INSURABILITY INFORMATION REQUEST - California

Complete this form and email it to AL-MedicalUnderwriting@standard.com

Please keep a copy of this form/notice for your records.

Standard Insurance Company

Medical Evidence Underwriting Unit
AL-MedicalUnderwriting@standard.com

Group no.

Evidence required because of: ☐ Over guaranteed issue amount ☐ Late entrant ☐ Change of benefits	This evidence is provided for: ☐ An effective date under a new group ☐ A post group effective date addition

SECTION 1. GENERAL INFORMATION

Last name	First name	M.I	Date of birth (MM/DD/YYYY)
Social security no.	Work phone no.	Home phone	Email
Employee address:	City:	State:	ZIP code:
State of birth:	Height:	Weight:	Request amount: $
Name of employer	Employer address		

SECTION 2. DEPENDENT INFORMATION. Complete for all dependents (if any) to be covered under this program.

Last name, first name, MI	Sex	Date of birth (MM/DD/YYYY)	State of birth	Relationship	Height	Weight	Dependent requested amount
	☐ M ☐ F			Spouse			
	☐ M ☐ F						
	☐ M ☐ F						
	☐ M ☐ F						

SECTION 3.MEDICAL AND ACTIVITIES QUESTIONNAIRE – LONG AND SHORT FORMS

COMPLETE THE FOLLOWING MEDICAL QUESTIONS FOR ALL PERSONS TO BE COVERED: For the purpose of the following questions, the term "Medical or Social Practitioner" includes but is not limited to: a doctor, nurse, psychologist, psychiatrist, social worker, chiropractor, podiatrist, therapist, pathologist, dentist, optometrist, osteopath, Christian Science practitioner, or any person affiliated with a self-help program such as Alcoholics Anonymous, a substance abuse program, or a weight loss program.

1. Are you or any of your dependents currently pregnant? ☐ Yes ☐ No
   If yes, who? .....
   Expected due date .....
2. Have you or any of your dependents smoked or used tobacco in the last 5 years? ..... ☐ Yes ☐ No
   If yes, who? _____ Type? _____
   Quit date (*if applicable*) _____
3. In the past 5 years, have you or any of your dependents ever:
   a. had high blood pressure or high cholesterol? ..... ☐ Yes ☐ No
      If yes, who? _____
      Last three readings _____
   b. had heart disease, cancer, diabetes, arthritis, or asthma? ... ☐ Yes ☐ No
   c. had counseling by a Medical or Social Practitioner for an emotional, mental or nervous condition? ..... ☐ Yes ☐ No
   d. been treated for alcohol or chemical dependency, or been convicted for driving while intoxicated? ..... ☐ Yes ☐ No
4. Have you or any of your dependents ever been diagnosed by, or received treatment from, a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ..... ☐ Yes ☐ No
5. In the past three years have you or any of your dependents been prescribed medication? ..... ☐ Yes ☐ No
6. In the past 5 years have you or any of your dependents had an inpatient admission and/or outpatient surgery? ..... ☐ Yes ☐ No
7. During the past 3 years, have you or any of your dependents sought medical treatment, or been advised by a Medical or Social Practitioner to seek treatment for any condition not indicated by the answers to the preceding six questions? ..... ☐ Yes ☐ No
8. Have you or any of your dependents ever been rated or declined for, or refused reinstatement or renewal of, life or health insurance? ☐ Yes ☐ No
   If yes, name of person, date, and reason:
   _____ _____
   _____ _____
9. In the past 3 years, have you or any of your dependents been engaged in sports or hobbies such as aviation, scuba diving, sky diving, racing, or similar activities? (Please list): ..... ☐ Yes ☐ No
   _____
   _____

IMPORTANT NOTICE: No person, including an employee or agent of Standard Insurance Company, has the authority to or omit any of these medical questions.

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.

Explain any "Yes" answers to any questions below. If additional space is necessary, attach a separate page including your signature and date.

Quest no.	Name of individual	Name of illness or injury	Dates of treatment	Any remaining effects	Name of medication and dosage	Name and address of physician/hospital

SECTION 4. NOTICE OF EXCHANGE OF INFORMATION

To proposed Insured and other persons proposed to be Insured, if any information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB Group, Inc., a non-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 may, upon request, supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of this information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901.

SECTION 5. AGREEMENT AND AUTHORIZATION

1. I authorize the release of any medical records or information concerning claims, conditions, or treatment of myself and for any dependents listed herein, by any provider of health services, pharmacy related service organization, medical or medically-related facility, or the MIB, Inc., to Standard Insurance Company (The Standard), its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of The Standard. This information will be used for purposes which include but are not limited to: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; and quality improvement programs. The Standard will advise such entities that such information must be kept confidential to the extent necessary or as otherwise provided by law and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to HIV virus or AIDS (excluding disclosure of HIV testing), sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, prescription history, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. I understand that The Standard may collect personal information about me and for any dependents listed herein, from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that The Standard collects about me, and for any dependents listed herein, and that I may receive a more detailed description of my rights under this law by writing to The Standard. California's privacy laws continue to apply.
2. If we approve your application for insurance, the Life and/or Disability coverages you have requested will become effective on the date established by the provisions of the group contract and certificates issued thereunder.
3. I understand that The Standard reserves the right to accept or decline the application and that no right whatsoever is created by this information request. I represent that the answers given to all questions on this information request are true and accurate to the best of my knowledge and I understand they are being relied on by the insurer in reviewing the application for insurance. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or omission that are false and made with actual intent to deceive or materially affect The Standard's risk, made by me in this information request may result in denial of benefits or rescission or cancellation of my coverage(s).

I give this authorization for myself and on behalf of my eligible dependents if covered by the plan, including my Spouse/Domestic Partner unless my Spouse/Domestic Partner signs below. I am acting as their agent and representative. Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

This authorization, for purposes of processing this information request form, is valid from the date signed for a period of thirty months unless revoked by me in writing, which I may do at any time by contacting The Standard. A photocopy is as valid as the original.

You or your authorized representative are entitled to receive a copy of the authorization.

Applicant signature: **X**	Date (MM/DD/YYYY):
Spouse/Domestic Partner signature (If to be covered): **X**	Date (MM/DD/YYYY)

This Authorization may be revoked at any time by the Applicant by sending a written revocation to us at: Standard Insurance Company, P.O. Box 2753, Portland, OR, 972018-9830. Such revocation must be signed and dated by the Applicant and spouse, if the spouse is to be covered. Revocation of this Authorization may result in denial of coverage or denial of a claim.

REFUSAL OF AUTHORIZATION – I refuse authorization to disclose health care information. I understand that such refusal may result in denial of coverage or denial of a claim.

Applicant signature ***X***	*Date (MM/DD/YYYY)*
Spouse/Domestic Partner signature (If to be covered) ***X***	*Date (MM/DD/YYYY)*

ELECTRONIC NOTICE – Signature required to opt-in to electronic delivery. Employee agrees to opt-in? **Yes** **No**
Consent to receive communications electronically is voluntary and may be withdrawn at any time by contacting The Standard as provided below.

Employee Email address: _____

I (primary applicant) have agreed to receive my plan-related communications, including written records required to be given or mailed to me by my Employer, for myself and any dependents, either by email or electronically. This may include my policy, certificate, evidence of coverage, explanation of benefits statements, required notices or helpful information to get the most out of my plan, and other relevant documents that are permitted by law to be sent electronically. I agree to provide and update The Standard with my current email address. At any time I can change my mind and request a copy of these materials (or any specific materials) by mail free of charge, by contacting The Standard at the address shown below. I or my enrolled dependents will update our communication preferences calling Member Services at 866-594-0516.

Standard Insurance Company
Customer Service
P.O. Box 2753
Portland, OR 97208-9830

Employee Signature: _____	***Date (MM/DD/YYYY):*** _____

Fraud Warning: *For your protection California law requires the following to appear on this form. "Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."*

Reset Form