Reset

IDI Application Checklist and Cover Sheet

Standard Insurance Company, Individual Underwriting P7B
1100 SW Sixth Avenue Portland OR 97204-1093

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)
- ☐ Student Loan Application (if applicable)

Conditional Receipt (optional):

- ☐ Must be signed same date as application
- ☐ Premium amount included $_____ (must be equal to one month or greater)
- ☐ Check, One-Time Premium Payment or EFT form submitted with application (if EFT form, one time debit section filled out)

For business products, please include the required supplemental form(s).

Business Overhead Expense

- ☐ Business Overhead Application Supplement (2967)

Business Buy-Out Expense

- ☐ Certification of Buy/Sell Agreement (7204)
- ☐ Disability Buy-Out Fact Sheet Application Supplement (7202)

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)

UNDERWRITING INFORMATION

- ☐ Matching illustration attached (contact sales for assistance)

Student/New Professional Limits? Yes ☐ No ☐
Is this Simplified Underwriting? Yes ☐ No ☐

If No, is income documentation attached?
Yes ☐ No ☐

If No, have labs been ordered?
Yes ☐ No ☐

(If labs have been completed with another carrier within the last 12 months, provide barcode or copy of lab slip)

_____

Is this a TeleApp? Yes ☐ No ☐
If Yes, has the TeleApp been ordered? Yes ☐ No ☐
Order Date_____ Referral #_____
Note other requirements or notes/comments here:

_____
_____
_____

GIVE TO APPLICANT:

- Disclosure Notice – Information Practices
- HIV information from application packet
- Copy of Conditional Receipt (only if premium collected)
- Copy of Replacement Notice
- Outline of Coverage required in the following states: **CA, GA, ID, ME, MT, NV, NH, SD, TX, WI, WV**
- Guaranty Association Notice from application packet: **MN**
- Any other miscellaneous or state-specific form provided in the application packet

Print (11/18)

Reset

Standard Insurance Company

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

Producer Information Report for Application for Disability Insurance

For use in: CA, CT, DC, FL

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)

   _____

   _____

8. Discounts applied, if any (Please review the Discounts section of the Product Guide for requirements)

   ☐ Employer Multi-Life
   Employer's Name _____
   Employer's TIN _____
   In the Remarks area below, list the names and policy numbers of the other employees or business owners who have submitted applications and requested the discount.

   ☐ Multi-Product
   Other product applied for _____

   ☐ Business Owner (20% or more ownership)

   ☐ Resident Multi-Life (Platinum Advantage Only)
   ACGME/AOA/CODA Institution:

   _____

9. Has TeleApp been ordered? ..... ☐ Yes ☐ No
   Referral Number _____ Date and time scheduled _____

10. **Remarks.** Also, note anything not disclosed in the application that might affect the proposed insured's insurability.

    _____

    _____

I Declare That: I gave the Disclosure Notice - Information Practices to the proposed insured. This application was read and signed by the proposed insured and owner, if different, after all required questions were asked and answered. I have accurately recorded on this application all information given to me by the proposed insured and owner, if different. Regardless of whether medical questions will be asked of the proposed insured in any telephone or other interview process, I know of nothing affecting the risk that is not recorded on this application or in any accompanying written statement or letter.

_____ _____

Producer Signature Date

Print (9/19)

Reset

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

Application for Disability Insurance
Part I

Proposed Insured

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

4. Home Address _____ City _____ State _____ Zip Code _____

5. Current Primary Occupation _____ 6. Email Address (optional) _____

7. Date of Birth _____ 8. State of Birth _____ 9. Length of US Residence _____ 10. Driver's License No./Issue State _____

11. Phone Numbers HOME( ) _____ WORK( ) _____ OTHER( ) _____ 12. Preferred Place to Call ☐H ☐W ☐OTHER

13. Rates Illustrated as: ☐SMOKER ☐NONSMOKER ☐OTHER
14. Occupation Class: ☐5A ☐4A ☐4P ☐3A ☐3P ☐2A ☐2P ☐A ☐B
15. Premium Mode: ☐EFT (MONTHLY) ☐LIST BILL (MONTHLY) ☐ANNUAL ☐OTHER _____

Insurance Applied For

16. Plan Type & Features:

A. Disability Income

BASIC MONTHLY BENEFIT $_____
BENEFIT WAITING PERIOD _____ DAYS
BENEFIT PERIOD _____
SELECT ONE:
☐ **PROTECTOR PLATINUM**SM ☐ **PROTECTOR ESSENTIAL**SM
SELECT ADDITIONAL BENEFIT(S):
☐ NONCANCELABLE (PLATINUM ONLY)
☐ INDEXED COST OF LIVING: ☐ 3% / ☐ 6%
☐ CATASTROPHIC $_____ (PLATINUM ONLY)
☐ FUTURE PURCHASE OPTION
$_____ POOL AMOUNT
☑ PARTIAL DISABILITY (ALWAYS INCLUDED)
☐ OTHER _____

B. Business Overhead Expense

(Application Supplement required) BASE AMOUNT $ _____
WAITING PERIOD _____ DAYS
BENEFIT MULTIPLE _____ MONTHS
☐ PARTIAL DISABILITY
☐ FUTURE PURCHASE OPTION $_____
OTHER _____

C. 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
OTHER _____

Other Insurance Coverage

17. 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 12 months? ..... ☐YES ☐NO
    c. Is there any other individual or group disability insurance currently in force or pending on you? ..... ☐YES ☐NO

STATUS CODES: NOW IN FORCE WITH STANDARD INSURANCE COMPANY (STANDARD) OR OTHER COMPANY (**N**); PENDING (**P**); APPLIED FOR IN THE LAST 12 MONTHS (**A**); WILL BECOME ELIGIBLE IN THE NEXT 12 MONTHS (**F**).

TYPE CODES: INDIVIDUAL (**I**); SOCIAL SECURITY SUBSTITUTE (**S**); GROUP (**G**); ASSOCIATION (**X**); OVERHEAD EXPENSE (**OE**); OTHER (**O** - EXPLAIN).

COMPANY AND POLICY NUMBER:	STATUS:	TYPE:	MONTHLY AMOUNT:	BENEFIT PERIOD:	WAITING PERIOD:	IF GROUP: WHO PAYS PREMIUM?	IF GROUP: BENEFIT CAP MAXIMUM?	IF GROUP: % OF INCOME:	WILL COVERAGE BE REPLACED OR REDUCED?
									☐YES ☐NO
									☐YES ☐NO
									☐YES ☐NO

Note: By signing the Agreement in Part III, the owner agrees to terminate or reduce the insurance coverage indicated as being replaced or reduced after a Standard policy is delivered. The owner understands that, if that insurance is not terminated or reduced as required by Standard, any policy issued based on this application may be rescinded.

Proposed Insured_________________________________

General, Financial and Avocation Information

18. Your current annual earned income from your current primary Occupation is $__________. For last year it was $_________. "Earned income" means: salary, other compensation for services rendered or commissions. If you are self employed, earned income is after business expenses, but before personal income taxes. Explain any significant fluctuations between years. Do not include any income that is not reported to the IRS. Do not include investment or other unearned income.
19. Complete questions a and b only if the amount of disability coverage currently in force plus the amount applied for exceeds $5,000 per month:
    a. Is unearned income greater than 25% of earned income or $50,000? Unearned income includes: capital gains, interest, dividends, net rental income, pensions, annuities, royalties. .... ☐YES ☐NO
    b. Is net worth, excluding primary residence, greater than $6,000,000? .... ☐YES ☐NO
20. Will your employer pay for any part of this requested insurance? .... ☐YES ☐NO
    If YES, answer a, b and c. If NO, go to question 21.
    a. What percent of premium will employer pay?________%
    b. Will employer's contribution be included in your taxable income? .... ☐YES ☐NO
    c. Will you reimburse employer for any premium? .... ☐YES ☐NO
21. Are you currently working in your primary occupation at least 30 hours per week? .... ☐YES ☐NO
    If NO, please explain in REMARKS.
22. 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 23.
    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____________________________
23. Have you ever applied for life, disability or health insurance and had it declined, postponed or withdrawn; or has any such policy issued on you been modified, or rated up or canceled; or has renewal of any such policy been refused? If YES, please explain.. ☐YES ☐NO
24. Have you been alerted to, received orders for, or had any indication of an overseas assignment or active service with any armed forces or military unit? .... ☐YES ☐NO

QUESTION NUMBER:	**REMARKS AREA.** EXPLAIN ALL YES ANSWERS. GIVE ADDITIONAL INFORMATION REGARDING ANY QUESTIONS AND RESPONSES SHOWN ON THIS APPLICATION.

If TeleApp complete 24A; then go to Part III. If Traditional process, skip 24A and proceed to Part II.

24A. In the last 5 years have you had, been treated for, or been diagnosed as having: A heart condition; chest pain; stroke; back or neck problem; psychological condition including, but not limited to, counseling from a mental health or substance abuse provider, and/or psychotherapy; cancer; diabetes; alcohol or drug abuse or dependency? ....☐YES ☐NO
If YES, give details in the REMARKS area above. Include date, diagnosis, duration and severity; treatment and results; and include health care provider name(s) and address(es).

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

Application for Disability Insurance
Part III

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 includes Parts I, II and III, and all signed application supplements and amendments. If this is a TELEAPP, this application also includes all questions Standard Insurance Company (Standard) or its representatives will ask the proposed insured, and all answers given in response to those questions, after I sign this form. This application will become part of the policy issued by Standard based on this application.

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 signed and dated by the proposed insured and owner, if different. **No insurance will be in force until: (a) 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, change any of Standard's requirements, or 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 17 of Part I be permanently terminated or reduced as a condition of issuing the insurance applied for. 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 in accordance with the TIME LIMIT ON CERTAIN DEFENSES provision of the policy. I REPRESENT that: All answers in this application are true and complete to the best of my information and belief and correctly recorded; and that any and all answers I have provided to any Standard representative are recorded in this application. 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. I signed this application in the city and state and on the date shown below.

NOTE: A person commits a fraudulent act when that person knowingly files an application for insurance which either contains materially false information or conceals material information with intent to mislead.

_____ Signed at _____ _____ on____/____/_____
Signature of Proposed Insured City State Date

_____ Signed at _____ _____ on____/____/_____
Signature of Policyowner (If Other than Proposed Insured) City State 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 rep and co. name.

_____ _____
Owner's Address City, State Zip Code Email Address (optional)

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.

_____ Signed at _____ _____ on____/____/_____
Signature of Soliciting Producer City State Date

Individual Disability Insurance

Telephone Interview

What to Expect

Thank you for your interest in individual disability insurance from The Standard.‡ Your insurance representative has ordered a telephone interview, or "TeleApp," as part of the application process.

Your appointment is scheduled for:

_____ **a.m./p.m. on** _____
(time) (date)

If you don't have an appointment scheduled yet, a LifePlans representative will contact you to set up a convenient time for your interview.

What to Expect During Your Interview

A highly trained interviewer will ask you about your activities and health, including your work and medical history. Please allow 30 to 40 minutes for your interview.

Be prepared to provide the following information during your interview:

- Names, addresses and phone numbers of medical providers you have visited in the last 10 years
- Approximate dates of injuries, surgeries, emergency room visits, hospitalization(s), illnesses and/or conditions
- Prescription history over the last three years, including medication names, dosages, dates taken and reasons for use
- Foreign travel history for the last five years
- Name(s) of employer(s) and dates of employment

What to Expect After Your Interview

After your interview, LifePlans will send your completed interview to your insurance representative and The Standard. If approved, the final application and resulting policy with The Standard will include information you provide during your telephone interview.

When you receive your policy, review it carefully for completeness and accuracy. Incomplete, incorrect or untrue statements could affect your eligibility for benefits.

Print

‡ The Standard is a marketing name for StanCorp Financial Group, Inc., and subsidiaries. Insurance products are offered by Standard Insurance Company of 1100 SW Sixth Avenue, Portland, Oregon, in all states except New York, where insurance products are offered by The Standard Life Insurance Company of New York of 333 Westchester Avenue, West Building, Suite 300, White Plains, New York. Product features vary by state and company, and are solely the responsibility of each subsidiary. Each company is solely responsible for its own financial condition. Standard Insurance Company is licensed to solicit insurance business in all states except New York. The Standard Life Insurance Company of New York is licensed to solicit insurance business in only the state of New York.

Standard Insurance Company
The Standard Life Insurance Company of New York

www.standard.com

TeleApp Information for Customers
16459 (1/19) SI/SNY

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

Disclosure Notice - Information Practices

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, health and medical history, personal characteristics and activities, avocations, income and finances. This personal information is obtained and disclosed by us in order to evaluate your insurability, determine appropriate premium rates, support our normal business practices and 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 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 physicians, medical professionals, health care providers, hospitals, clinics, pharmacies and other medical or medically-related facilities; consumer reporting agencies, insurance sales representatives, insurance support organizations, insurance or reinsurance companies, and the MIB, Inc. (see below); employers, and personal and business associates. We may also request that you have medical examinations and tests.

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 or persons, including insurance sales representatives, that perform services or functions on your or our behalf, and to regulatory, law enforcement or governmental authorities. We or our reinsurers may also release information 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 us at the address at the bottom 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.

INVESTIGATIVE CONSUMER REPORTS: We may ask that an investigative consumer report be prepared by an independent source called a consumer reporting agency. The report is for insurance purposes only. It may include information about your character, general reputation, personal characteristics and activities and mode of living. The consumer reporting agency may obtain information for the report through personal interviews with your family members, friends, neighbors or others with whom you are acquainted. If we request a report and you wish to be interviewed, please let us know in writing and we will notify the consumer reporting agency. On written request, we will disclose to you whether or not such a report was done and provide a more detailed description of the nature and scope of the report. You have a right to receive a copy of the investigative consumer report from the consumer reporting agency. If you would like a copy of the report, please contact us and we will give you the name and address of the consumer reporting agency.

MIB, INC.: We, or our reinsurers, may make a brief report to the MIB, Inc. 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. 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.

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

Reset

Authorization to Obtain and Disclose 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 this personal information may be in paper or electronic format and may include information about my age, occupation, avocations, driving record, travel, aviation, character, general reputation, personal characteristics and activities, mode of living, income and finances and other insurance. I also understand that personal information may include medical records, in paper or electronic format, containing health information related to medical history, examinations, diagnoses, prognoses, test results, prescriptions and treatments of any physical or mental conditions.

Authorization to Obtain Personal Information
I authorize MIB, Inc., and any licensed physician, medical professional, health care provider, hospital, medical or medically-related facility, clinic, pharmacy, alcohol or drug treatment facility, insurance or reinsurance company, insurance sales representative, consumer reporting agency, government department or agency, employer, and any other person, organization or institution having records or knowledge of me, to release personal information about me, to Standard, its reinsurers, and any insurance support organization acting on behalf of Standard. I further authorize Standard to request and obtain an investigative consumer report about me from a consumer reporting agency, as described in the Disclosure Notice-Information Practices.

Authorization to Use Personal Information
I authorize Standard to use personal information obtained about me for the purposes of evaluating eligibility for insurance and reinsurance, 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 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. I understand that any health information that is disclosed pursuant to this Authorization may be subject to redisclosure as permitted or required by law and may no longer be protected by federal laws governing privacy and confidentiality of health information.

Certain Types of Health Information
I understand that certain health information cannot be released without my specific consent, in accordance with federal and state laws. I hereby expressly consent to the release of information related to my use of alcohol, drugs and tobacco; diagnosis or treatment of Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and sexually transmitted diseases; and diagnosis and treatment of psychological or mental illness (excluding psychotherapy notes). I also understand that blood, urine, saliva or other medical tests or examinations may be required to determine my insurability.

Expiration and Revocation
This Authorization will expire automatically twenty-four (24) months following the date of my signature below. 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 97204-1093. 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.

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 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*)	Date of Birth

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

Authorization for Release of Personal Psychotherapy Notes to Standard Insurance Company

Name of (Proposed) Insured/Patient (please print) _____ Date of Birth _____

I authorize any licensed physician, medical professional, health care provider, hospital, medical or medically-related facility, laboratory, clinic, pharmacy, alcohol or drug treatment facility that has provided medical treatment, care or services to me to disclose my entire medical record and any other health information **solely relating to psychotherapy notes** to Standard Insurance Company ("Standard") or an insurance support organization acting on behalf of Standard. Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of my medical record.

By my signature below, I acknowledge that any agreements that I have made to restrict my health information do not apply to this Authorization and I instruct my health care providers to release and disclose my entire medical record relating to psychotherapy notes without restriction.

I understand that the health information to be disclosed to Standard will be used for the purposes of evaluating eligibility for insurance and reinsurance, determining appropriate premium rates, evaluating claims for insurance benefits and conducting other legally permissible activities that relate to my application and insurance coverage. I also understand that any health information that is disclosed pursuant to this Authorization may be subject to redisclosure as permitted or required by law and may no longer be protected by federal laws governing privacy and confidentiality of health information.

This Authorization will expire automatically twenty-four (24) months following the date of my signature below. 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 Underwriting, 1100 SW Sixth Avenue, Portland, Oregon 97204-1093. 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 collection, use or disclosure of information prior to Standard's receipt of my revocation and any action taken before Standard receives my written revocation will be valid.

I acknowledge that I have read this Authorization and that I have the right to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization is as valid as the original.

Signature of (proposed) Insured/Patient _____ Date _____

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

HIV Test Informed Consent Form

In order for us to evaluate your eligibility for insurance coverage, Standard Insurance Company (Standard) may require that you provide blood, urine and/or saliva samples for testing and analysis. One of the tests performed on these bodily fluids will determine the presence of antibodies to the human immunodeficiency virus (HIV). By signing and dating this form, you agree that the HIV antibody test may be performed on samples of your blood, urine and saliva and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

THE HIV VIRUS

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to HIV are found in most people with AIDS and AIDS-Related Complex (ARC). They can also be found in people who do not have AIDS or ARC but have been exposed to the virus. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant. Symptoms of AIDS include, but are not limited to: fever, tiredness, lymph node enlargement, pneumonia, diarrhea and certain tumors and infections.

The HIV antibody test is actually a series of tests performed upon a sample of your blood, urine and/or saliva by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory. Testing will include, but may not be limited to, antibody, antigen or viral culture.

PRE-TESTING CONSIDERATIONS

Many public health organizations have recommended that before taking an HIV test a person seek counseling to become informed concerning the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested. You may obtain further information about HIV testing and AIDS by contacting the organizations on the List of Counseling Resources in California on page 2 of this form.

DISCLOSURE AND CONFIDENTIALITY OF TEST RESULTS

All test results are confidential, except as provided by law. The results of the test will be reported to us. We may not, by law, release positive test results except as provided below.

If your HIV antibody test result is normal, you will not be notified. However, we will disclose any positive test result to you through a physician of your choice. If you do not name a physician for this purpose, we will disclose positive test results directly to you.

We may disclose abnormal test results to reinsurers involved in the underwriting process, or as otherwise allowed by law. We may also disclose positive test results to legal counsel, if such information is needed to represent us in regard to an insurance application on you.

In addition, if your HIV antibody test is abnormal, a generic code signifying a non-specific blood, oral fluid (saliva) or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB). The MIB is an organization of life insurance companies, which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test. However, there will be a record that you have some blood, oral fluid (saliva) or urine abnormality. If you apply to another MIB member company for life or disability income insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

TEST RESULTS

While a positive HIV test result does not necessarily mean that you have AIDS, it does mean that you are at serious risk of developing AIDS or AIDS-related conditions. You may be infected with the HIV virus and infectious to others. If you test positive, you should seek medical follow-up care with your personal health care provider.

HIV test results are highly reliable but not 100% accurate. If the test gives a positive result you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected persons. It takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months. If you have reason to believe that a negative test result is incorrect, you should be retested.

(THIS FORM CONTINUES ON THE NEXT PAGE.)

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

OTHER SOURCES OF INFORMATION

You may obtain further information about HIV testing and AIDS by contacting the organizations on the List of Counseling Resources in California, below.

CONSENT FOR HIV TESTING

I have read and understand this HIV Test Informed Consent Form, and I have received a copy. I voluntarily consent to the withdrawal of blood, the obtaining of my urine and saliva, and the testing of my blood, urine and saliva for HIV antibodies, and the disclosure of the test results as described in this form. A photocopy of this form is as valid as the original.

HIV/AIDS PUBLICATION

I have received a copy of the National Institute of Allergy and Infectious Diseases publication, "HIV Infection and AIDS: An Overview."

NOTIFICATION OF POSITIVE TEST RESULTS

I understand that Standard Insurance Company will disclose any HIV positive test result to me through a physician of my choice, named below. If I do not name a physician for this purpose, Standard will disclose a positive result directly to me.

_____

Name of Physician

_____

Street Address City State Zip

_____ _____

Signature of Proposed Insured or Parent/Guardian Date Signed

_____

Print Name of Proposed Insured

LIST OF COUNSELING RESOURCES IN CALIFORNIA

The following counseling centers can assist you in understanding the meaning of the Human Immunodeficiency Virus (HIV) Antibody Test and its results.

SAN FRANCISCO AIDS FOUNDATION
25 Van Ness Avenue, Suite 660
San Francisco, CA 94102
(415) 864-5855

SACRAMENTO AIDS FOUNDATION
1900 K Street, Suite 201
Sacramento, CA 95814
(916) 448-2437

CENTRAL VALLEY AIDS TEAM
P.O. Box 4640
Fresno, CA 93744
(209) 264-2436

AIDS PROJECT LOS ANGELES
3670 Wilshire Blvd., Suite 300
Los Angeles, CA 90010
(213) 380-2000

AIDS SERVICES FOUNDATION OF ORANGE COUNTY
1685-A Babcock Street
Costa Mesa, CA 92627
(714) 646-0411

SAN DIEGO AIDS PROJECT
3777 Fourth Avenue
San Diego, CA 92103
(619) 543-0300

AIDS PROJECT - EAST BAY
400 40th Street, Suite 20
Oakland, CA 94609
(415) 420-8181

ARIS PROJECT
595 Millich Drive, Suite 104
Campbell, CA 95008
(408) 370-3171

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

HIV Test Informed Consent Form

In order for us to evaluate your eligibility for insurance coverage, Standard Insurance Company (Standard) may require that you provide blood, urine and/or saliva samples for testing and analysis. One of the tests performed on these bodily fluids will determine the presence of antibodies to the human immunodeficiency virus (HIV). By signing and dating this form, you agree that the HIV antibody test may be performed on samples of your blood, urine and saliva and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

THE HIV VIRUS

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to HIV are found in most people with AIDS and AIDS-Related Complex (ARC). They can also be found in people who do not have AIDS or ARC but have been exposed to the virus. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant. Symptoms of AIDS include, but are not limited to: fever, tiredness, lymph node enlargement, pneumonia, diarrhea and certain tumors and infections.

The HIV antibody test is actually a series of tests performed upon a sample of your blood, urine and/or saliva by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory. Testing will include, but may not be limited to, antibody, antigen or viral culture.

PRE-TESTING CONSIDERATIONS

Many public health organizations have recommended that before taking an HIV test a person seek counseling to become informed concerning the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested. You may obtain further information about HIV testing and AIDS by contacting the organizations on the List of Counseling Resources in California on page 2 of this form.

DISCLOSURE AND CONFIDENTIALITY OF TEST RESULTS

All test results are confidential, except as provided by law. The results of the test will be reported to us. We may not, by law, release positive test results except as provided below.

If your HIV antibody test result is normal, you will not be notified. However, we will disclose any positive test result to you through a physician of your choice. If you do not name a physician for this purpose, we will disclose positive test results directly to you.

We may disclose abnormal test results to reinsurers involved in the underwriting process, or as otherwise allowed by law. We may also disclose positive test results to legal counsel, if such information is needed to represent us in regard to an insurance application on you.

In addition, if your HIV antibody test is abnormal, a generic code signifying a non-specific blood, oral fluid (saliva) or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB). The MIB is an organization of life insurance companies, which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test. However, there will be a record that you have some blood, oral fluid (saliva) or urine abnormality. If you apply to another MIB member company for life or disability income insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

TEST RESULTS

While a positive HIV test result does not necessarily mean that you have AIDS, it does mean that you are at serious risk of developing AIDS or AIDS-related conditions. You may be infected with the HIV virus and infectious to others. If you test positive, you should seek medical follow-up care with your personal health care provider.

HIV test results are highly reliable but not 100% accurate. If the test gives a positive result you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected persons. It takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months. If you have reason to believe that a negative test result is incorrect, you should be retested.

(THIS FORM CONTINUES ON THE NEXT PAGE.)

OTHER SOURCES OF INFORMATION

You may obtain further information about HIV testing and AIDS by contacting the organizations on the List of Counseling Resources in California, below.

CONSENT FOR HIV TESTING

I have read and understand this HIV Test Informed Consent Form, and I have received a copy. I voluntarily consent to the withdrawal of blood, the obtaining of my urine and saliva, and the testing of my blood, urine and saliva for HIV antibodies, and the disclosure of the test results as described in this form. A photocopy of this form is as valid as the original.

HIV/AIDS PUBLICATION

I have received a copy of the National Institute of Allergy and Infectious Diseases publication, "HIV Infection and AIDS: An Overview."

NOTIFICATION OF POSITIVE TEST RESULTS

I understand that Standard Insurance Company will disclose any HIV positive test result to me through a physician of my choice, named below. If I do not name a physician for this purpose, Standard will disclose a positive result directly to me.

_____

Name of Physician

_____

Street Address City State Zip

_____ _____

Signature of Proposed Insured or Parent/Guardian Date Signed

_____

Print Name of Proposed Insured

LIST OF COUNSELING RESOURCES IN CALIFORNIA

The following counseling centers can assist you in understanding the meaning of the Human Immunodeficiency Virus (HIV) Antibody Test and its results.

SAN FRANCISCO AIDS FOUNDATION
25 Van Ness Avenue, Suite 660
San Francisco, CA 94102
(415) 864-5855

SACRAMENTO AIDS FOUNDATION
1900 K Street, Suite 201
Sacramento, CA 95814
(916) 448-2437

CENTRAL VALLEY AIDS TEAM
P.O. Box 4640
Fresno, CA 93744
(209) 264-2436

AIDS PROJECT LOS ANGELES
3670 Wilshire Blvd., Suite 300
Los Angeles, CA 90010
(213) 380-2000

AIDS SERVICES FOUNDATION OF ORANGE COUNTY
1685-A Babcock Street
Costa Mesa, CA 92627
(714) 646-0411

SAN DIEGO AIDS PROJECT
3777 Fourth Avenue
San Diego, CA 92103
(619) 543-0300

AIDS PROJECT - EAST BAY
400 40th Street, Suite 20
Oakland, CA 94609
(415) 420-8181

ARIS PROJECT
595 Millich Drive, Suite 104
Campbell, CA 95008
(408) 370-3171

Exploring
National Institute of Allergy and Infectious Diseases
National Institutes of Health
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

October 2003

HIV Infection and AIDS: An Overview

AIDS - acquired immunodeficiency syndrome - was first reported in the United States in 1981 and has since become a major worldwide epidemic. AIDS is caused by the human immunodeficiency virus (HIV). By killing or damaging cells of the body's immune system, HIV progressively destroys the body's ability to fight infections and certain cancers. People diagnosed with AIDS may get life-threatening diseases called opportunistic infections, which are caused by microbes such as viruses or bacteria that usually do not make healthy people sick.

More than 830,000 cases of AIDS have been reported in the United States since 1981. As many as 950,000 Americans may be infected with HIV, one-quarter of whom are unaware of their infection. The epidemic is growing most rapidly among minority populations and is a leading killer of African-American males ages 25 to 44. According to the U.S. Centers for Disease Control and Prevention (CDC), AIDS affects nearly seven times more African Americans and three times more Hispanics than whites.

HOW IS HIV TRANSMITTED?

HIV is spread most commonly by having unprotected sex with an infected partner. The virus can enter the body through the lining of the vagina, vulva, penis, rectum, or mouth during sex.

HIV also is spread through contact with infected blood. Before donated blood was screened for evidence of HIV infection and before heat-treating techniques to destroy HIV in blood products were introduced, HIV was transmitted through transfusions of contaminated blood or blood components. Today, because of blood screening and heat treatment, the risk of getting HIV from such transfusions is extremely small.

HIV frequently is spread among injection drug users by the sharing of needles or syringes contaminated with very small quantities of blood from someone infected with the virus. It is rare, however, for a patient to give HIV to a health care worker or vice-versa by accidental sticks with contaminated needles or other medical instruments.

Women can transmit HIV to their babies during pregnancy or birth. Approximately one-quarter to one-third of all untreated pregnant women infected with HIV will pass the infection to their babies. HIV also can be spread to babies through the breast milk of mothers infected with the virus. If the mother takes the drug AZT during pregnancy, she can significantly reduce the chances that her baby will get infected with HIV. If health care providers treat mothers with AZT and deliver their babies by cesarean section, the chances of the baby being infected can be reduced to a rate of 1 percent.

A study sponsored by the National Institute of Allergy and Infectious Diseases (NIAID) in Uganda found a highly effective and safe drug for preventing transmission of HIV from an infected mother to her newborn. This regimen is more affordable and practical than any other examined to date. Results from the study show that a single oral dose of the antiretroviral drug nevirapine (NVP) given to an HIV-infected woman in labor and another to her baby within three days of birth reduces the transmission rate of HIV by half compared with a similar short course of AZT.

Although researchers have found HIV in the saliva of infected people, there is no evidence that the virus is spread by contact with saliva. Laboratory studies reveal that saliva has natural properties that limit the power of HIV to infect. Research studies of people infected with HIV have found no evidence that the virus is spread to others through saliva by kissing. No one knows, however, whether so-called "deep" kissing, involving the exchange of large amounts of saliva, or oral intercourse increase the risk of infection. Scientists also have found no evidence that HIV is spread through sweat, tears, urine, or feces.

Studies of families of HIV-infected people have shown clearly that HIV is not spread through casual contact such as the sharing of food utensils, towels and bedding, swimming pools, telephones, or toilet seats. HIV is not spread by biting insects such as mosquitoes or bedbugs.

HIV can infect anyone who practices risky behaviors such as

- Sharing drug needles or syringes
- Having sexual contact with an infected person without using a condom
- Having sexual contact with someone whose HIV status is unknown

Having a sexually transmitted disease such as syphilis, genital herpes, chlamydial infection, gonorrhea, or bacterial vaginosis appears to make people more susceptible to getting HIV infection during sex with infected partners.

SYMPTOMS OF HIV INFECTION

Many people do not have any symptoms when they first become infected with HIV. Some people, however, have a flu-like illness within a month or two after exposure to the virus. This illness may include

- Fever
- Headache
- Tiredness
- Enlarged lymph nodes (glands of the immune system easily felt in the neck and groin

These symptoms usually disappear within a week to a month and are often mistaken for those of another viral infection. During this period, people are very infectious, and HIV is present in large quantities in genital fluids.

More persistent or severe symptoms may not appear for 10 years or more after HIV first enters the body in adults, or within two years in children born with HIV infection. This period of "asymptomatic" infection is highly individual. Some people may begin to have symptoms within a few months, while others may be symptom-free for more than 10 years.

Even during the asymptomatic period, the virus is actively multiplying, infecting, and killing cells of the immune system. The most obvious effect of HIV infection is a decline in the number of CD4 positive T cells (also called T4 cells) found in the blood -- the immune system's key infection fighters. At the beginning of its life in the human body, the virus disables or destroys these cells without causing symptoms.

As the immune system worsens, a variety of complications start to take over. For many people, the first signs of infection are large lymph nodes or "swollen glands" that may be enlarged for more than three months. Other symptoms often experienced months to years before the onset of AIDS include

- Lack of energy
- Weight loss
- Frequent fevers and sweats
- Persistent or frequent yeast infections (oral or vaginal)
- Persistent skin rashes or flaky skin
- Pelvic inflammatory disease in women that does not respond to treatment
- Short-term memory loss

Some people develop frequent and severe herpes infections that cause mouth, genital, or anal sores, or a painful nerve disease called shingles. Children may grow slowly or be sick a lot.

AIDS

The term AIDS applies to the most advanced stages of HIV infection. CDC developed official criteria for the definition of AIDS and is responsible for tracking the spread of AIDS in the United States.

CDC's definition of AIDS includes all HIV-infected people who have fewer than 200 CD4 positive T cells (abbreviated CD4+ T cells) per cubic millimeter of blood (Healthy adults usually have CD4 positive T-cell counts of 1,000 or more.). In addition, the definition includes 26 clinical conditions that affect people with advanced HIV disease. Most of these conditions are opportunistic infections that generally do not affect healthy people. In people with AIDS, these infections are often severe and sometimes fatal because the immune system is so ravaged by HIV that the body cannot fight off certain bacteria, viruses, fungi, parasites, and other microbes.

Symptoms of opportunistic infections common in people with AIDS include

- Coughing and shortness of breath
- Seizures and lack of coordination
- Difficult or painful swallowing
- Mental symptoms such as confusion and forgetfulness
- Severe and persistent diarrhea
- Fever
- Vision loss
- Nausea, abdominal cramps, and vomiting
- Weight loss and extreme fatigue
- Severe headaches
- Coma

Children with AIDS may get the same opportunistic infections as do adults with the disease. In addition, they also have severe forms of the bacterial infections all children may get, such as conjunctivitis (pink eye), ear infections, and tonsillitis.

People with AIDS are particularly prone to developing various cancers, especially those caused by viruses such as Kaposi's sarcoma and cervical cancer, or cancers of the immune system known as lymphomas. These cancers are usually more aggressive and difficult to treat in people with AIDS. Signs of Kaposi's sarcoma in light-skinned people are round brown, reddish, or purple spots that develop in the skin or in the mouth. In dark-skinned people, the spots are more pigmented.

During the course of HIV infection, most people experience a gradual decline in the number of CD4 positive T cells; although some may have abrupt and dramatic drops in their CD4 positive T-cell counts. A person with CD4 positive T cells above 200 may experience some of the early symptoms of HIV disease. Others may have no symptoms even though their CD4 positive T-cell count is below 200.

Many people are so debilitated by the symptoms of AIDS that they cannot hold steady employment or do household chores. Other people with AIDS may experience phases of intense life-threatening illness followed by phases in which they function normally.

A small number of people first infected with HIV 10 or more years ago have not developed symptoms of AIDS. Scientists are trying to determine what factors may account for their lack of progression to AIDS, such as particular characteristics of their immune systems or whether they were infected with a less aggressive strain of the virus, or if their genes may protect them from the effects of HIV. Scientists hope that understanding the body's natural method of control may lead to ideas for protective HIV vaccines and use of vaccines to prevent the disease from progressing.

DIAGNOSIS

Because early HIV infection often causes no symptoms, a doctor or other health care provider usually can diagnose it by testing a person's blood for the presence of antibodies (disease-fighting proteins) to HIV. HIV antibodies generally do not reach detectable levels in the blood for one to three months following infection. It may take the antibodies as long as six months to be produced in quantities large enough to show up in standard blood tests.

People exposed to the virus should get an HIV test as soon as they are likely to develop antibodies to the virus - within 6 weeks to 12 months after possible exposure to the virus. By getting tested early, people with HIV infection can discuss with a health care provider when they should start treatment to help their immune systems combat HIV and help prevent the emergence of certain opportunistic infections (see section on treatment below). Early testing also alerts HIV-infected people to avoid high-risk behaviors that could spread the virus to others.

Most health care providers can do HIV testing and will usually offer counseling to the patient at the same time. Of course, individuals can be tested anonymously at many sites if they are concerned about confidentiality.

Health care providers diagnose HIV infection by using two different types of antibody tests, ELISA and Western Blot. If a person is highly likely to be infected with HIV and yet both tests are negative, the health care provider may request additional tests. The person also may be told to repeat antibody testing at a later date, when antibodies to HIV are more likely to have developed.

Babies born to mothers infected with HIV may or may not be infected with the virus, but all carry their mothers' antibodies to HIV for several months. If these babies lack symptoms, a doctor cannot make a definitive diagnosis of HIV infection using standard antibody tests until after 15 months of age. By then, babies are unlikely to still carry their mothers' antibodies and will have produced their own, if they are infected. Health care experts are using new technologies to detect HIV itself to more accurately determine HIV infection in infants between ages 3 months and 15 months. They are evaluating a

number of blood tests to determine if they can diagnose HIV infection in babies younger than 3 months.

TREATMENT

When AIDS first surfaced in the United States, there were no medicines to combat the underlying immune deficiency and few treatments existed for the opportunistic diseases that resulted. During the past 10 years, however, researchers have developed drugs to fight both HIV infection and its associated infections and cancers.

The U.S. Food and Drug Administration (FDA) has approved a number of drugs for treating HIV infection. The first group of drugs used to treat HIV infection, called nucleoside reverse transcriptase (RT) inhibitors, interrupts an early stage of the virus making copies of itself. Included in this class of drugs (called nucleoside analogs) are AZT, ddC (zalcitabine), ddI (dideoxyinosine), d4T (stavudine), 3TC (lamivudine), abacavir (ziagen), and tenofovir (viread). These drugs may slow the spread of HIV in the body and delay the start of opportunistic infections.

Health care providers can prescribe non-nucleoside reverse transcriptase inhibitors (NNRTIs), such as delvaridine (Rescriptor), nevirapine (Viramune), and efravirenz (Sustiva), in combination with other antiretroviral drugs.

FDA also has approved a second class of drugs for treating HIV infection. These drugs, called protease inhibitors, interrupt virus replication at a later step in its life cycle. They include

- Ritonavir (Norvir)
- Saquinivir (Invirase)
- Indinavir (Crixivan)
- Amprenivir (Agenerase)
- Nelfinavir (Viracept)
- Lopinavir (Kaletra)

Because HIV can become resistant to any of these drugs, health care providers must use a combination treatment to effectively suppress the virus. When RT inhibitors and protease inhibitors are used in combination, it is referred to as highly active antiretroviral therapy, or HAART, and can be used by people who are newly infected with HIV as well as people with AIDS.

Researchers have credited HAART as being a major factor in significantly reducing the number of deaths from AIDS in this country. While HAART is not a cure for AIDS, it has greatly improved the health of many people with AIDS and it reduces the amount of virus circulating in the blood to nearly undetectable levels. Researchers, however, have shown that HIV remains present in hiding places, such as the lymph nodes, brain, testes, and retina of the eye, even in patients who have been treated.

Despite the beneficial effects of HAART, there are side effects associated with the use of antiviral drugs that can be severe. Some of the nucleoside RT inhibitors may cause a decrease of red or white blood cells, especially when taken in the later stages of the disease. Some may also cause inflammation of the pancreas and painful nerve damage. There have been reports of complications and other severe reactions, including death, to some of the antiretroviral nucleoside analogs when used alone or in combination. Therefore, health care experts recommend that people on antiretroviral therapy be routinely seen and followed by their health care providers. The most common side effects associated with protease inhibitors include nausea, diarrhea, and other gastrointestinal symptoms. In addition, protease inhibitors can interact with other drugs resulting in serious side effects.

A number of drugs are available to help treat opportunistic infections to which people with HIV are especially prone. These drugs include

- Foscarnet and ganciclovir to treat cytomegalovirus (CMV) eye infections
- Fluconazole to treat yeast and other fungal infections
- Trimethoprim/sulfamethoxazole (TMP/SMX) or pentamidine to treat Pneumocystis carinii pneumonia (PCP)

In addition to antiretroviral therapy, health care providers treat adults with HIV, whose CD4+ T-cell counts drop below 200, to prevent the occurrence of PCP, which is one of the most common and deadly opportunistic infections associated with HIV. They give children PCP preventive therapy when their CD4+ T-cell counts drop to levels considered below normal for their age group. Regardless of their CD4+ T-cell counts, HIV-infected children and adults who have survived an episode of PCP take drugs for the rest of their lives to prevent a recurrence of the pneumonia.

HIV-infected individuals who develop Kaposi's sarcoma or other cancers are treated with radiation, chemotherapy, or injections of alpha interferon, a genetically engineered protein that occurs naturally in the human body.

PREVENTION

Because no vaccine for HIV is available, the only way to prevent infection by the virus is to avoid behaviors that put a person at risk of infection, such as sharing needles and having unprotected sex.

Many people infected with HIV have no symptoms. Therefore, there is no way of knowing with certainty whether a sexual partner is infected unless he or she has repeatedly tested negative for the virus and has not engaged in any risky behavior.

People should either abstain from having sex or use male latex condoms or female polyurethane condoms, which may offer partial protection, during oral, anal, or vaginal sex. Only water-based lubricants should be used with male latex condoms.

Although some laboratory evidence shows that spermicides can kill HIV, researchers have not found that these products can prevent a person from getting HIV.

The risk of HIV transmission from a pregnant woman to her baby is significantly reduced if she takes AZT during pregnancy, labor, and delivery, and if her baby takes it for the first six weeks of life.

RESEARCH

NIAID-supported investigators are conducting an abundance of research on all areas of HIV infection, including developing and testing preventive HIV vaccines and new treatments for HIV infection and AIDS- associated opportunistic infections. Researchers also are investigating exactly how HIV damages the immune system. This research is identifying new and more effective targets for drugs and vaccines. NIAID-supported investigators also continue to trace how the disease progresses in different people.

Scientists are investigating and testing chemical barriers, such as topical microbicides, that people can use in the vagina or in the rectum during sex to prevent HIV transmission. They also are looking at other ways to prevent transmission, such as controlling sexually transmitted diseases and modifying people's behavior, as well as ways to prevent transmission from mother to child.

MORE INFORMATION

AIDSinfo is a comprehensive information and referral service that provides the most current information on federally and privately funded clinical trials for AIDS patients and others infected with HIV. AIDS clinical trials evaluate experimental drugs and other therapies for adults and children at all stages of HIV infection -- from patients who are HIV positive with no symptoms to those with various symptoms of AIDS.

As the main dissemination point for federally approved HIV treatment and prevention guidelines, AIDSinfo provides information about the current treatment regimens for HIV infection and AIDS-related illnesses, including the prevention of HIV transmission from occupational exposure and mother-to-child transmission during pregnancy. As an education and resource center, AIDSinfo also offers links and other downloadable resources that are designed for patients, health care providers, researchers and the general public.

AIDSinfo is primarily web-based and can be found at http://aidsinfo.nih.gov. AIDSinfo also operates a telephone service from 12:00 p.m. to 5:00 p.m. Eastern Time, Monday through Friday. English and Spanish-speaking health information specialists are available to answer questions about HIV/AIDS, treatment options, and navigating the website.

Telephone: 800-HIV-0440 (1-800-448-0440)
International: 301-519-0459
TTY/TDD: 888-480-3739
Email: ContactUs@aidsinfo.nih.gov

For information specifically about clinical trials conducted by the NIAID Intramural AIDS Research Program, call 1-800-243-7644 (http://clinicaltrials.gov).

To receive materials or to talk with a Health Communication Specialist, contact the CDC National HIV and STD Hotline. This service is available 24 hours a day.

1-800-2278922
1-800-342-2437
1-800-243-7889 (TTY/Deaf Access)

NIAID is a component of the National Institutes of Health (NIH), which is an agency of the Department of Health and Human Services. NIAID supports basic and applied research to prevent, diagnose, and treat infectious and immune-mediated illnesses, including HIV/AIDS and other sexually transmitted diseases, illness from potential agents of bioterrorism, tuberculosis, malaria, autoimmune disorders, asthma and allergies.

News releases, fact sheets and other NIAID-related materials are available on the NIAID Web site at http://www.niaid.nih.gov.

Prepared by:
Office of Communications and Public Liaison
National Institute of Allergy and Infectious Diseases
National Institutes of Health
Bethesda, MD 20892

Print

Reset

Standard Insurance Company

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

Business Overhead Expense Insurance Application Supplement

_____
Proposed Insured (please print)

This application supplement is part of application(s) for insurance on the above named proposed insured. In this application supplement, "you" and "your" mean the proposed insured.

1. The Proposed Insured is a: (check and complete one.)
   a. ☐ Sole proprietor (100% owner).
   b. ☐ Partner. Give your ownership percentage: _____%
   c. ☐ Shareholder of a corporation. Give your ownership percentage: _____%
   d. ☐ Other. Explain and give your ownership percentage:_____

   _____

2. Number of employees (exclude the proposed insured and other partners or shareholders):
   a. _____ Part-time b. _____ Full-time

3. If proposed insured is a partner or shareholder (or if 1-d above, is checked):
   a. Number of other partners or shareholders? _____ How many work full-time for this business? _____
   b. Are all other full-time employees of the business who are partners or shareholders already covered by or now applying for Business Overhead Expense Insurance? ☐ yes ☐ no
      If no, give details:_____

      _____
   c. What percentage of the total business expenses are you responsible for? _____% If this percentage is different from your percentage of ownership, please explain here or in the Remarks:

      _____

      _____

4. Does your business share office space and/or expenses with another person or firm? ☐ yes ☐ no
   If yes, give details: _____

   _____

5. Do you or your business own all or part of the building in which your business is located? ☐ yes ☐ no
   If yes: a. Is it owned by you personally (all or part) or by your business? Give details: _____

   _____

   b. Give percentage owned: _____% by you; _____% by your business.

6. Are there any other members of your profession, or a related profession, employed by you or your business?
   ☐ yes ☐ no If yes, how many _____? Give details: _____

   _____

7. Do you have any other Business Overhead Expense Insurance in force or pending? ☐ yes ☐ no
   If yes, give details: _____

   _____

(THIS FORM CONTINUES ON THE NEXT PAGE.)

Standard Insurance Company

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

Business Overhead Expense Insurance Application Supplement

Proposed Insured (print) _____

8. For occupations 3A and higher, what base salary, fees and wages would you pay a person hired to perform your duties? $_____ per month. Identify and enter amount in "Other Fixed Expenses", below. This amount is limited to the lesser of 50% of all other covered expenses or 80% of the insured's current salary, fees and wages.

9. List your current average (last 12 months) **monthly** expenses. In the event of shared business ownership, list only your share of the expenses. Exclude any payments to you or to any person sharing expenses of your business or profession:

a. Employee wages ..... $_____
b. Employer paid FICA, other taxes and benefits paid for employees ..... _____
c. Rent, lease payments ..... _____
d. Equipment lease, rental payments ..... _____
e. Utilities (telephone, electricity heat, water) ..... _____
f. Laundry, janitorial ..... _____
g. Legal, accounting ..... _____
h. Property, liability insurance ..... _____
i. Malpractice insurance for you ..... _____
j. Professional, association dues ..... _____
k. Interest on business debt ..... _____
l. Mortgage interest ..... $_____
m. Mortgage principal or depreciation, whichever is greater ..... _____
n. Business property taxes ..... _____
o. Office supplies, postage, subscriptions ... _____
p. Equipment loan principal or depreciation, whichever is greater ..... _____

Other fixed expenses* (specify):

q. _____ _____
r. _____ _____
s. _____ _____

Total of all your listed expenses ..... $_____

* Exclude bonus, profit or commission paid to anyone, cost of sales or inventory, travel and entertainment, you or your business's income taxes, any business expenses for which you are not liable and compensation for any person sharing overhead expenses or any person employed to perform your duties.

Remarks (use this space for any explanations or details regarding any above questions):

I DECLARE that all answers to the above questions are correctly recorded and are true and complete to the best of my knowledge and belief. I agree that this application supplement shall become part of any contract of insurance based on such application.

_____ Signed at _____ on ___/___/___
Signature of Proposed Insured City, State

_____ Signed at _____ on ___/___/___
Signature of Policyowner (If Other Than Proposed Insured) City, State

_____ Signed at _____ on ___/___/___
Signature of Soliciting Producer City, State

Note: A person commits a fraudulent act when that person knowingly files an application for insurance which either contains materially false information or conceals material information with intent to mislead.

Print

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

Producer Instructions for The Business Equity Protector℠ (Disability Buy/Sell Insurance)

DEFINITION OF POLICYOWNER

The policyowner for a disability buy/sell policy can be either another owner of a business (Cross Purchase) or the business entity (Entity Purchase). If the proposed policyowner is a business entity, the authorized signee must be someone other than the proposed insured. **The proposed insured cannot be the policyowner of his/her own policy.**

REQUIRED FORMS AND INFORMATION

- The **Business Equity Protector℠ Application Supplement** (Form 7202) and the **Certification of Buy/Sell Agreement** (Form 7204) must accompany the application.
- All financial questions must be answered on The Business Equity Protector Application Supplement.
- For a **Cross Purchase** arrangement, we require a completed 7202 and 7204 from each policyowner.
- For an **Entity Purchase** arrangement, only one of each form 7202 and 7204 is required. All of the proposed insureds must sign on the same form. An authorized representative must sign on behalf of the company as the policyowner.

COMPLETING SIGNATURE SECTION OF APPLICATION

When it is a Cross Purchase:
In addition to the proposed insured, the owner of the policy must also complete the signature section of the application.

When the policyowner is a business entity:
Ask the authorized representative of the company to sign on the *Signature of Policyowner* line. His or her title must be included. Enter the name of the business entity on the *Print Name of Policyowner* line.

EXAMPLE

John Smith Signed at *xxxx* *xx* on *00/00/00*
Signature of Proposed Insured — City — State — Date

Thomas Jones, President Signed at xxxx *xx* on *00/00/00*
Signature of Policyowner (If other than Proposed Insured) If a business entity is policyowner, signature and title of authorized representative — City — State — Date

ABC Company
Print Name of Policyowner If a business entity is policyowner, also print title of authorized representative and company name

000-00-0000
Owner's Tax ID Number (If other than Proposed Insured)

xxxx *xxxx,xx 00000*
Owner's Address — City, State & Zip Code

xxxx
Email Address (optional)

xxxx Signed at *xxxx* *xx* on *00/00/00*
Signature of Producer — City — State — Date

Reset

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

Disability Buy-Out Fact Sheet Application Supplement

This Application Supplement is part of the application(s) for insurance on the proposed insureds, as outlined in Question 6 below.

1. Name of business entity: _____ Date organized: _____
2. Form of business: (Check one.) ☐C Corp ☐S Corp ☐Partnership ☐LLC ☐LLP ☐Other:_____
3. Nature of business: (Briefly describe product, service, etc.)_____

4.

Financial Data for Business Entity:	Last Full Year as of (date)_____:	Previous Year as of (date)_____:
a. Assets:	$	$
b. Liabilities:	$	$
c. Net Worth (Book Value):	$	$
d. Gross Income/Sales:	$	$
e. Net Profit (Loss):	$	$
f. Business Owners' Compensation from the Business Entity, including bonuses and commissions:	$	$

5. a. What is your estimate of the current fair market value of the business entity? $_____
   b. How was this determined? _____

6.

Names of All Proposed Insured Business Owners:	Age:	Position or Title:	Current Annual Total Compensation From This Business:	Percent of Business Owned:	Monthly Amount of Disability Income Coverage In Force:	Other Disability Buy-Out Coverage In Force:

For Questions 7 through 14, please use the Remarks section on Page 2 to give details and explanations.

7. Is there a written disability buy-sell agreement in effect for this business entity? ..... ☐Yes ☐No
   a. If yes, a copy of the agreement may be requested at the underwriter's discretion.
   b. If no, when will a disability buy-sell agreement be executed? _____
   A buy-sell agreement must be in effect within one year after the effective date of any disability buy-out policy issued.
8. Are all business owners of this business entity being insured for disability buy-out? If no, please explain.... ☐Yes ☐No
9. Are there any familial relationships among the business owners? If yes, please explain. ..... ☐Yes ☐No
10. Are there related business entities?..... ☐Yes ☐No
    a. If yes, are those entities included in the buy-sell agreement? ..... ☐Yes ☐No
    b. If not included in the buy-sell agreement, please explain.
11. Do any proposed insured business owners have life insurance in force or applied for to fund a buy-out requirement at death? If no, explain..... ☐Yes ☐No
12. Do all proposed insured business owners work full-time in the business? If no, please explain. ..... ☐Yes ☐No
13. Are all proposed insured business owners aware of the need for a formal disability buy-sell agreement that coincides with the provisions of the proposed coverage? If no, please explain..... ☐Yes ☐No

(THIS FORM CONTINUES ON THE NEXT PAGE.)

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

Disability Buy-Out Fact Sheet Application Supplement

14. Has the business entity experienced a net loss or a year-to-year decrease in net profit, before income taxes, in any of the last 5 years? If yes, please explain..... ☐Yes ☐No

15. **Remarks:**

QUESTION NUMBER:	Please give details and explanations as requested for Questions 7 through 14. Other information may also be added here.

I REPRESENT that all answers to the above questions are correctly recorded, and they are true and complete to the best of my knowledge and belief. I agree that this application supplement shall become part of any contract of insurance based on such application.

_____ Signed at _____ on ___/___/___
Signature of Proposed Insured — City, State — Date

_____ Signed at _____ on ___/___/___
Signature of Proposed Insured — City, State — Date

_____ Signed at _____ on ___/___/___
Signature of Proposed Insured — City, State — Date

_____ Signed at _____ on ___/___/___
Signature of Proposed Insured — City, State — Date

_____ Signed at _____ on ___/___/___
Signature of Proposed Insured — City, State — Date

_____ Signed at _____ on ___/___/___
Signature of Policyowner (If Other Than A Proposed Insured) — City, State — Date

_____ _____
Title (print) — Company Name (print)

I declare and affirm that no changes, additions or alterations of any kind have been made to this form after it was signed by the proposed insured(s) and owner (if other than proposed insured). If this form has been sent to Standard electronically, the copy of this form sent to Standard is a true and exact copy of the original.

_____ Signed at _____ on ___/___/___
Signature of Soliciting Producer — City, State — Date

Note: A person commits a fraudulent act when that person knowingly files an application for insurance which either contains materially false information or conceals material information with intent to mislead.

Standard Insurance Company

Individual Disability Insurance
1100 SW Sixth Avenue Portland OR 97204

Certification of Buy/Sell Agreement

The undersigned has applied for The Business Equity Protector disability insurance policy (the "Policy") from Standard

Insurance Company: _____ _____.
Name of Insured Policy Number (if known)

The undersigned understands and acknowledges that disability benefits under the Policy will be payable only if there is an enforceable disability buy-out obligation under a written buy/sell agreement which buy/sell agreement must be fully executed and in effect prior to the onset of the disability for which benefits are claimed. The undersigned understands that the buy/sell agreement does not have to be fully executed and in effect at the time the Policy is issued, but the buy/sell agreement must be executed and in effect no later than one year after the Policy effective date.

Therefore, the undersigned certifies the following (Either Part A or Part B must be signed):

A. No buy/sell agreement has been executed at this time.

I acknowledge that no buy/sell agreement has been executed at this time, and I certify that a written, enforceable buy/sell agreement will be executed and in effect within one year from the effective date of the Policy. I understand if no buy/sell agreement is executed and in effect within one year of the policy effective date the Policy will be void from the beginning and of no force and effect, and no disability benefits will be paid under the policy. I agree to provide the certification set forth in section B below to Standard Insurance Company at its home office within one year of the Policy's effective date.

_____ _____
Signature of Proposed Policyowner Date
(or Authorized Representative of Proposed Policyowner)

_____ _____
Print Name of Proposed Policyowner or Authorized Representative Title (if applicable)

_____
Print Name of Proposed Policyowner, if entity purchase

B. A written buy/sell agreement is in effect at this time.

I certify that a written buy/sell agreement between the appropriate parties has been executed and is in effect at this time.

_____ _____
Signature of Proposed Policyowner Date
(or Authorized Representative of Proposed Policyowner)

_____ _____
Print Name of Proposed Policyowner or Authorized Representative Title (if applicable)

_____
Print Name of Proposed Policyowner, if entity purchase

This Certification is not a buy/sell agreement. The terms of the policy shall control any questions that may arise at the time of any claim for benefits.

Print

Reset

STANDARD INSURANCE COMPANY
Home Office: P.O. Box 711, Portland, Oregon 97207
800-247-6888

INSURED: _____

POLICY NUMBER: _____

INDIVIDUAL DISABILITY INCOME INSURANCE OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Standard Insurance Company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

DISABILITY INCOME INSURANCE COVERAGE

This is an individual disability income insurance policy. This category of coverage is designed to provide benefits for Disability resulting from a covered Injury or Sickness, subject to any exclusions and limitations set forth in the policy. Benefits do not cover surgical, hospital, or medical expenses.

Date _____ Sales Producer_____

Address_____

_____

Telephone_____

POLICY BENEFITS

Disability Benefits are the monthly benefit payment(s) for Total Disability or Partial Disability. Benefits begin on the Commencement Date. This is the next day immediately following completion of the the Benefit Waiting Period.

The **Benefit Waiting Period** is the period, measured from the first day of your Disability, throughout which you must be Disabled before Disability Benefits become payable. The Benefit Waiting Period is shown on the Policy Data Page.

The **Maximum Benefit Period** is the maximum period of time we will pay benefits for any one Disability.

Commencement Date: _____ Day of Disability

Basic Monthly Benefit: $_____

Maximum Benefit Period: _____

BENEFIT FOR TOTAL DISABILITY – You will be eligible for a Disability Benefit during your Total Disability. The Disability Benefit payable each month will equal the Basic Monthly Benefit.

Total Disability/Totally Disabled means that due to your Injury or Sickness you are unable to perform with reasonable continuity the Substantial And Material Acts necessary to perform your Own Occupation in the usual and customary way.

Substantial And Material Acts means the usual duties that are essential to your ability to perform in your Own Occupation.

Own Occupation means the occupation or occupations which you are regularly engaged in at the time your Disability begins. If you have limited your practice to a professionally recognized specialty in medicine or law, then that specialty will be deemed your Own Occupation.

BENEFIT FOR PRESUMPTIVE DISABILITY – We will consider you to be Totally Disabled if your Injury or Sickness causes you to totally and permanently lose one of the following: speech; hearing in both ears not restorable by hearing aids; sight in both eyes; use of both hands; use of both feet; or use of one hand and one foot. There is no Benefit Waiting Period if you become Presumptively Disabled.

BENEFITS FOR PARTIAL DISABILITY – If you are not Totally Disabled, you may be eligible for Disability Benefits for your Partial Disability. During the **Initial Period of Partial Disability**, after you have satisfied the Benefit Waiting Period, the Disability Benefit will equal the Basic Monthly Benefit, regardless of your Monthly Earnings. During the **Extended Partial Disability** period, the amount of Disability Benefit will depend on your Monthly Earnings.

For benefits to be payable in each period, you must meet the definition of Partial Disability applicable to that period.

Initial Period of Partial Disability: This is the Benefit Waiting Period and the first six months that Disability Benefits are payable for Partial Disability. During this period, Partial Disability means you are not Totally Disabled and:

- You are working in your Own Occupation or any other occupation; and
- Due to your Injury or Sickness, you have a Loss Of Duties, or a Loss Of Time, or a Loss Of Income.

Loss Of Duties means you are able to perform some but not all Substantial And Material Acts.

Loss of Time means you are able to do all Substantial And Material Acts but unable to do them for at least 20% of the time you spent in your Own Occupation prior to the date of Disability

Loss of Income means that your Monthly Earnings is 80% or less of your Indexed Predisability Earnings.

Extended Partial Disability: After the Initial Period, Partial Disability means you are not Totally Disabled and:

- You are working in your Own Occupation or any other occupation; and
- Due to your Injury or Sickness, you have a Loss Of Income.

During Extended Partial Disability, the amount of Disability Benefit will depend on your Monthly Earnings. If your Monthly Earnings is:

- Less than 20% of your Indexed Predisability Earnings, the Disability Benefit will equal the Basic Monthly Benefit.
- 20% to 80% of your Indexed Predisability Earnings, the Disability Benefit will equal:

$$\frac{\text{your Loss Of Earnings for that month}}{\text{your Indexed Predisability Earnings}} \times \text{the Basic Monthly Benefit}$$

- More than 80% of your Indexed Predisability Earnings, no Disability Benefit is payable.

RECOVERY BENEFIT – Immediately after you have Recovered from your Disability, we will pay a Recovery Benefit if you experience a Loss Of Income and that Loss Of Income is solely the result of the previous Injury or Sickness that caused your Disability. The amount of Recovery Benefit will be determined by the formulas set forth for Extended Partial Disability provision.

The Recovery Benefit will no longer be payable on the date that the first of the following events occurs:

- You no longer experience a Loss Of Income;
- Your Loss Of Income is no longer solely the result of the Injury or Sickness that caused your Disability;
- You become Disabled;
- The Maximum Benefit Period ends;
- The policy terminates.

REHABILITATION PROGRAM – While you are Disabled, you may participate in a Rehabilitation Program to help you prepare for your return to full time work. The program is voluntary. We will pay the reasonable costs of the Program and periodically review your progress. We will continue to pay the agreed upon costs for as long as we determine the Rehabilitation Program is meeting the mutually agreed upon objectives.

PREMIUM WAIVER BENEFIT – We will waive all premiums due under this policy while Disability Benefits or Recovery Benefits are payable. After completion of the Benefit Waiting Period, we will refund to the Owner any premium due and paid after the date your Disability began.

COMPASSIONATE DISABILITY BENEFIT – We will pay a Compassionate Disability Benefit while:

- you are working at least 20% fewer hours in order to care for your Loved One while he or she has a Serious Health Condition; and
- your Monthly Earnings is at least 20% less than your Predisability Earnings due to that reduction in hours worked; and
- you are not Disabled; and
- no other benefit is payable under this policy.

Loved One means your parent, child (including an adopted child and stepchild), spouse, Domestic Partner, and child of your Domestic Partner.

Serious Health Condition means that due to your Loved One's Injury or Sickness, he or she:

- is receiving inpatient care in a hospital, hospice or residential medical care facility; or
- requires Substantial Supervision for his or her health or safety due to Severe Cognitive Impairment; or
- is unable to safely and completely perform two or more Activities Of Daily Living without assistance; or
- is terminally ill with a condition that is reasonably expected to result in death within 12 months.

For a Compassionate Disability Benefit to be payable, the Serious Health Condition must be caused by an Injury or Sickness that first occurs after the Policy Effective Date and before the Termination Date. The Benefit Waiting Period is measured from the day the Serious Health Condition begins. The maximum amount of Compassionate Disability Benefit we will pay for all claims and all Loved Ones is limited to a total amount equal to six times the Basic Monthly Benefit.

The amount of Compassionate Disability Benefit we will pay each month will depend on your Monthly Earnings. If your Monthly Earnings is:

- Less than 20% of your Indexed Predisability Earnings, the benefit amount will equal the Basic Monthly Benefit.
- 20% to 80% of your Predisability Earnings, the benefit amount will equal:

$$\frac{\text{your Predisability Earnings} - \text{your Monthly Earnings}}{\text{your Predisability Earnings}} \times \text{the Basic Monthly Benefit}$$

- More than 80% of your Indexed Predisability Earnings, no Compassionate Disability Benefit is payable.

AUTOMATIC INCREASE BENEFIT – This benefit provides for Automatic Increases to the Basic Monthly Benefit, compounded each year during the Increase Period. You are eligible for this benefit if your Issue Age is under age 60. Evidence of insurability is not required. Each Automatic Increase is an amount equal to 4% of the Basic Monthly Benefit. That amount is added to the Basic Monthly Benefit on each Policy Anniversary during an Increase Period.

An **Increase Period** is a period of five consecutive years during which an Automatic Increase can occur. The first Increase Period begins on the day after the Policy Effective Date and it ends on the fifth Policy Anniversary. The Owner may apply for additional Increase Periods. If you are over age 55 at the start of any Increase Period, that Increase Period will be the number of years between the start of the Increase Period and the Increase Date next following your 60th birthday.

SURVIVOR BENEFIT – If you die while the benefit for Total Disability is being paid, we will pay a benefit to the Owner or the Owner's estate. The benefit will be paid for three months. Each benefit payment will equal the Basic Monthly Benefit.

EXCLUSIONS AND LIMITATIONS

EXCLUSIONS FROM COVERAGE

We will not pay benefits for:

- Disability due to an act of War or act incident to War. War includes any declared or undeclared War, whether civil or international, involving nations and/or sovereign territories. Acts of War or acts incident to War do not include acts of terrorism, so long as such acts are isolated in nature and unrelated to and not arising from War, as defined above.
- The first 90 days of your Disability due to pregnancy or childbirth.
- Disability caused or contributed to by your committing or attempting to commit a felony.
- Disability caused or contributed to by your actively participating in a riot. “Actively participating” does not include your being at the scene of a riot while performing your official duties.
- Intentionally self-inflicted Injury.
- Any Disability or condition we have excluded by name or specific description in an endorsement made part of the policy.

PRE-EXISTING CONDITIONS

Benefits for a Disability caused or substantially contributed to by a Pre-existing Condition, or by a medical or surgical treatment of a Pre-existing Condition, will be payable only if on the date you become Disabled, the policy has been continuously in force of 24 consecutive months.

Pre-existing Condition means any physical or mental condition, whether diagnosed or undiagnosed, which was misrepresented or not disclosed in your application for which, during the 365 days immediately prior to the Policy Effective Date:

- You have received a Physician’s advice, treatment or services; or
- A reasonably prudent person would have sought medical advice, care or treatment.

If during the first two years the policy is in force, we find that any answer in your application is misstated, incorrect or incomplete: we may rescind the policy or deny a claim for Disability starting within the two-year period.

LIMITATION FOR RESIDENCE OUTSIDE THE UNITED STATES AND CANADA – Payment of Disability Benefits is limited to 12 months for each period of continuous Disability while you reside outside of the United States or Canada.

POLICY RENEWABILITY

GUARANTEED RENEWABLE – If all required premiums are paid, the policy is guaranteed renewable to the Termination Date. We cannot change any part of the policy, except its premium, until the Termination Date. We can change the premium rates only: (1) after the policy has been in force for three years; and (2) if the change applies to all policies with like benefits insuring the same Risk Class. The policy ends on the Termination Date, except as provided by the Renewal Option (below). The Termination Date is shown on the Policy Data page.

RENEWAL OPTION – If you are not Disabled, Disability coverage may be continued beyond the Termination Date. Coverage will be for Total Disability only. There will be a limited benefit period. You must be actively and regularly employed for at least 30 hours per week. We may change premium rates.

PREMIUMS – Premiums may be paid under any of these modes: annual, semi-annual, or quarterly. We may allow for payment under a special monthly mode. The special mode premium is paid through your bank. There is a 31-day grace period for all premiums due except the first.

The annual premium for this policy is $_____. If premiums are payable under a different mode, the premium for that mode is:

[Special Monthly] [Quarterly] [Semi-Annual] $_____

DEFINITIONS

These definitions apply to both the policy and this outline of coverage. Other terms are defined in the policy.

Disability/Disabled means that you are either Totally Disabled or Partially Disabled.

Indexed Predisability Earnings means your Predisability Earnings adjusted by the applicable rate of increase in the average Consumer Price Index For All Urban Consumers (CPI-U).

Injury means an accidental bodily injury which is sustained after the Policy Effective Date and while this policy is in force.

Owner means the owner of the policy.

Policy Anniversary means the anniversary of the Policy Effective Date occurring each year the policy remains in force.

Predisability Earnings means the sum of your highest Annual Earnings for any two full tax years within the three full tax years preceding the date of your Disability or your Loved One's Serious Health Condition began, divided by 24.

Sickness means an illness or disease which first manifests itself after the Policy Effective Date and while this policy is in force.

Termination Date means the date the policy ends, unless it ended earlier. This date is shown on the Policy Data page.

We/us/our mean Standard Insurance Company.

You/your mean the Insured.

THIS OUTLINE OF COVERAGE IS ONLY A SUMMARY OF THE COVERAGE PROVIDED BY THE POLICY. THIS OUTLINE IS NOT THE CONTRACT AND IS NOT PART OF IT. SEE THE POLICY FOR THE ACTUAL CONTRACT PROVISIONS.

Print

Reset

STANDARD INSURANCE COMPANY
Home Office: P.O. Box 711, Portland, Oregon 97207
800-247-6888

INSURED: _____

POLICY NUMBER: _____

INDIVIDUAL DISABILITY INCOME INSURANCE OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Standard Insurance Company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

DISABILITY INCOME INSURANCE COVERAGE

This is an individual disability income insurance policy. This category of coverage is designed to provide benefits for Disability resulting from a covered Injury or Sickness, subject to any exclusions and limitations set forth in the policy. Benefits do not cover surgical, hospital, or medical expenses.

Date _____ Sales Representative _____

Address _____

_____

Telephone _____

(THIS FORM CONTINUES ON THE OTHER SIDE.)

DEFINITIONS

The following definitions apply to both the policy and this outline of coverage. Other terms are defined in the policy.

DISABILITY - This means the same as Total Disability, defined below.

INJURY - Injury sustained by You:

1. After the Effective Date; and
2. While this policy is in force.

REGULAR OCCUPATION - Your occupation at the time Disability begins. Regular Occupation is not necessarily limited to the job You are performing when the Disability begins. If You have limited Your practice to a professionally recognized specialty in medicine or law, the specialty will be deemed to be Your Regular Occupation. If you are retired at the time Disability begins, being retired will be deemed to be Your Regular Occupation.

SICKNESS - Your Sickness or disease which first manifests itself:

1. After the Effective Date; and
2. While this policy is in force.

SUBSTANTIAL AND MATERIAL ACTS - This means those acts normally required for the performance of Your Regular Occupation and which cannot be reasonably omitted or modified.

TERMINATION DATE - The date the policy ends, unless it ended earlier. This date is shown on the data page.

TOTAL DISABILITY/TOTALLY DISABLED - Because of Your Injury or Sickness You are unable to perform with reasonable continuity the Substantial and Material acts necessary to perform Your Regular Occupation in the usual and customary way and You choose not to work in any occupation.

If You choose to work at any job, You will not be considered Totally Disabled under this policy. However, You may qualify for the benefit for Partial Disability found in the Partial Disability Rider. In compliance with California law, the Partial Disability Rider is mandatory and is attached to this policy

(THIS FORM CONTINUES ON PAGE 3.)

WAITING PERIOD - That period, measured from the first day of Your Disability, throughout which You must be Disabled before Disability Benefits become payable.

WE/OUR - Standard Insurance Company.

YOU/YOUR - The Insured under the policy.

POLICY BENEFITS

BENEFIT FOR TOTAL DISABILITY - You will be eligible for the benefit for Total Disability during Your Continuous Total Disability. We will pay the Basic Monthly Benefit. Benefits will begin on the Commencement Date. (This is the day immediately following completion of the Waiting Period.) We will pay the benefit for Total Disability for up to the Maximum Benefit Period, as long as You remain Continuously Disabled.

Commencement Date: _____ Day of Disability

Basic Monthly Benefit: $ _____

Maximum Benefit Period: _____

PRESUMPTIVE TOTAL DISABILITY BENEFIT - We will consider You to be Totally Disabled if Your Injury or Sickness causes You to totally and permanently lose one of the following:

1. Speech;
2. Hearing in both ears, not restorable by hearing aids;
3. Sight in both eyes;
4. Use of both hands;
5. Use of both feet; or
6. Use of one hand and one foot.

REHABILITATION BENEFIT - While Disability Benefits are being paid, You may participate in a Rehabilitation Program. We will pay:

1. The reasonable costs of the Program; and
2. The difference, if any, between:
   a. The benefit You would be eligible for if You were Totally Disabled; and
   b. The Disability Benefit for which You are eligible;

for up to 36 months. We will not pay this benefit beyond the Maximum Benefit Period.

PREMIUM WAIVER BENEFIT – We will waive all premiums due under this policy while benefits are payable. If the Waiting Period is greater than 90 days, We will waive all premiums due and payable after the 90th day of Continuous Disability, up to the Commencement Date, as long as You remain Continuously Disabled. On and after the Commencement Date, policy benefits must be payable for premiums to be waived. After completion of the Waiting Period, We will refund to the Owner any premium due and paid after the date Your Disability began.

EXCLUSIONS AND LIMITATIONS

We will not pay benefits for:

1. Disability due to an act of War or act incident to War. War includes any declared or undeclared War, whether civil or international, involving nations and/or sovereign territories. Acts of War or acts incident to War do not include acts of terrorism, so long as such acts are isolated in nature and unrelated to and not arising from War, as defined above.
2. The first 90 days of Your Disability due to pregnancy or childbirth;
3. Disability caused or contributed to by Your: (a) committing or attempting to commit a felony; or (b) actively participating in a riot;
4. Intentionally self-inflicted injury; or
5. Any Disability or condition We have excluded by name or specific description in an endorsement made part of the policy.

PRE-EXISTING CONDITIONS – For Disabilities caused or substantially contributed to by a Pre-existing Condition, or by a medical or surgical treatment of a Pre-existing condition, We will pay benefits only if, on the date You become Disabled, the policy has been continuously in force for 24 consecutive months.

A Pre-existing Condition is any physical or mental condition, whether diagnosed or undiagnosed, which was misrepresented or not disclosed in your application, and for which:

1. You have received a Physician's advice, treatment or services; or
2. A reasonably prudent person would have sought medical advice, care or treatment for symptoms occurring;

during the 365 day period ending the day before this policy's Effective Date.

If during the first two policy years, we find that any answer in your application is misstated, incorrect or incomplete, we may:

1. Rescind the policy; or
2. Deny a claim;

for Disability starting within the two year period.

CLAIMS

WRITTEN NOTICE OF CLAIM – We must receive Written Notice of Claim from You or the Owner within 30 days after a Loss starts, or as soon as reasonably possible after that.

WRITTEN PROOF OF LOSS – We must receive written proof of Loss within 90 days after the end of any period for which Disability Benefits are being claimed. If that is not reasonably possible, the claim will not be affected, provided written proof is furnished as soon as is reasonably possible. However, unless You lack legal capacity, We must be given written proof within one year after the 90th day referred to above, for that claim to be valid.

PAYMENT OF CLAIMS - We will pay benefits to the Insured unless the Insured names a payee to receive them. We can pay benefits of up to $1,000 to any relative of the Insured or named payee if the Insured or payee lacks legal capacity to give a valid release, or if any benefit is otherwise payable to the Insured's estate.

POLICY RENEWABILITY

GUARANTEED RENEWABLE - If all required premiums are paid, the policy is guaranteed renewable to the Termination Date. We cannot change any part of the policy, except its premium, until the Termination Date. We can change the premium only: (1) after the policy is three years old; and (2) if the change applies to all policies with like benefits insuring the same Risk Class. The policy ends on the Termination Date, except as provided by the Renewal Option (below). The Termination Date is shown on the data page.

RENEWAL OPTION - If You are not Disabled, Disability coverage may be continued beyond the Termination Date. Coverage will be for Total Disability only. There will be a limited benefit period. You must be actively and regularly employed for at least 30 hours per week. We may change premium rates.

PREMIUMS

Premiums may be paid under any of these modes: annual, semi-annual, or quarterly. We may allow for payment under a special monthly mode. The special mode premium is paid through Your bank. There is a 31-day grace period for all premiums due except the first.

The annual premium for this policy is $ _____. If premiums are payable under a different mode, the premium for that mode is:

Special Monthly $ _____

THIS OUTLINE OF COVERAGE IS ONLY A SUMMARY OF THE COVERAGE PROVIDED BY THE POLICY. THIS OUTLINE IS NOT THE CONTRACT AND IS NOT PART OF IT. SEE THE POLICY FOR THE ACTUAL CONTRACT PROVISIONS.

Reset

STANDARD INSURANCE COMPANY
Home Office: P.O. Box 711, PORTLAND, OREGON 97207
1-800-247-6888

INSURED:

POLICY NUMBER:

BUSINESS PROTECTOR
DISABILITY INCOME PROTECTION COVERAGE
OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Standard Insurance Company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

DISABILITY INCOME PROTECTION COVERAGE

This category of coverage is designed to provide, to persons insured, benefits for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Benefits are not provided for basic hospital, basic medical-surgical, or major-medical expenses.

Date _____ Agent _____

Address _____

Telephone _____

BENEFITS OF THIS POLICY

Standard Insurance Company will pay the benefits provided by this policy if the insured becomes totally disabled as a result of:

SICKNESS - Sickness or disease which first manifests itself after the effective date and while this policy is in force; OR

INJURY - Injury sustained after the effective date and while this policy is in force.

DISABILITY - This includes total disability, as defined below.

TOTAL DISABILITY - Because of your injury or sickness you are unable to perform with reasonable continuity the Substantial And Material Acts of your regular occupation in the usual and customary way.

BENEFITS PAYABLE FOR DISABILITY -

Commencement Date: **Day of Disability**

Base Amount: $ **Maximum Benefit: $**

On and after the commencement date, your covered business overhead expenses, as provided by the policy, will be reimbursed during any continuous period of total disability until the maximum benefit has been paid. For the first month following the commencement date, we will not pay more than the base benefit. Base benefits not paid in a month or covered expenses not reimbursed may be carried over to succeeding months. (See policy provisions regarding Benefit Limits.)

If you die while total disability benefits are being paid, we will pay a benefit to the owner. The benefit will be the lesser of:

a. Three times the base amount; and
b. The maximum benefit less the sum of all benefits paid for that period of disability.

We will pay each premium falling due after the commencement date if disability benefits are payable on the premium's due date. If benefits are payable, we will refund to the owner any premium due and paid prior to the commencement date and during your continuous disability.

PRESUMPTIVE TOTAL DISABILITY - We will consider you to be totally disabled if injury or sickness causes you to totally and permanently lose one of the following:

1. Speech;
2. Hearing in both ears;
3. Sight in both eyes;
4. Use of both hands;
5. Use of both feet; or
6. Use of one hand and one foot.

The commencement date for any presumptive total disability will be the first day of that presumptive total disability.

PREMIUM FOR THIS POLICY

The annual premium for this policy is $_____. If premiums are payable other than annually, the premium for the mode chosen is as follows:

Special Monthly $_____

Premiums may be paid annually, semi-annually or quarterly. Standard may agree to the payment of premiums under a special monthly arrangement through your bank. This arrangement will continue at the option of Standard, subject to written notice of termination. A 31-day grace period for paying premiums follows the due date of all premiums except the first.

EXCEPTIONS, REDUCTIONS AND LIMITATIONS OF THIS POLICY

Benefits under this policy are not payable during the first 90 days of disability due to pregnancy or childbirth. We will not pay benefits for declared or undeclared war or an act or incident of war. Also, benefits are not payable if disability is caused or contributed to by a pre-existing condition which is specifically excluded or which is not disclosed on your application.

After two years from the Effective Date, no misstatements, except fraudulent misstatements, in the application shall be used to rescind the policy or deny a claim for disability starting after the end of such two year period.

RENEWABILITY OF THIS POLICY

NONCANCELLABLE/GUARANTEED RENEWABLE - This policy is noncancellable and guaranteed renewable to the policy anniversary on or next following the insured's 65th birthday, provided that all required premiums are paid. As long as the policy remains in force, Standard can neither cancel the policy nor change its terms or the premium charged. The policy terminates by its terms on the policy anniversary on or next following the insured's 65th birthday, except as provided by the Renewal Option.

RENEWAL OPTION - Business overhead expense coverage may be continued from your age 65 as long as you remain actively at work for at least 30 hours per week, you are responsible for the expense of maintaining an office or business and you are not disabled when we receive your request. Coverage will be for total disability only. There will be a limited benefit period. We may change premium rates.

THIS OUTLINE OF COVERAGE IS ONLY A SUMMARY OF THE COVERAGE PROVIDED BY THE POLICY. THIS OUTLINE IS NOT THE CONTRACT AND IS NOT PART OF IT. SEE THE POLICY FOR GOVERNING CONTRACT PROVISIONS.

Print

STANDARD INSURANCE COMPANY
Home Office: P.O. Box 711, PORTLAND, OREGON 97207
800-247-6888

INSURED:

POLICY NUMBER:

BUSINESS EQUITY PROTECTOR
BUSINESS BUY-OUT EXPENSE DISABILITY COVERAGE
OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Standard Insurance Company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

BUSINESS BUY-OUT EXPENSE DISABILITY COVERAGE

This is a disability policy for Business Buy-Out Expense. This category of coverage is designed to provide benefits for disability resulting from a covered injury or sickness, subject to any limitations set forth in the policy. Benefits do not cover surgical, hospital, or medical expenses.

Date _____ Agent _____

Address _____

Telephone _____

 (THIS FORM CONTINUES ON THE OTHER SIDE.)

DEFINITIONS

Active Full-Time Employment - You average working at least 30 hours a week for the Business over any continuous six month period.

Age 65 - The Policy Anniversary on or next following your 65th birthday.

Business - The business entity, named in the application, in which you have an ownership interest.

Buy-Out Expense - Any amount payable to you under the terms of the Buy-Sell Agreement as a result of your Total Disability.

Buy-Sell Agreement - A written agreement including the Owner and you which is in effect no later than one year of the Effective Date and remains continuously in effect until the time your Total Disability begins. It must provide for the purchase of your entire ownership interest in the Business in the event of your Total Disability.

Injury - Injury sustained by you:

1. After the policy Effective Date; and
2. While the policy is in force.

Owner - The Owner of this policy, as shown on the data page, unless later changed.

Regular Occupation - Your occupation at the time Disability begins. The work you do as your Regular Occupation must be the same work you do in your Active Full-Time Employment.

Sickness - Your Sickness or disease which first manifests itself:

1. After the policy Effective Date; and
2. While the policy is in force.

Total Disability - Because of your Injury or Sickness, you are unable to perform with reasonable continuity the Substantial And Material Acts of your Regular Occupation in the usual and customary way.

When used in this form “we”, “us” and “our” mean Standard Insurance Company and “you” and “your” mean the Insured.

(THIS FORM CONTINUES ON PAGE 3.)

POLICY BENEFITS

BENEFIT FOR TOTAL DISABILITY - A benefit for Total Disability will become payable on the later of the Commencement Date or the date a Buy-Out Expense is payable to you as a result of your Total Disability.

The amount we will pay will equal the Buy-Out Expense and will be payable under the selected funding method, subject to the benefit limits. Funding methods are:

1. Monthly - The benefit will be paid each month. We will not pay more than the Monthly Benefit Limit for any one month. We will not pay beyond the Benefit Period.
2. Downpayment - The first payment will be equal to the initial Buy-Out Expense amount, but not more than the Lump Sum Benefit Limit. Each month after that, we will pay the remaining benefit owed on a monthly basis, but not more than the Monthly Benefit Limit. We will not pay beyond the Benefit Period.
3. Lump Sum - The benefit will be paid in a lump sum payment. We will not pay more than the Lump Sum Benefit Limit.

The total of all payments we make may not exceed the lesser of the total Buy-Out Expense or the Aggregate Benefit Limit.

The policy provides for these terms:

Commencement Date: _____ day of Disability
Funding Method: _____
Lump Sum Benefit Limit: $_____
Monthly Benefit Limit: $_____
Aggregate Benefit Limit: $_____

These benefit limits will be multiplied by the applicable percentage from the table below to determine the benefit limit for Total Disability starting on or after your 61st birthday.

Total Disability Starting:	Percentage of Benefit Limit:
On or after your 61st birthday, but prior to your 62nd birthday:	80%
On or after your 62nd birthday, but prior to your 63rd birthday:	60%
On or after your 63rd birthday, but prior to your 64th birthday:	40%
On or after your 64th birthday:	20%

(THIS FORM CONTINUES ON THE OTHER SIDE.)

WAIVER OF PREMIUM - When policy benefits are payable and after the Commencement Date, we will:

1. Waive any future premium due; and
2. Refund to the Owner that amount of premium due and paid during the Waiting Period.

LEGAL/ACCOUNTING FEE REIMBURSEMENT - We will reimburse the Owner up to $3,000 for reasonable legal and/or accounting fees owed and paid by the Owner to carry out the terms of the Buy-Sell Agreement. This reimbursement is not included in the Aggregate Benefit Limit. It is payable on the later of:

1. The Commencement Date; or
2. The date the first Buy-Out Expense is payable to you under the Buy-Sell Agreement.

EXCLUSIONS AND LIMITATIONS

We will not pay benefits for:

1. Disability due to an act of War or act incident to War. War includes any declared or undeclared War, whether civil or international, involving nations and/or sovereign territories. Acts of War or acts incident to War do not include acts of terrorism, so long as such acts are isolated in nature and related to and not arising from War, as defined above;
2. Disability caused or contributed to by your committing or attempting to commit a felony or actively participating in a riot;
3. Intentional, self-inflicted injury or sickness; or
4. Any Disability or condition we have excluded by name or specific description in an endorsement made part of the policy.

If during the first two policy years, we find that any answer in your application is misstated, incorrect or incomplete, we may:

1. Rescind the policy; or
2. Deny a claim for Disability starting within the two year period.

(THIS FORM CONTINUES ON PAGE 5.)

POLICY TERMINATION

RENEWAL OF POLICY SUBJECT TO SPECIFIED CONDITIONS - The policy may be continued until the earliest of:

1. 12:01 a.m. on the Termination Date shown on the data page;
2. The date your work for the Business no longer constitutes Active Full-Time Employment;
3. The date the Buy-Sell Agreement terminates or the date the last payment under it is made;
4. The date the Aggregate Benefit Limit is reached;
5. The date one person owns more than 90% of the Business; or
6. The date of the your death. Benefit payments begun prior to your death under the monthly or downpayment funding methods will continue as provided for under the policy terms.

In addition, the Owner may terminate this policy by sending a written request to us at our home office.

As long as the premium is paid by the end of each grace period, we cannot change the premium or the terms of the policy until the policy ends.

PREMIUMS

Premiums may be paid under any of these modes: annual, semi-annual, or quarterly. We may allow for payment under a special monthly mode. The special mode premium is paid through your bank. This special mode will continue at our option, subject to written notice of termination. There is a 31 day grace period for all premiums due except the first.

The annual premium for this policy is $_____. [If premiums are payable under a different mode, the premium for that mode is:

[Special Monthly, Quarterly, Semi-Annual] $_____]

THIS OUTLINE OF COVERAGE IS ONLY A SUMMARY OF THE COVERAGE PROVIDED BY THE POLICY. THIS OUTLINE IS NOT THE CONTRACT AND IS NOT PART OF IT. SEE THE POLICY FOR THE ACTUAL CONTRACT PROVISIONS.