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

Short Form Application for Disability Income Insurance
Graduate Medical Education/Dental Education Program

Applicant

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

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

5. Date of Birth _____ 6. State of Birth _____ 7. Length of US Residence _____ 8. Email _____

Insurance Applied For

9. Plan Type & Features:

Disability Income

BASIC MONTHLY BENEFIT $_____
WAITING PERIOD 90 DAYS
BENEFIT PERIOD To Age 67

- ☑ NONCANCELABLE
- ☑ OWN OCCUPATION
- ☑ MENTAL DISORDER/SUBSTANCE ABUSE LIMITATION
- ☐ INDEXED COST OF LIVING 3%
- ☑ FUTURE PURCHASE OPTION $ 10,000 POOL AMOUNT
- ☑ RESIDUAL/PARTIAL DISABILITY (ALWAYS INCLUDED)
- ☐ CATASTROPHIC $_____
- ☑ PRE-EXISTING CONDITIONS AMENDED
- ☐ OTHER_____

10. Occupation Class: _____ (Available classes: 4P, 3P, 2P)
11. Premium Mode: _____ EFT ☐ Other _____
12. Other Disability Insurance Coverage: Explain all YES answers in the table below. Do not include the disability insurance you are applying for with this application.
    a. Have you applied for any individual disability insurance (IDI) in the last 12 months?..... ☐YES ☐NO
    b. Have you been declined or been postponed for IDI coverage in the last 7 years? ..... ☐YES ☐NO
    If YES please explain, and give reasons:_____
    c. Is there any other individual or group disability insurance currently in force or pending on you? ..... ☐YES ☐NO
    d. Have you filed a claim for or received any disability insurance benefits in the last 12 months?..... ☐YES ☐NO
    If YES please explain: _____

COMPANY OR SOURCE	TYPE OF COVERAGE*	IF GROUP INSURANCE: WHO PAYS PREMIUM?	IF GROUP INSURANCE: BENEFIT CAP MAXIMUM?	MONTHLY AMOUNT	FUTURE INCREASE AMOUNT	WAITING PERIOD	WILL THIS COVERAGE BE REPLACED OR REDUCED?
							☐YES ☐NO
							☐YES ☐NO
							☐YES ☐NO

***USE TYPE CODES:** I - INDIVIDUAL; G - GROUP; X - ASSOCIATION; O - OTHER

General Information

13. Program Name: University of Florida College of Medicine
14. Year in Doctoral Program or Post Graduate Year (PGY) _____
15. Program Address: 1600 SW Archer Road
City, State: Gainesville, FL
Zip Code: 32603
16. Current Primary Specialty (Include professional designation, or degree) _____
17. Expected Completion Date of Current Program:_____

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Applicant Name (print):_____

General Information Continued

18. For the period of time starting **180 days prior to and including the date of this application:**
Have you been continuously at work on a full time basis performing all the duties of your occupation without limitation due to an injury or sickness?..... ☐YES ☐NO

If NO, please explain:_____

19. Have you used tobacco or nicotine in any form, including cigarettes, cigar, pipe, smokeless, gum, patch, or any other form, in the last 5 years? If yes, provide details below.....☐YES ☐NO

TYPE: _____ AMT PER DAY: _____ DATE LAST USED: _____

TYPE: _____ AMT PER DAY: _____ DATE LAST USED: _____

Agreement

I, THE UNDERSIGNED, AGREE TO THE FOLLOWING: This application includes pages 1 and 2 and all signed application supplements and amendments. In this application, "you" and "your" mean the proposed insured unless otherwise specified. I understand that Standard Insurance Company (Standard) will rely on the information I have provided in this application in considering the proposed insured's eligibility for insurance and for various premium rates. This application will not be effective unless signed and dated by the owner (proposed insured). **No insurance will be in force until: (a) the date 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 outlined in a written agreement between Standard and the employer as payer for the policy. Premium will be calculated to begin on the Policy Effective Date. No sales representative is authorized to judge insurability or change any of Standard's requirements. No corrections or amendments to this application may be made without the owner's written consent. We may require that any disability policy listed in answer to Question 12 be permanently terminated or reduced. 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 all premiums returned. If any insurance applied for is intended to replace other insurance in force with Standard, the Standard policy(s) 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. I REPRESENT that: To the best of my knowledge and belief, all answers in this application are true and complete and correctly recorded; and that any and all answers I have provided to any Standard licensed producer are recorded in this application. I signed this application in the city and state and on the date shown below.

Note: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

_____ Signed at_____ _____ on____/____/____
SIGNATURE OF OWNER (PROPOSED INSURED) CITY STATE DATE

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 owner (proposed insured).

_____ Signed at_____ _____ on____/____/____
SIGNATURE OF SOLICITING PRODUCER CITY STATE DATE

_____ _____
NAME OF SOLICITING PRODUCER (PRINT) FLORIDA LICENSE IDENTIFICATION NUMBER

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

Authorization to Obtain and Disclose Personal (Nonmedical) 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 that personal information may include information about my age, occupation, other insurance, income and finances. I also understand that personal information does not include any information related to my physical or mental condition, medical history or medical treatment.

Authorization to Obtain Personal Information
I authorize any insurance or reinsurance company, insurance sales representative, employer, MIB, Inc. and any other person, organization or institution having records or knowledge of me, to release personal information about me, as described above, to Standard, its reinsurers, and any insurance support organization acting on behalf of Standard.

Authorization to Use Personal Information
I authorize Standard to use personal information obtained about me for the purposes of determining eligibility for insurance and reinsurance and 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 any 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.

Expiration and Revocation
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. 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.

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

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, or my authorized representative, 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*)

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

Disclosure Notice - Information Practices (Nonmedical)

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, income and finances. This personal information is obtained and disclosed by us in order to evaluate your insurability and determine appropriate premium rates; to support our normal business practices; and to 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 insurance 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: insurance producers, insurance or reinsurance companies, and the Medical Information Bureau (see below); employers, and personal and business associates.

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 Medical Information Bureau, reinsurers; organizations that perform services or functions on our behalf or to serve you, and to regulatory, law enforcement and governmental authorities. Standard or its reinsurers may also release information in its file to other life 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 the address at the top 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.

Medical Information Bureau (MIB)
Standard, or its reinsurers, may make a brief report to the MIB. The MIB is a nonprofit membership organization of life and health 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, the MIB, upon request, will supply the company with the information in its file. At your request, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the MIB's file, you may contact the MIB and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

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 Underwriting, 1100 SW Sixth Ave., Portland, OR 97204-1093.