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The Standard Life Insurance Company of New York
Medical Underwriting, 900 SW Fifth Avenue Portland OR 97204

Medical History Statement
For Group Life and Disability Insurance

DIRECTIONS FOR APPLYING FOR COVERAGE

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

MEMBER/EMPLOYEE INFORMATION

Name of Group		Group Number	Check who is Applying (One per form) ☐ Member/Employee ☐ Spouse ☐ Child
Member/Employee Name		Birthdate (Mo/Day/Year)	Date Hired (Mo/Day/Year)
Occupation	Salary	Social Security Number	Member/Employee Identification No.

APPLICANT INFORMATION

Applicant's Name (Person to be insured)			Email Address
Street Address	City		State Zip
Sex ☐M ☐F	Birthdate (Mo/Day/Year)	Birthplace	Social Security Number	Work Phone ( ) Home Phone ( )

APPLICATION INFORMATION

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

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

☐ Short Term Disability

☐ Long Term Disability _____ (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)

MEDICAL HISTORY STATEMENT QUESTIONS

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

1. Are you now unable to work full-time because of any physical or mental condition, or injury? ☐ Yes ☐ No
2. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
   - A. Disease of the liver, pancreas, kidney, ulcers, stomach, intestinal ailment, or digestive system disorder? ☐ Yes ☐ No
   - B. Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, blindness, deafness, or any other neurological or muscle disorder? ☐ Yes ☐ No
   - C. Cancer, tumor, lesions, leukemia, lymphoma, blood clotting or other malignancy or growth? ☐ Yes ☐ No
   - D. Cardiovascular disease, heart ailment, arteriosclerosis, abnormal pulse, high blood pressure, heart murmur, valve, circulatory, or vascular disorders? ☐ Yes ☐ No
   - E. Emphysema, asthma, bronchitis, sleep apnea, or other respiratory or lung disease? ☐ Yes ☐ No
   - F. Lupus, scleroderma, vasculitis, connective tissue disease, or other immune system disorder not related to Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
   - G. Osteoarthritis, rheumatoid arthritis, osteoporosis, pain in the joints, amputations, or other disease or disorder of the bones, joints, back, or spine, arthritic or disc conditions? ☐ Yes ☐ No
   - H. Diabetes, thyroid, gland, spleen, or nephritis? ☐ Yes ☐ No
   - I. Drug or alcohol abuse, or have you used alcohol, drugs or nicotine in a manner that has resulted in medical treatment? ☐ Yes ☐ No
   - J. Psychiatric or mental condition, depression, adjustment disorder, affective disorder, anxiety disorder, or obsessive-compulsive disorder? ☐ Yes ☐ No
3. In the past 7 years have you had any illness or injury not listed above which resulted in the use of prescribed medication or physician visits? ☐ Yes ☐ No
4. 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)? ☐ Yes ☐ No
5. Do you plan any operation or visit to a doctor or practitioner for an existing physical or mental condition, or injury? ☐ Yes ☐ No
6. Are you currently pregnant? ☐ Yes ☐ No

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

Applicant Name	Social Security Number

Describe any "yes" answers below. (Please provide the entire question number.)

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

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

- I represent that the statements contained herein, including those made in response to the Medical History Statement questions and any attachments, are true and complete 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 subject to the Incontestability Provisions in the Group Policy(ies) and Group Certificate(s), any misstatements or failure to report information, including any change in my medical condition while my application is pending, which is material to the issuance of coverage may be used as a basis for contesting my insurance and/or denial of payment of a claim. I understand that The Standard Life Insurance Company of New York (The Standard) has the right to require additional information, including an examination, blood test and/or urinalysis. I agree to notify 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) and Group Certificate(s), 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 the diagnosis and treatment of mental illness, any disorder of the immune system, including Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, any communicable or sexually transmitted disease or disorder, and information on the diagnosis and treatment of the use of alcohol, drugs, and tobacco. **But, this release does not allow disclosure of the following records: alcohol and/or drug records received or acquired by a federally assisted alcohol or drug program, psychotherapy notes, or HIV.**
- By my signature below, I acknowledge that prior 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 medical records consistent with this authorization for the purpose as described immediately below.
- I understand that The Standard will use information to determine my eligibility for group insurance coverage. I understand The Standard may release information it has about me to its reinsurers and to any person performing business or legal services for The Standard in connection with my application. I understand The Standard may release information it has about me to MIB for the purpose of reporting to the MIB information exchange and for MIB to audit The Standard's reporting. I understand The Standard may release information it has about me to other insurance companies to which I have applied for insurance coverage or benefits.
- I understand that information retained and disclosed by The Standard related to my life and/or disability insurance application is not protected under the Health Insurance Portability and Accountability Act (HIPAA).
- 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), Group Certificate(s) 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) and Group Certificate(s).
- For contributory coverage: I understand and consent to the following: a) that the policy permits the group policyholder to change, reduce, restrict or terminate my rights or benefits under the policy; and b) such change, reduction, restriction or termination may occur at a time when my health status has changed and may affect my ability to procure individual coverage.
- I understand and consent to the electronic delivery of and/or the posting on the insurer's website of my certificate.

Signature of Applicant (or Member/Employee for Dependent Child)	**Dated**

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

Applicant Name	Social Security Number

INFORMATION PRACTICES NOTICE

- To help us determine your eligibility for group insurance we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or MIB, Inc. (MIB), formerly known as Medical Information Bureau. We will use the authorization you signed on this form when we seek this information.
- MIB – Information regarding your insurability will be treated as confidential. The Standard Life Insurance Company of New York 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.

  The Standard Life Insurance Company of New York may release information in its file to its reinsurers, and The Standard Life Insurance Company of New York, 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, The Standard Life Insurance Company of New York, 900 SW Fifth Avenue, Portland, Oregon 97204 or call 1-888-456-3505.

FRAUD NOTICE *(Only applies to Accident and Health Insurance (AD&D/Disability/Dental))*

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Print and Sign