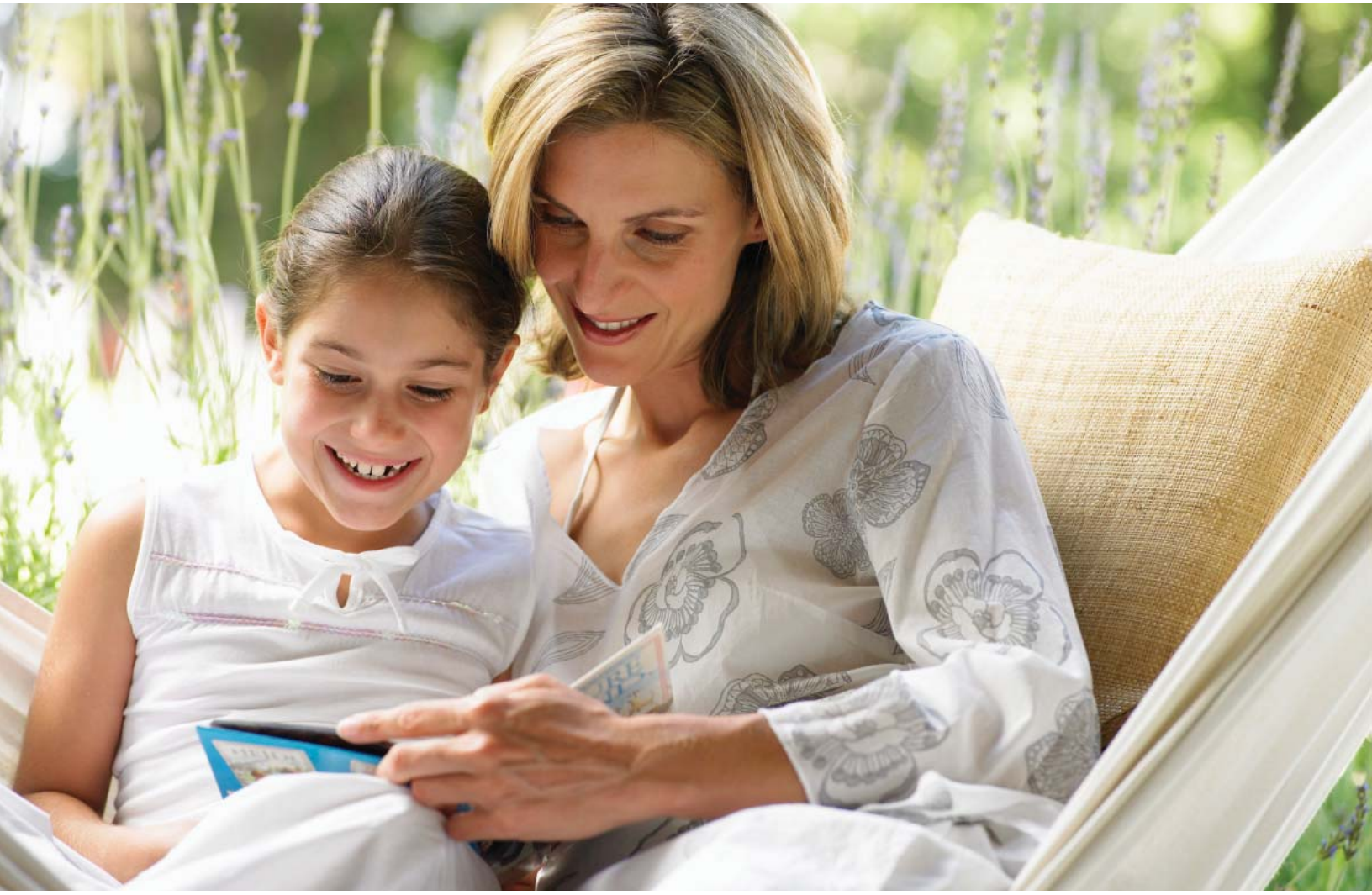
Group Voluntary Life Insurance

For City of Spokane Employees
Protecting What's Priceless



Standard Insurance Company

Group Voluntary Life Insurance

TheStandard®

About This Booklet

This booklet is designed to answer some common questions about the group Voluntary Life insurance coverage offered to the eligible employees in your company. It is not intended to provide a detailed description of the coverage. Features of the coverage may vary by state.

If coverage becomes effective and you become insured, you will receive a certificate containing a detailed description of the insurance coverage including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. Neither this booklet nor the certificate modify the group policy or the insurance coverage in any way.

Voluntary Life Insurance Features

It's not easy to think about, but what if you suddenly died? Could your family live without your income? Would your family be able to cover the medical expenses associated with a terminal illness or with burial and funeral expenses?

You make a great investment in your family. You spend time with them. You care for them. You work for them. And if you're not there for them, you want them to be protected. By sponsoring Voluntary Life insurance from Standard Insurance Company, your employer offers you an excellent opportunity to help protect your loved ones.

The advantages to you and your loved ones include:

- **Choice** - You decide how much coverage you need from the range of amounts available
- **Flexibility** - If your needs change, you can apply to change the amount of your coverage
- **Convenience** - With premiums deducted directly from your paycheck, you don't have to worry about mailing monthly payments
- **Peace of mind** - You can take comfort and satisfaction in knowing that you have done something positive for your family's future

Commonly Asked Questions

The following information provides details to give you a better understanding of the Voluntary Life insurance available from The Standard.

How Much Coverage Do I Need?

It can be difficult to determine the amount of insurance you need. Each family has its own unique set of circumstances, combined with needs that may arise with the unexpected loss of life.

Use the worksheet below to guide you in calculating the amount of Voluntary Life insurance you may need. The final total is the amount of Life insurance you might want to consider applying for to meet your obligations. Once you determine how much coverage you need, complete the Enrollment form found in the back of this booklet and submit it to Employee Benefits.

Voluntary Group Life Insurance Worksheet

Immediate Needs	You	Your Spouse
Medical and hospital expenses	$ _____	$ _____
Funeral/burial expenses	_____	_____
Taxes		
Federal and state income taxes	_____	_____
Property taxes	_____	_____
Federal and state estate taxes	_____	_____
Loans/debts requiring payment upon death	_____	_____
Long Term Needs		
Mortgage	$ _____	$ _____
Debts (credit cards, car and student loans, etc.)	_____	_____
Educational/vocational fund	_____	_____
Childcare expenses	_____	_____
Emergency fund for unforeseen expenses	_____	_____
Income Replacement		
Consider the income needed to support your family and the number of years that support is needed.	$ _____	$ _____
Total Income Needs		
Add all of the above.	$ _____	$ _____
Available Resources		
Existing Life insurance coverage	$ _____	$ _____
Other assets such as 401(k), stocks, bonds, etc.	_____	_____
Total Available Resources		
Add all of your available resources.	$ _____	$ _____
Total Life Insurance Needed		
Subtract the amount of your total available resources from your total income needs.	$ _____	$ _____

Am I Eligible For Coverage?

If you are an active employee, regularly working at least 30 hours each week, other than a temporary seasonal, contract or project employee, or full time member of any country's armed forces, you are eligible to apply for coverage as a group member.

For coverage to become effective, members must complete any required eligibility waiting period and satisfy applicable evidence of insurability requirements (see next page). Members must also meet the active work requirement: Active work and actively at work mean performing the material duties of your own occupation at your employer's usual place of business.

How Much Insurance May I Purchase For Myself?

The amount of insurance you may apply for as an eligible employee depends upon the design of the Voluntary Life insurance plan offered by your employer.

With an increment-based plan design, eligible employees may apply for insurance coverage for themselves in increments of $10,000, from a minimum of $10,000 to a maximum of $300,000.

May I Purchase Insurance For My Dependents?

Spouse Coverage: If you become insured, you can apply to purchase insurance for your spouse in increments of $10,000 up to $300,000. You cannot, however, purchase more insurance for your spouse than for yourself. (The combined maximum amount of Life Insurance and Dependent Life Insurance for your spouse may not exceed $300,000.)

Dependent Children Coverage: If you become insured, you can apply to purchase insurance for your dependent children in amounts of $2,000, $5,000 or $10,000. All of your children will be insured for the same amount. Children may not be insured by more than one member.

Note: Subject to state variations, dependent children eligible for coverage are defined as natural or adopted children, or step-children living in your home. Dependent children may be covered from live birth through age 25. Dependents who are full-time members of the armed forces of any country are not eligible for coverage.

What Is Guarantee Issue?

If you apply for insurance during your initial 31-day enrollment period and meet the active work requirement, you will automatically qualify for a set amount of insurance coverage called guarantee issue. This means that you will not have to answer medical questions to purchase coverage up to the guarantee issue amount during this period.

If you apply to cover your dependents within 31 days of becoming eligible for Dependents Life insurance, your spouse will also qualify for a limited amount of insurance (guarantee issue) without answering medical questions.

The guarantee issue amounts for this plan are as follows:

Member	$50,000
Spouse	$20,000
Dependent Child(ren)	$10,000

Guaranteed Issue is not applicable for member or spouse if increasing coverage.

What If I Want More Than The Guarantee Issue Amounts Or If I Want To Purchase Insurance After The Initial Eligibility Period?

Applications for insurance over the guarantee issue amounts, or made beyond the first 31 days of eligibility, are subject to evidence of insurability requirements. Providing evidence of insurability means that, at a minimum, applicants must complete and submit a Medical History Statement. Some applicants may be required to provide additional information or take a physical exam, which may include blood testing and urinalysis. Your medical history can be submitted at **www.standard.com/mybenefits/mhs_ho.html** or by using the form found in the back of this booklet. If you have any questions, please contact Employee Benefits.

How much will the Voluntary Life Coverage Cost Me?

Use the following Voluntary Life rates to determine the monthly premium for you, your spouse and/or children.

Monthly Cost Per $10,000 of Benefit
Member or Spouse

Age[1]	Tobacco Use	Tobacco Free
0-29	$1.20	$0.80
30-34	$1.40	$0.90
35-39	$1.40	$0.90
40-44	$2.40	$1.60
45-49	$4.40	$2.90
50-54	$7.00	$4.60
55-59	$11.20	$8.10
60-64	$14.50	$9.70
65-69	$23.80	$17.10
70+	$38.30	$28.50

Child(ren) Rates

Cost	Coverage Amount
$0.40	$2,000
$1.00	$5,000
$2.00	$10,000

Cost Summary Example

Monthly cost for a member, age 38, tobacco free, purchasing $50,000 on self, $20,000 on Spouse (age 34, tobacco free); and $5,000 on Child(ren):

Member	=	$50,000[2]	=	5 x $10.000	=	$4.50
Spouse	=	$20,000[2]	=	2 x $10,000	=	$1.80
Child(ren)	=	$5,000	=	N/A	=	$1.00

Total Monthly Payroll Deduction = $7.30

[1] Rates based on age as of January 1 of current year.
[2] Amount above the Guaranteed Issue levels require approval of Evidence of Isurability.

When Does My Coverage Over The Guarantee Issue Go Into Effect?

Your life insurance will go into effect the first day of the calendar month coinciding with or next following the date we approve your application. If sickness, injury or pregnancy prevents you from working the day before this date, insurance won't go into effect until the day after you complete one full day of active work as an eligible member. The same rule applies to an increase in your insurance.

How Are Benefits Paid?

The Standard pays benefits of $25,000 or more to beneficiaries by depositing funds into convenient, no-fee, interest-bearing draft accounts. Each beneficiary receives a personalized checkbook and has complete control of the account. Beneficiaries can write checks as needed or for the full amount.

This arrangement allows beneficiaries to earn interest on their benefits while making difficult, but important, financial decisions.

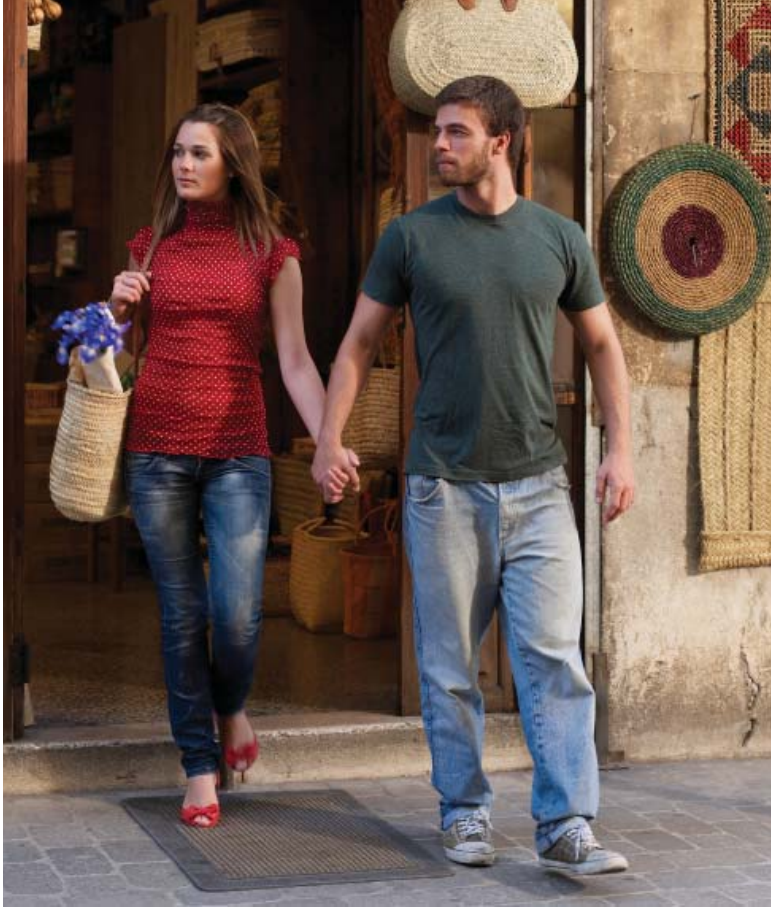
If the amount payable is less than $25,000, The Standard will pay it in a lump sum.

Will Insurance Benefits Be Reduced With Age?

There is a graded reduction in insurance beginning at age 70. The following table shows the graded reduction. To determine the benefit at different ages, take the benefit that would have been available to the member or spouse before turning age 70 and multiply by the applicable percentage.

Example: a 72-year-old woman whose benefits were $10,000 at age 69 are now $6,500 ($10,000 x 0.65).

Age	Percentage
70-74	65
75-79	45
80-84	30
85-89	20
90-94	15
95+	10



What If I Leave My Current Employer?

You are eligible to take your coverage with you if you leave your current employer. This provision of the plan is known as continuation of coverage or portability. If continuation of coverage is approved, then dependents coverage can also be continued.

What Happens If My Insurance Ends?

If your Voluntary Life or Dependents Life insurance from The Standard ends or reduces for any reason other than failure to pay premiums, the Right to Convert provision allows you to convert your Voluntary Life or Dependents Life coverage to certain types of individual life insurance policies without having to submit a Medical History Statement. You must apply for conversion and pay the required premium within 31 days after group coverage ends or reduces.

What Happens If I'm Totally Disabled And Can't Work?

If you become totally disabled before age 70 and meet other eligibility requirements, Life insurance coverage may be continued under this insurance plan's waiver of premium provision. This provision allows coverage without premium payments until the first day of the calendar month coinciding or the next month following the date you reach age 70.

What Happens If I Become Terminally Ill?

With the Accelerated Benefit provision,[1] you may be eligible to receive up to 75 percent of your Life insurance benefits early if you become terminally ill, have a life expectancy of less than 12 months and meet other eligibility requirements. You can then use funds from your accelerated benefit to pay bills, medical expenses or anything else you choose. There are no restrictions on how this money may be spent.

When Does My Coverage End?

Your Voluntary Life insurance coverage automatically ends on the earliest of these dates:

- The date the last period ends for which you made a premium contribution
- The date the group policy terminates
- The date your employer's participation under the group policy terminates
- The date your employment terminates, unless you apply for continuation of insurance (portability)
- The last day of the calendar month in which you cease to be an eligible member of the plan

Dependents Life insurance coverage for your dependents automatically ends on the earliest of these dates:

- The date you die. As a result of your death, portability will not be available to your surviving spouse or children.
- The date your Voluntary Life insurance ends; however, if your Voluntary Life insurance ends because your employment with your employer terminates, you may have the right to continue your Dependents Life insurance under the continuation of insurance (portability) provision
- The date the last period ends for which you made a premium contribution for Dependents Life insurance
- The date your employer's participation under the group policy for Dependents Life insurance ceases
- For your spouse, the date of your divorce
- For any dependent, the date the dependent ceases to be a dependent
- For a disabled child, 90 days after The Standard mails you a request for proof of disabled child status, if proof is not given

[1] The Accelerated Benefit provision is subject to state variations.

How Do I Apply?

Determine how much coverage you need, and then complete the Enrollment Form provided and return it to Employee Benefits. If you are applying for insurance over the guarantee issue amount, you may submit your medical history information at **www.standard.com/mybenefits/mhs_ho.html** or complete the Medical History Statement in the back of this booklet. Your Employee Benefits Staff can answer any questions you may have about the enrollment process.

Additional Questions?

If you have any questions, please contact your Employee Benefits Staff.

Standard Insurance Company
Portland, Oregon

Standard Voluntary Insurance
Enrollment Form
Increment Plan

Check with Employee Benefits, or call Standard at 1-800-378-4668, if you have any questions concerning the coverage options that apply to your group. If you are requesting coverage in excess of the Guarantee Issue Amount, requesting an increase in existing coverage, or if this is a late application, you must complete a medical history form, which is included in this booklet or online by going to www.standard.com/mybenefits/mhs_ho.html.

EMPLOYER USE ONLY

Employer Name **City of Spokane** Group I.D. - VT **100054**
Employer Telephone # ( ) Division Billing Category

MEMBER INFORMATION

Your Name
(Last, First, Middle)
Social Security # Date of Birth ☐ Male ☐ Female
Your Address
City State Zip Phone: Home ( ) Work ( )
Earnings $ Per: ☐ Year ☐ Month ☐ Week ☐ Hour Hours worked per week
Date of Hire Job Title
Spouse Name
(Last, First, Middle)
Social Security # Date of Birth ☐ Male ☐ Female
Have you used tobacco in any form in the last 12 months? Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

REASON FOR APPLICATION

☐ Member: ☐ Initial Enrollment
☐ Reinstatement / Rehire Date.....
☐ Adding Dependents: Date of marriage.....
Date of birth / adoption.....
☐ Change in Beneficiary

VOLUNTARY COVERAGE

Coverage(s) applying for: ☐ Life
☐ Member Amount Requested..... $
☐ Spouse Amount Requested..... $
☐ Child ☐ $2,000 ☐ $5,000 ☐ $10,000

BENEFICIARY

BENEFICIARY – **Please see reverse side of form for Beneficiary Rules and Instructions.**

PRIMARY – Full Name	Address	Social Security #	Date of Birth	Relationship

CONTINGENT – Full Name	Address	Social Security #	Date of Birth	Relationship

SIGNATURE

I hereby apply for insurance under the provisions of the Group Policy(ies) for which I am eligible. I authorize deductions from my wages to cover the cost of this insurance. I represent that the statements contained herein are true and complete, to the best of my knowledge and belief. I acknowledge that I have read the Fraud Notice which pertains to my state of residency on the back of this form.

Member Signature Required Date *(Mo/Day/Yr)*

Beneficiary Rules

If there is not enough room on this form to name all your Beneficiaries, please make your entire designation on a separate sheet of paper, following the format shown on the front of this form. Be sure to sign and date the separate sheet, and attach it to this form.

Your designation: (1) revokes all prior designations; and (2) applies to all of your Voluntary Life Insurance and Accidental Death and Dismemberment Insurance, if any. Dependents Insurance, if any, is payable to you, if living, or as provided under the terms of your Employer's coverage under the Group Policy. Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary*(ies)*. Unless specified otherwise: (1) benefits will be divided equally between Beneficiaries in the same class (primary or contingent); and (2) if a Beneficiary predeceases you, the Beneficiary's share will be divided equally among surviving Beneficiaries of the same class. If no Beneficiary (primary or contingent) survives you, payment will be made under the terms of your Employer's coverage under the Group Policy.

Beneficiary Instructions

- Please provide the full name and address, Social Security Number, date of birth and relationship of your Beneficiary*(ies)*.

- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."

- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.

FRAUD NOTICES

FOR RESIDENTS OF ARKANSAS, COLORADO, KENTUCKY, NEW MEXICO, AND 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.

FOR RESIDENTS OF FLORIDA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

FOR RESIDENTS OF PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Standard Insurance Company
Medical Underwriting, 900 SW Fifth Avenue Portland OR 97204

City of Spokane
Medical History Statement

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)
City of Spokane		**100054**	☐ Member/Employee ☐ Spouse ☐ 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 ☐M ☐F	Birth Date (Mo/Day/Year)	Birthplace	Social Security Number	Work Phone ( ) Home Phone ( )

APPLICATION INFORMATION

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

☐ 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			

Applicant Name	Social Security Number

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. 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? ☐ 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 disorder, or digestive system disorder? ☐ Yes ☐ No
   - B. Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, deafness, or another neurological or muscle disorder? ☐ Yes ☐ No
   - C. Cancer (malignancy or growth), leukemia, lymphoma, chronic anemia, or blood clotting (thrombophlebitis, pulmonary embolism)? ☐ Yes ☐ No
   - D. Cardiovascular disease, heart ailment, arteriosclerosis, chest pain, high blood pressure, heart murmur, valve, circulatory or vascular disorder? ☐ Yes ☐ No
   - E. Emphysema, asthma, chronic bronchitis, sleep apnea, or other 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, or arthritic conditions? ☐ Yes ☐ No
   - H. Endocrine (including thyroid or adrenal), diabetes? ☐ Yes ☐ No
   - 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? ☐ Yes ☐ No
   - J. Psychiatric or mental condition, depression, adjustment disorder, affective disorder, or obsessive-compulsive disorder? ☐ Yes ☐ No
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
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? ☐ Yes ☐ No
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
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

Height _____ **Weight** _____

DETAILS OF ANY "YES" ANSWERS ABOVE

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.

Question #	Diagnosis/Description	Month/Year	Details/Current Status	Physicians Consulted, City and State

Applicant Name	Social Security Number

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.

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

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

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.
- LOUISIANA, NEW MEXICO: 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.
- MARYLAND, RHODE ISLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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, VIRGINIA, 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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To learn more about The Standard, visit us at **www.standard.com**. For more information about Group Voluntary Life insurance from The Standard, contact your human resources department.

* As of June 30, 2010, based on internal data developed by Standard Insurance Company.

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