## DIRECTIONS FOR APPLYING FOR COVERAGE

Read the Information Practices Notice(s) on page 3. This form must be completed when Evidence Of Insurability or Proof of Good Health is required to apply for coverage. Complete all items, date and sign in the space at the bottom of page 2. Keep a copy for your records, and send the original to Standard Insurance Company at the address given above.

# **RETIREE/APPLICANT INFORMATION**

Name of Group		Group N	Group Number		Date Retired (Mo/Day/Year)	
City of San	lose - Retirement Services	645765				
Name of Retiree		Birthdate	Birthdate (Mo/Day/Year)		Birthplace	
Street Address City		ty	State	Zip		Social Security Number
Sex	Work Phone		Home Phone	(	)	
$\Box M \Box F$	( )			`	/	

### **APPLICATION INFORMATION**

Type of Application (check	one) 🗌 Initial			
Check the insurance coverage you are requesting.				
□ Voluntary Life	Current Amount In Force, if any +	Additional Amount Requested	Total Amount Requested	

### MEDICAL HISTORY STATEMENT QUESTIONS

Chec	k yes or i	no for each of	these questions, and give details for any "yes" answers. Attach a separate sheet if necessary.		
1.	Are you	now unable to	work full-time because of any physical or mental condition, or injury? $\ldots$ $\Box$ Yes $\Box$ No		
2.	Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:				
	A. Disea	ase of the liver	, pancreas, kidney, ulcers, stomach, intestinal ailment, or digestive system disorder?		
	B. Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, blindness, deafness, or any other neurological or muscle disorder?				
	C. Canc	er, tumor, lesi	ons, leukemia, lymphoma, blood clotting or other malignancy or growth?		
			se, heart ailment, arteriosclerosis, abnormal pulse, high blood pressure, heart murmur, valve, circulatory, rs?		
	E. Empł	nysema, asthn	na, bronchitis, sleep apnea, or other respiratory or lung disease?		
G.	<ul> <li>F. Lupus, scleroderma, vasculitis, connective tissue disease, or other immune system disorder not related to Human Immunodeficiency Disorder (HIV)?</li> <li>G. Osteoarthritis, rheumatoid arthritis, osteoporosis, pain in the joints, amputations, or other disease or disorder of the bones, joints,</li> </ul>				
			ritic or disc conditions?		
			land, spleen, or nephritis? Yes 🗆 No		
	•		se, or have you used alcohol, drugs or nicotine in a manner that has resulted in medical treatment? $\Box$ Yes $\Box$ No		
			al condition, depression, adjustment disorder, affective disorder, anxiety disorder, or obsessive- r? Second		
3.	8. In the past 10 years have you had any illness or injury not listed above which resulted in the use of prescribed medication or physician visits?				
4.	I. Has a medical professional ever diagnosed you as having or prescribed medication to you for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?				
5.	5. Are you currently pregnant?				
Н	leight	Weight	Physician or Medical Facility with Applicant's Complete Medical Records		
			Name and Full Mailing Address		

Applicant Name (to be completed if applying online)	Social Security Number

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

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

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

- I represent that the statements contained herein, including those made in response to the Medical History Statement questions and any attachments, are true and complete, to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, The Standard's liability is limited to the return of any premium which may have been paid.
- To any health plan, physician, health care provider, hospital, clinic, laboratory, pharmacy, medical facility, insurance or reinsurance company, and the Medical Information Bureau Inc. (MIB), I instruct you to disclose my entire medical record and any other protected health information concerning me to The Standard or its reinsurers. This includes information on any disorder of the immune system, including Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, and any communicable or sexually transmitted disease or disorder. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.
- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any of the above to release and disclose my entire medical records without restriction.
- I understand that The Standard will use information obtained by authorization to determine my eligibility for group insurance coverage.
   I understand The Standard may release information it has about me to its reinsurers and to any person performing business or legal services for The Standard in connection with my application. I understand The Standard may release information it has about me to the MIB for the purpose of reporting to the MIB information exchange and for MIB to audit The Standard's reporting. I understand The Standard may release information it has about me to other insurance companies to which I have applied for insurance coverage or benefits.
- I understand that information disclosed to The Standard pursuant to authorization may be subject to redisclosure with my authorization or as
  otherwise permitted by law. Life and disability insurance coverages are not subject to the Privacy Rule under the Health Insurance Portability and
  Accountability Act (HIPAA), and therefore release of information to The Standard is not protected under the Act.
- I understand that if my application is approved, premiums shall be paid in accordance with the provisions of the Group Policy(ies), and my coverage will be subject to all terms and conditions of the Group Policy(ies) and state limitations.
- For Member/Employee: If I currently have a Life and/or Trust Life beneficiary designation on file with my plan administrator, I understand the designation(s) on file will also apply to any approved amounts. If I have no beneficiary designation(s) on file or I wish to change the name of the current beneficiary(ies), I will contact my plan administrator.
- I understand that insurance on a Spouse or other Dependent, if any, is payable to the Member/Employee, if living, or as provided under the terms of the Group Policy(ies).
- I acknowledge that I have read and received the Information Practices Notice and I have kept a copy of this Medical History Statement.
- I understand that I am entitled to receive a copy of this authorization. This authorization will remain valid one year from the date of the signature below. A photocopy or facsimile of this authorization shall be as valid as the original.
- I understand that I have the right to refuse to sign this authorization. I further understand that I have a right to revoke this authorization at any time
  by sending a written statement to The Standard, except to the extent it has been relied upon to disclose requested records. I understand that the
  revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my application and
  may be a basis for denying my application for insurance coverage.

Signature of Applicant	Date

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

Applicant Name (to be completed if applying online)	Social Security Number

### **INFORMATION PRACTICES NOTICE**

- To help us determine your eligibility for group insurance we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or MIB, Inc. (Medical Information Bureau). We will use the authorization you signed on this form when we seek this information.
- MIB (MEDICAL INFORMATION BUREAU) Information regarding your insurability will be treated as confidential. Standard Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Standard Insurance Company may release information in its file to its reinsurers, and Standard Insurance Company, or its reinsurers, may release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

- DISCLOSURE TO OTHERS The information collected about you is confidential. We will not release any information about you without your authorization, except to the extent necessary to conduct our business or as required or permitted by law.
- YOUR RIGHTS You have a right to know what information we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices please write to us at Medical Underwriting, Standard Insurance Company, 900 SW Fifth Avenue, Portland, Oregon 97204 or call 1-800-843-7979.