

Producer Instructions

Note: Any policy and riders issued will be those most comparable to the base policy and riders available at the time of the increase and will be subject to our underwriting rules and income limits in effect as of the applicable option date. Supplemental social insurance riders (Supplemental Social Insurance, Supplemental Income Benefit, Social Security Agreement, and Social Security Benefit) and increase option riders are not available on increase policies. The Waiting/Elimination Period, Benefit Period/Multiple, and premium mode for any increase will be the same as, or the most comparable to, the base policy.

- 1. Prior to completing this application, give the Disclosure Notice - Information Practices (Nonmedical) to the proposed insured to read carefully.
- 2. **Complete all questions.** Print all responses. If applying for an increase option on a Business Overhead Expense (BP) or Buy-Out (BEP) policy, include the appropriate Application Supplement.
- 3. Complete the Producer Information Report, below. Use REMARKS to note special instructions or requests.
- 4. Staple all pages together and submit to your Standard Insurance Company regional office or assigned agency. Include a copy of the sales illustration used as a basis for the sale and the proposed insured's most recent tax return with all schedules and W-2's.

Producer Information Report

1. Producer Name (Please Print) _____ 2. Producer Number _____ 3. Agency Number _____

Home #() _____ Work #() _____ Other #() _____

4. Telephone Numbers

() _____

5. Fax Number _____ 6. E-mail Address _____

7. Other Producer(s) to Receive Credit for this Application:

NAME (PRINT) _____ PRODUCER NO. _____ PERCENT _____
NAME (PRINT) _____ PRODUCER NO. _____ PERCENT _____

8. To the best of your knowledge, is replacement involved or intended to be involved with this application? YES NO

9. Give billing instructions (if other than bill to policyowner): _____

10. REMARKS: Note anything not disclosed on the application that might affect the insured's eligibility for an increase.

I DECLARE THAT: I gave the Disclosure Notice - Information Practices (Nonmedical) to the proposed insured. This application was read and signed by the proposed insured and owner, if different, after all questions were asked and answered. I have accurately recorded on this application all of the information that was given to me by the proposed insured and owner, if different. I know of nothing affecting the risk that is not recorded on this application or in any accompanying application supplement, written statement or letter.

Producer Signature _____ Date _____

Standard Insurance Company

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

**Disclosure Notice - Information Practices
(Nonmedical)**

Standard Insurance Company (Standard) is committed to maintaining the confidentiality of your personal information. In order to offer and administer insurance products, Standard must obtain and review a certain amount and type of personal information about you. In general, we may seek information about your age, occupation, income and finances. This personal information is obtained and disclosed by us in order to evaluate your insurability and determine appropriate premium rates; to support our normal business practices; and to provide quality service in administering policies.

Sources of Information

You and your application for insurance are our primary sources of personal information. We, or our insurance representative, may call you for a personal history interview (PHI) to obtain supplementary information or to confirm information you provide on the application. With your written authorization, we may also collect or verify personal information by contacting: insurance producers, insurance or reinsurance companies, and the MIB, Inc. (see below); employers, and personal and business associates.

Disclosure of Information

In the course of conducting our business, there are circumstances in which we may disclose to others the information we collect about you. These disclosures are only made with your authorization, or as permitted or required by law. Such disclosures may be to the MIB, Inc., reinsurers; organizations that perform services or functions on our behalf or to serve you, and to regulatory, law enforcement and governmental authorities. Standard or its reinsurers may also release information in its file to other insurance companies to whom you have applied or may apply for life or health insurance or to whom a claim for benefits may be submitted. When information is disclosed to another party to perform services or functions on our behalf, we expect them to adhere to procedures and practices that maintain the confidentiality of your personal information, to use the information only for the limited purpose for which it was shared, and to abide by all applicable federal and state privacy laws.

Review and Correction of Information

In general, you have a right to learn the nature and substance of any personal information about you in our files. You also have a right to obtain a copy of that information, subject to limited restrictions. To access information about you, send a signed, written request to the address at the top of this page. If you believe that any information about you is inaccurate, you may notify us in writing of any correction, amendment, or deletion that you believe should be made. We will carefully review your request and, where appropriate, make the necessary change.

MIB, Inc. (Medical Information Bureau)

Standard, or its reinsurers, may make a brief report to the MIB, Inc., formerly known as Medical Information Bureau. MIB, Inc. is a not-for-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply the company with the information in its file. At your request, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek 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. The telephone number is 866-692-6901 (TTY 866-346-3642). Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

Additional Information

We hope this information helps you understand how and why we obtain information about you. To obtain a more detailed explanation of your rights and our information practices, please contact Standard Insurance Company, Individual Disability Insurance Underwriting, 1100 SW Sixth Ave., Portland, OR 97204-1093.

Proposed Insured

1. Full Name (Last, First, Middle) _____ 2. Sex _____ 3. Social Security Number _____

4. Home Address _____ City _____ State _____ Zip Code _____ 5. Date of Birth _____

HOME () _____ WORK () _____

6. Phone Numbers _____ 7. E-mail Address (optional) _____

Insurance Applied For

8. Exercising Increase Option on base policy # _____

9. Type of Increase Option (circle one): BIO FPO GFIA AMIO FIPA FIO Other: _____

10. Plan Type and Features: Note: Any policy and rider(s) issued will be those most comparable to the base policy and riders available at the time of the increase. No supplemental social insurance or increase option riders are available on increase policies. The Waiting/Elimination Period, Benefit Period/Multiple, and premium mode for any increase will be the same as, or the most comparable to, the base policy.

Disability Income
 Increase in Basic Monthly Benefit \$ _____

Business Overhead Expense*
 Increase in Base Amount \$ _____

Business Buy-Out Expense*
 Increase in Aggregate Benefit Limit \$ _____

Other: _____

* Include the appropriate Application Supplement.

11. Is there any other individual or group disability insurance currently in force or pending on you? YES NO
 Explain Yes answer in the table below.

STATUS CODES: NOW IN FORCE (N); PENDING (P).									
TYPE CODE: INDIVIDUAL (I); SOCIAL SECURITY SUBSTITUTE (S); GROUP (G); ASSOCIATION (X); OVERHEAD EXPENSE (OE); OTHER (O - EXPLAIN.)									
COMPANY NAME: If replacement, give policy number.	STATUS	TYPE	MONTHLY AMOUNT:	BENEFIT PERIOD:	WAITING PERIOD:	IF GROUP:			WILL COVERAGE BE REPLACED OR REDUCED?
						WHOPAYS PREMIUM?	BENEFIT CAP MAXIMUM?	% OF INCOME:	
									<input type="checkbox"/> Yes <input type="checkbox"/> No
									<input type="checkbox"/> Yes <input type="checkbox"/> No
									<input type="checkbox"/> Yes <input type="checkbox"/> No

General Information

12. Current Primary Occupation (include professional designation, specialty or degree) _____

13. Current Employer _____ 14. Employer Address _____ City, State _____ Zip Code _____

15. How many hours a week do you work in your primary occupation? _____

16. How much of the premium for this increase will be paid by your employer? NONE 100% OTHER ____%

17. Do you own any part of the business where you work? YES NO
 If yes, answer a, b and c. If no, go to question 18.
 a. Percent owned: _____ years owned: _____
 b. Number of employees: full time _____ part time _____
 c. Business type: C-Corp S-Corp LLC LLP Sole Proprietor Partnership
 Other (explain) _____

18. Your current earned income at an annual rate is \$ _____. For last year it was \$ _____.
 "Earned Income" means salary, other compensation and commissions. Exclude investment income. If you are self-employed, earned income is after business expenses, but before personal income taxes. Do not include any income that is not reported to the IRS. Explain any significant fluctuations between years. _____

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

Receipt for Payment
(Application to Exercise a Policy Increase Option)

Proposed Insured: _____
(please print)

* Amount Received: \$ _____

Standard Insurance Company (Standard) acknowledges receipt of the above amount paid with the Application to Exercise a Policy Increase Option (Application) having the same proposed insured, owner and date(s) as this receipt. No insurance or increase in insurance is provided by this receipt, and this receipt does not guarantee issuance of any insurance coverage or increase in coverage.

I, the undersigned owner, have read this receipt. I understand and agree that payment of the above amount, and issuance of this receipt, does not provide any disability insurance coverage or increase in coverage, and that any insurance coverage that may be issued pursuant to the Application will be subject to the terms, conditions, limitations and exclusions of whatever issued policy governs such increase. I ask that Standard apply this payment to the first premium due for the increase applied for, if the increase is issued. I understand Standard will return this payment to me if the increase is not issued. Each copy of this receipt is considered to be a duplicate original.

Signature of Owner
If company owner, signature of authorized representative

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

Signature of Soliciting Producer

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

*** INSTRUCTIONS FOR PAYMENT WITH APPLICATION:** Any amount paid with the Application must equal at least ONE MODAL PREMIUM, based on the premium mode for the base policy. All checks must be payable to Standard Insurance Company. Do not make checks payable to the producer. Do not leave the payee blank.

PRODUCER INSTRUCTIONS: Use this receipt if money is paid with the Application. The owner and producer must complete, sign and date both copies of this receipt on the same date the owner signs the Application. Each copy must be identical. Give one copy to the owner. Send the other copy with the Application and check to the home office.

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

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(Application to Exercise a Policy Increase Option)

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(please print)

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I, the undersigned owner, have read this receipt. I understand and agree that payment of the above amount, and issuance of this receipt, does not provide any disability insurance coverage or increase in coverage, and that any insurance coverage that may be issued pursuant to the Application will be subject to the terms, conditions, limitations and exclusions of whatever issued policy governs such increase. I ask that Standard apply this payment to the first premium due for the increase applied for, if the increase is issued. I understand Standard will return this payment to me if the increase is not issued. Each copy of this receipt is considered to be a duplicate original.

Signature of Owner
If company owner, signature of authorized representative

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

Signature of Soliciting Producer

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

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1100 SW Sixth Avenue Portland OR 97204-1093

**Authorization to Obtain and Disclose
Personal (Nonmedical) Information**

Types of Personal Information Collected

I understand that it is necessary for Standard Insurance Company (Standard) to collect and review personal information about me in order to offer and administer insurance products. I understand that personal information may include information about my age, occupation, other insurance, income and finances. I also understand that personal information does not include any information related to my physical or mental condition, medical history or medical treatment.

Authorization to Obtain Personal Information

I authorize any insurance or reinsurance company, insurance sales representative, employer, MIB, Inc. (Medical Information Bureau) and any other person, organization or institution having records or knowledge of me, to release personal information about me, as described above, to Standard, its reinsurers, and any insurance support organization acting on behalf of Standard.

Authorization to Use Personal Information

I authorize Standard to use personal information obtained about me for the purposes of determining eligibility for insurance and reinsurance and determining appropriate premium rates, evaluating claims for insurance benefits, and conducting other legally permissible activities that relate to my application and insurance coverage.

Authorization to Disclose Personal Information

I authorize Standard to disclose any personal information about me to Standard's reinsurers, MIB, Inc., other insurance companies to whom I have applied or may apply for insurance, and to organizations or persons, including insurance sales representatives, performing business services for Standard related to my application and policy administration. No other disclosure may be made without my further authorization except to the extent necessary for the conduct of Standard's business or as permitted or required by law.

Expiration and Revocation

I understand that I have the right to revoke this Authorization at any time by sending a written request for revocation to Standard Insurance Company, Attention: Individual Disability Insurance Underwriting, 1100 SW Sixth Avenue, Portland, Oregon 97204. Revocation of this Authorization, or failure to sign this Authorization, will impair Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage. I realize that if I do revoke this Authorization it will not affect any use or disclosure of information prior to the receipt of my revocation and that any action taken before Standard receives my written revocation will be valid.

This Authorization will expire automatically twenty-four (24) months following the date of my signature below.

I acknowledge that I have read and received a copy of the Disclosure Notice-Information Practices. A copy of this Authorization will be provided to me, or my authorized representative, upon request. A photocopy or facsimile of this Authorization is as valid as the original. Any alteration made to this Authorization will render it invalid and unacceptable by Standard.

Signature of (Proposed) Insured

Date of Signature

Name (please print)