disorder? ☐ Yes ☐ No

c. Stroke, seizure, paralysis, headaches or migraines; or mental deficiency, dizziness or fainting; or restless leg syndrome; or Attention Deficit Disorder (ADD); or any other disease or disorder of the brain or nervous system? ☐ Yes ☐ No

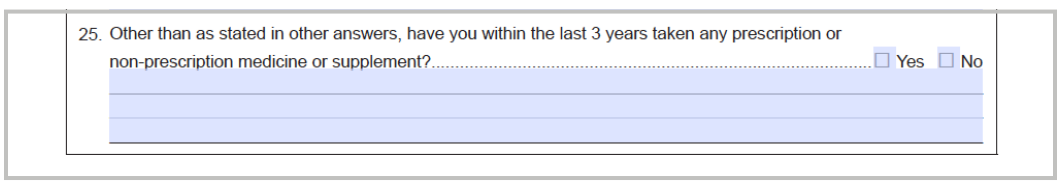
d. Fibromyalgia, chronic fatigue, rheumatoid arthritis or lupus; or any other disease or disorder of the immune system? ☐ Yes ☐ No

e. Kidney, urinary system or prostate disorder? ☐ Yes ☐ No

f. Sleep apnea, asthma or bronchitis; or any other disease or disorder of the lungs or respiratory system? ☐ Yes ☐ No

Please collect information about:

- Date of diagnosis/injury
- Treating physician including contact information
- Last date of symptoms
- Treatment details to include prescription medication, chiropractic treatment, physical therapy, etc)

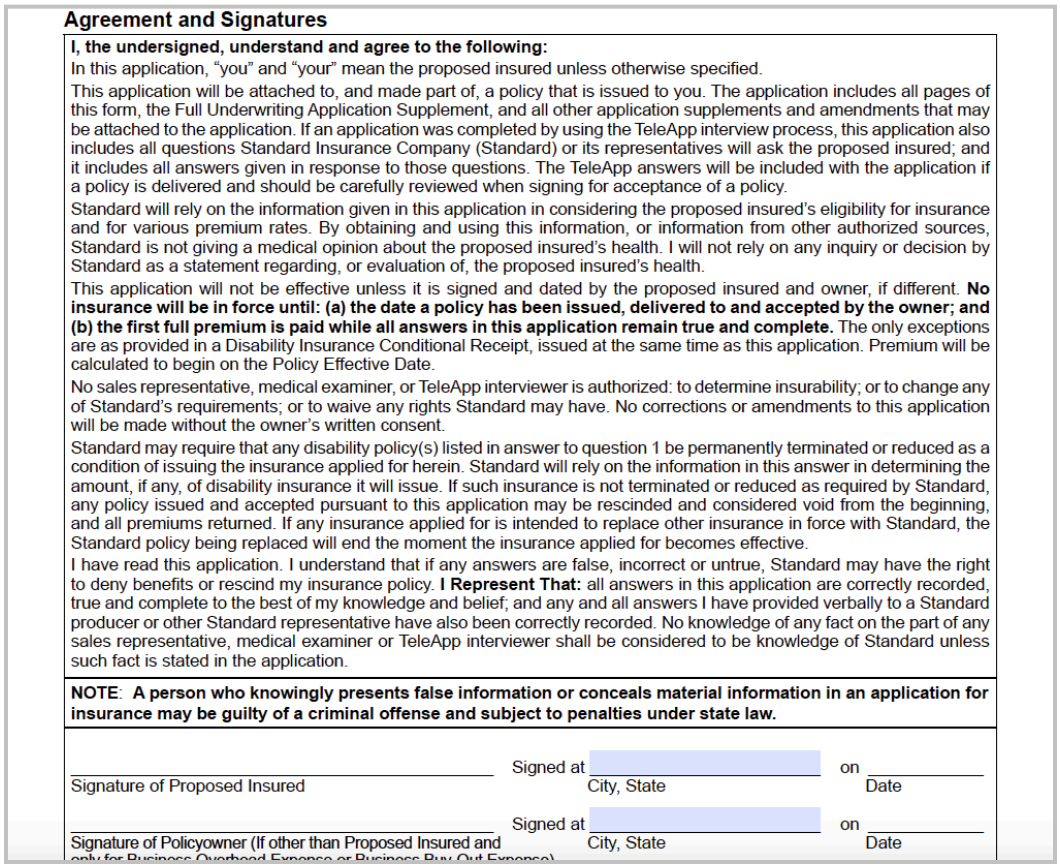


25. Other than as stated in other answers, have you within the last 3 years taken any prescription or non-prescription medicine or supplement? ☐ Yes ☐ No

Medical prescription details should include:

- Reason for prescription
- Date last used
- Prescribing physician with contact information

Signing the Application



Agreement and Signatures

I, the undersigned, understand and agree to the following:

In this application, "you" and "your" mean the proposed insured unless otherwise specified.

This application will be attached to, and made part of, a policy that is issued to you. The application includes all pages of this form, the Full Underwriting Application Supplement, and all other application supplements and amendments that may be attached to the application. If an application was completed by using the TeleApp interview process, this application also includes all questions Standard Insurance Company (Standard) or its representatives will ask the proposed insured; and it includes all answers given in response to those questions. The TeleApp answers will be included with the application if a policy is delivered and should be carefully reviewed when signing for acceptance of a policy.

Standard will rely on the information given in this application in considering the proposed insured's eligibility for insurance and for various premium rates. By obtaining and using this information, or information from other authorized sources, Standard is not giving a medical opinion about the proposed insured's health. I will not rely on any inquiry or decision by Standard as a statement regarding, or evaluation of, the proposed insured's health.

This application will not be effective unless it is signed and dated by the proposed insured and owner, if different. **No insurance will be in force until: (a) the date a policy has been issued, delivered to and accepted by the owner; and (b) the first full premium is paid while all answers in this application remain true and complete.** The only exceptions are as provided in a Disability Insurance Conditional Receipt, issued at the same time as this application. Premium will be calculated to begin on the Policy Effective Date.

No sales representative, medical examiner, or TeleApp interviewer is authorized: to determine insurability; or to change any of Standard's requirements; or to waive any rights Standard may have. No corrections or amendments to this application will be made without the owner's written consent.

Standard may require that any disability policy(s) listed in answer to question 1 be permanently terminated or reduced as a condition of issuing the insurance applied for herein. Standard will rely on the information in this answer in determining the amount, if any, of disability insurance it will issue. If such insurance is not terminated or reduced as required by Standard, any policy issued and accepted pursuant to this application may be rescinded and considered void from the beginning, and all premiums returned. If any insurance applied for is intended to replace other insurance in force with Standard, the Standard policy being replaced will end the moment the insurance applied for becomes effective.

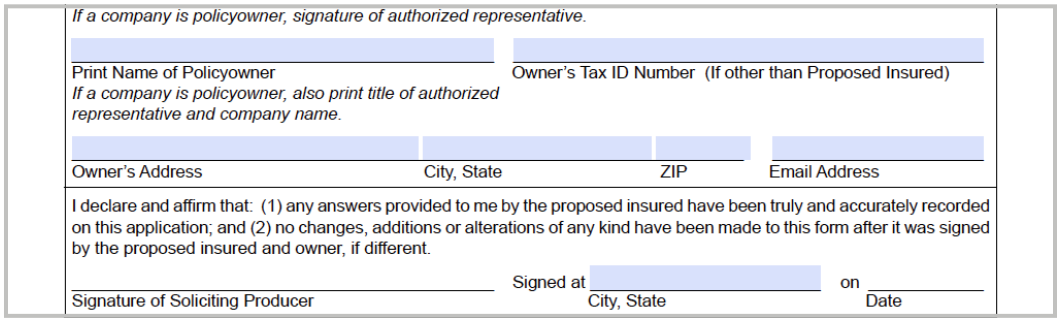
I have read this application. I understand that if any answers are false, incorrect or untrue, Standard may have the right to deny benefits or rescind my insurance policy. **I Represent That:** all answers in this application are correctly recorded, true and complete to the best of my knowledge and belief; and any and all answers I have provided verbally to a Standard producer or other Standard representative have also been correctly recorded. No knowledge of any fact on the part of any sales representative, medical examiner or TeleApp interviewer shall be considered to be knowledge of Standard unless such fact is stated in the application.

NOTE: A person who knowingly presents false information or conceals material information in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signature of Proposed Insured — Signed at (City, State) — on (Date)

Signature of Policyowner (If other than Proposed Insured and only for Business Overhead Expense or Business Buy-Out Expense) — Signed at (City, State) — on (Date)

The proposed insured must sign and date.



If a company is policyowner, signature of authorized representative.

Print Name of Policyowner — Owner's Tax ID Number (If other than Proposed Insured)

If a company is policyowner, also print title of authorized representative and company name.

Owner's Address — City, State — ZIP — Email Address

I declare and affirm that: (1) any answers provided to me by the proposed insured have been truly and accurately recorded on this application; and (2) no changes, additions or alterations of any kind have been made to this form after it was signed by the proposed insured and owner, if different.

Signature of Soliciting Producer — Signed at (City, State) — on (Date)

Producer must sign and date after the proposed insured.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York, where insurance products are offered by The Standard Life Insurance Company of New York of White Plains, New York.