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Standard Insurance Company

ENROLLMENT FORM AND MEDICAL HISTORY STATEMENT

Medical Underwriting
900 SW Fifth Ave • Portland OR 97204-1282

FOR RESIDENTS OF CALIFORNIA. *DIRECTIONS: This form must be completed when Evidence Of Insurability is required under your plan. To apply for coverage (as a Member, Spouse or Child), read the notice(s) on page 3. Then complete all items, sign, and date below. When finished, send the original to Standard Insurance Company, and keep a copy for your records. If both the Member and his/her Dependent(s) (Spouse and/or Child) are applying, each must complete one of these forms.*

NAME OF GROUP	GROUP NUMBER	TYPE OF APPLICATION	DATE OF EMPLOYMENT WITH THE STATE OF CALIFORNIA	DATE OF MEMBERSHIP IN P.E.C.G.
P.E.C.G.	608009 or 641094	☐ INITIAL ☐ INCREASE IN COVERAGE		

MEMBER'S NAME	BIRTHDATE	SOCIAL SECURITY NO.	OCCUPATION	CHECK WHO IS APPLYING (ONE PER FORM) ☐ MEMBER ☐ SPOUSE ☐ CHILD

APPLICANT'S NAME (PERSON TO BE INSURED)	APPLICANT'S ADDRESS (STREET, CITY, STATE, ZIP)	WORK PHONE ( ) HOME PHONE ( )

SEX ☐M ☐F	BIRTHDATE	BIRTHPLACE	SOCIAL SECURITY NO.	BASE MONTHLY EARNINGS FROM THE STATE OF CALIFORNIA $ _____

Please check option desired:

☐ 1. Supplemental Plan *(Member Only)* $26,000
The Medical History Statement must always be completed if you have been employed by the State of California more than 90 days.
Please complete the Beneficiary Designation below and then, if applicable, answer the medical questions on page two.

☐ 2. Basic Dependents Life *(Spouse and Children)* $5,000
If you do not apply for Basic Dependents Life within 31 days of your approval for Supplemental Life, your dependents will need to complete the Medical Questions on page two. Your Dependents may become insured for Basic Dependents Life only if you are insured under the Supplemental Plan (option 1 above). **Please have each Dependent complete a separate medical history statement, if applicable.**

☐ 3. Supplemental Plus *(Member Only)* Any Multiple of $15,000, up to $495,000. (E.g. $15,000, $30,000, $45,000, $60,000, etc.)
Amount Requested $ _____
The Medical History Statement must always be completed. A physical examination and/or medical records may be required for evaluation. You may become insured under the Supplemental Plus plan only if you are insured under the Supplemental Plan (option 1 above). **Please complete the Beneficiary Designation below and then answer medical questions on page two.**

☐ 4. Supplemental Plus Dependents Life *(Spouse Only)* Any Multiple of $15,000, up to $255,000. (E.g. $15,000, $30,000, $45,000, $60,000, etc.)
Amount Requested $ _____
Amount requested must not exceed 50% of the Member's total Life Insurance Amount. The Medical History Statement must always be completed. A physical examination and/or medical records may be required for evaluation. Your spouse may become insured for Supplemental Plus Dependents Life only if you are insured under the Supplemental Plus Plan (option 3 above). **Please have your Spouse answer the medical questions on page two.**

☐ 5. Life Only *(Excludes Accidental Death Benefits)*
Do not check if you want Accidental Death Benefits included with options 1 and 3 above.

☐ 6. Long Term Disability *(Member Only)* ☐ 60 days ☐ 90 days ☐ 180 days
Premium rates are based on whether or not you use tobacco. Check one of the following:
☐ I use tobacco ☐ I do not use tobacco

The Medical questions on page two must always be completed. A physical examination and/or medical records may be required for evaluation.

You must be insured under the Supplemental Plan (option 1) to be eligible for the "Supplemental Plus" plan (option 3) and "Basic Dependents Life" plan (option 2). You must be insured under the "Supplemental Plus" plan (option 3) to be eligible for the "Supplemental Plus Dependents Life" plan (option 4).

BENEFICIARY DESIGNATION

Complete beneficiary designation for Life and Life/AD&D coverages above. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 3 for further beneficiary information.

Primary – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Contingent – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

SIGNATURE OF APPLICANT _____ **DATED** _____

For approved applicants, premiums shall be paid in accordance with the provisions of the Group Policy(ies). Declinations do not affect either Guarantee Issue Amounts not subject to Evidence Of Insurability or other coverages already inforce with Standard Insurance Company. Coverage will be subject to all applicable terms and conditions of the Group Policy(ies) and state limitations.

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

1. Have you had any physical, mental or emotional condition, injury, sickness, or surgery in the past 5 years? ☐ Yes ☐ No
2. Have you consulted or been attended by a physician or practitioner for any cause in the past 5 years? ☐ Yes ☐ No
3. Are you now unable to work full time because of any physical, mental or emotional condition, injury, or sickness? ☐ Yes ☐ No
4. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
   - A. High blood pressure, cardiovascular disease, heart ailment, arteriosclerosis, or stroke? ☐ Yes ☐ No
   - B. Mental condition, depression, epilepsy, or nervous system disorder? ☐ Yes ☐ No
   - C. Cancer, diabetes, or nephritis? ☐ Yes ☐ No
   - D. Arthritis, strained or injured back, slipped disc, or any bone, joint, or muscle disorder? ☐ Yes ☐ No
   - E. Lung, kidney, stomach, genital, urinary, or intestinal ailment? ☐ Yes ☐ No
   - F. Blindness or deafness? ☐ Yes ☐ No
   - G. Acquired Immune Deficiency Syndrome (AIDS), AIDS–Related Complex (ARC), or an immune system disorder? ☐ Yes ☐ No
5. Have you sought or received advice or treatment for the use of alcohol or drugs in the past 10 years? ☐ Yes ☐ No
6. In the past 10 years have you had a persistent cough, unintentional weight loss of 10 pounds or more, persistent fatigue, persistent lymph node enlargement, prolonged night sweats, pneumonia, lesions, or growths? ☐ Yes ☐ No
7. Do you take medication for any physical, mental or emotional condition, injury, or sickness? ☐ Yes ☐ No
8. Do you plan any operation or visit to a doctor or practitioner for an existing physical, mental or emotional condition, injury, or sickness? ☐ Yes ☐ No
9. Are you now pregnant? ☐ Yes ☐ No

HEIGHT	WEIGHT	PHYSICIAN OR MEDICAL FACILITY WITH APPLICANT'S COMPLETE MEDICAL RECORDS
		NAME FULL MAILING ADDRESS

Describe below any "yes" answers which were given for questions above. (Please provide the entire question number.)

Question #	*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 on page 1 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 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 of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by 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, Standard's liability is limited to the return of any premium which may have been paid.

I acknowledge that I have read and received the Information Practices Notice (on page 3) and I have kept a copy of this Medical History Statement.

To any physician, health care provider, hospital, insurance or reinsurance company, the Medical Information Bureau, Inc. (MIB), or any employer: I authorize you to release to Standard or its reinsurers all medical information you have about me including medical history, diagnosis, prognosis and treatment of any physical, mental or emotional condition. I understand that Standard will use the information obtained by this authorization to determine my eligibility for group insurance coverage. I further authorize Standard to release this information to its reinsurers, MIB, and to other insurance companies to which I have applied for insurance coverage or benefits.

I understand a copy of this authorization will be provided upon request. This authorization will remain valid one year from the date below. A photocopy of this authorization shall be as valid as the original. I understand that I have the right to revoke this authorization at any time by sending a written statement to Standard. I understand that the revocation of the authorization, or the failure to sign the authorization, may impair Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.

SIGNATURE OF APPLICANT (OR MEMBER FOR DEPENDENT CHILD) **DATED**

PLEASE RETAIN A COPY FOR YOUR RECORDS.

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. (Medical Information Bureau). We will use the authorization you signed on this form when we seek this information.

MIB (MEDICAL INFORMATION BUREAU) – 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 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: Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

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 insurance, or to whom a claim for benefits may be submitted.

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 97204-1282 or call 1-800-843-7979.

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:

  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.

- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.
- 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.

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