Standard Insurance Company

Life Benefits Department
PO Box 2800 Portland OR 97208 800.628.8600 Tel

KPERS

Life Insurance Benefits
Beneficiary Statement

Tax Information

Under the Federal Income Tax law, we are required to request that you *(as the payee)* provide Standard Insurance Company *(as payor)* with your correct Social Security Number or Taxpayer Identification Number.

Please read and complete the following information in order to comply with Federal Income Tax law.

Certification — Under Penalties Of Perjury, I Certify That:

1. The number shown on this form is my correct Social Security/Taxpayer Identification Number *(or I am waiting for a number to be issued to me)*, **and**
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions — Check here if you are subject to backup withholding ☐

Method Of Payment —

Please read the information on page 2 and then mark the box below for the payment option you would like to select. If a payment option is not selected below, the payment will be made in accordance with the Group Policy unless payment by check is required by state law, regulation or direction.

☐ Standard Secure Access (SSA) Account

☐ Lump Sum Check

If you decide to assign a portion of your benefits to a funeral home, please include a notarized assignment form *(supplied by the funeral home)* and an itemized copy of the funeral bill. A separate check for the amount of the assignment will be delivered directly to the funeral home.

Acknowledgement

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 3 of this form.

Signature of Beneficiary *(please use dark ink and sign as you would a check)*	Relationship to Deceased
Name *(please print)*	Date of Birth
Beneficiary's Social Security No./Taxpayer ID No. *(required)*	
Mailing Address *(if this is a PO Box, a street address is required)*	City State Zip Code
Street Address *(only if your mailing address is a PO Box)*	City State Zip Code
Work Phone No.	Home Phone No.

Policyholder Use Only

Name of Deceased: _____

Group Policy No.: 753781

Standard Secure Access (SSA) Account:

The SSA Account is a money market checking account. Checks drawn on the SSA Account are payable through The Northern Trust Company, Chicago, Illinois. Checks for $250 or more may be written against the account balance using special checks provided. There is no limit on the number of checks that can be written against the balance of the account. A check for the full balance may be written at any time. If at any time the account balance falls below $500, the account automatically will be closed at the end of that month. The final account balance, including interest credited, will be provided by mail.

The SSA Account funds begin earning interest the day they are deposited, with interest compounded daily and added to the account on the last day of the month. The account accrues interest based on the 13-week U.S. Treasury Bill auction rate. Principal and any interest earned are fully guaranteed by The Standard. The interest earned on the SSA Account may be taxable. A personal tax and/or legal advisor should be consulted with questions related to tax issues, and a financial advisor should be consulted for information about other investment opportunities.

An SSA Account statement showing the beginning balance, any withdrawals, interest credited, special service charges if any and the current interest rate that the account is earning is provided monthly by mail.

The SSA Account has no monthly service fees, no per check charges and no charge for additional checks. However, there may be special fees for some services. The current special fees are: $25.00 for each check returned by the bank as unpaid, such as a check written for more than the account balance; and $25.00 per check for each Stop Payment order. These fees will be deducted from the account balance and will appear on the monthly statement. The fees are applicable from the date of this disclosure and may change in the future.

Depositing the total proceeds in an SSA Account fully discharges The Standard's obligation under the group life insurance policy. Additional deposits cannot be made to an SSA Account.

The Beneficiary will be mailed a checkbook once the claim is approved. In addition, all SSA accountholders have access to 24-hour customer service via voice response unit (VRU) and a dedicated customer service team.

The account is not insured by the Federal Deposit Insurance Corporation (FDIC). The National Association of Insurance Commissioners (NAIC) advises that you can contact the National Organization of Life and Health Insurance Guarantee Associations at www.nolhga.com for information about coverage and limitations for retained asset accounts by State Guaranty Associations.

While accountholders may choose not to withdraw any portion of these proceeds from their account, they must keep the account active. We will contact accountholders periodically to confirm that they wish to maintain their account. If we do not receive a response, the account may become dormant and presumed abandoned, after which the proceeds may be transferred to the accountholder's state treasurer's office, and the accountholder will need to file a claim with the state to get the proceeds back.

If there are questions, please contact The Standard Life Benefits Department, PO Box 2800, Portland, OR 97208-9929, or call 800.628.8600.

Standard Insurance Company
Life Benefits Department
PO Box 2800 Portland OR 97208 800.628.8600 Tel

Some states require us to provide the following information to you:

ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA RESIDENTS

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO RESIDENTS

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DISTRICT OF COLUMBIA RESIDENTS

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA RESIDENTS

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

NEW JERSEY RESIDENTS

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim, containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ALL OTHER RESIDENTS

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

TheStandard®

Standard Secure Access Confirmation Certificate

Standard Insurance Company agrees to retain the opening balance and to credit interest and allow checking privileges in accordance with the terms and conditions outlined on the back of this certificate.

Checks drawn on the Standard Secure Access account are payable through The Northern Trust Company, Chicago, Illinois, or any successor bank appointed by The Standard.

If you have any questions, please call:

800.343.2551

Or write to us at:

Standard Secure Access Account
PO Box 92987
Chicago IL 60675-2987

Standard Insurance Company

Possession of this Confirmation Certificate does not necessarily mean you are an accountholder.

Standard Secure Access

Terms and Conditions

Ownership Rights

You are the owner of this account. The owner alone has the right to write checks against the account balance and to exercise all the rights and privileges provided by this account or allowed by Standard Insurance Company ("The Standard").

Effective Date

The effective date is the date the account was established.

Interest

Interest is earned on your account from the effective date at a rate based on the 13-week Treasury Bill auction rate but not to exceed 5% and as shown on your monthly statement. Interest is compounded daily and is credited to your account on the last day of the month. Principal and any interest earned in the Standard Secure Access account are fully guaranteed by The Standard.

Minimum Balance Requirements

If at any time the account balance falls below $500, the account automatically will be closed at the end of that month. The final account balance, including interest credited, will be mailed to you.

Minimum Check Amount

You may write checks for $250 or more against your account balance using the special checks provided to you. There is no limit on the number of checks you can write against the balance of your account.

Statements

Each month you will receive a statement of your account by mail showing your beginning balance, any withdrawals, interest credited, special service charges if any (see Special Fees section) and the interest rate that your account is earning. Canceled checks are not returned with your account statement but are available at no cost.

Special Fees

Basic Services on your account are provided to you at no cost. There are no monthly services fees, no per check charges and no charge for additional checks. There are special fees for special services you may incur. The current special fees are:

- $25.00 for each check returned by the bank as unpaid, such as a check written for more than your account balance
- $25.00 per check for each Stop Payment order

Rules and Regulations of the Bank

Checks drawn on Standard Secure Access accounts are payable as drafts through The Northern Trust Company, Chicago, IL. Your Standard Secure Access account is also subject to applicable banking laws and regulations.

Deposits

Additional deposits cannot be made into this account.

Assignments

No assignment of the Standard Secure Access account will be permitted. Any attempted assignment will not be binding on The Standard, its third party administrator or any successor administrator.

Changes in Terms and Conditions

The Standard reserves the right to terminate this program, make changes to the terms and conditions and change the commercial bank being used as a clearing facility. If termination occurs or such changes are made, The Standard will notify you of the changes. All agreements made by The Standard are signed by an officer of The Standard. No other person can change or waive any of the conditions of this certificate or make any agreement that will be binding upon The Standard.

Standard Insurance Company

Greg Ness, President and CEO

TheStandard®

Standard Insurance Company
844.289.2306 Tel 971-321-5033 Fax
800 SW Jackson, Ste 1110, Topeka, KS 66612

KPERS

Spouse/Dependent Accelerated Benefit Instructions

Please Read Carefully

1. The receipt of an Accelerated Benefit may be taxable and may affect your eligibility for Medicaid or other government benefits or entitlements. If you or your Spouse/Dependent meet the definition of "terminally ill individual" in the Internal Revenue Code Section 101, your Spouse/Dependent's Accelerated Benefit may be non-taxable. A personal tax advisor and/or legal advisor should be consulted before your Spouse/Dependent applies for an Accelerated Benefit.
2. Your Group Policy provides a benefit which allows your Spouse/Dependent to receive an early payment of a portion of the Group Life Insurance once during their lifetime, if they meet certain requirements. Please consult the Accelerated Benefit provision of your Life Insurance Certificate for details.
3. To be eligible for this benefit, your Spouse/Dependent must be insured under the Group Policy and have a Qualifying Medical Condition as defined in the Group Policy. If you have questions regarding the Qualifying Medical Conditions, please contact your Employer or our office.
4. If your Spouse/Dependent is eligible for this benefit, your Spouse/Dependent may apply to receive part of the Dependents Life Insurance Benefit as an Accelerated Benefit.
5. You must apply on behalf of a Child.
6. In order to apply for the benefit, you must submit a completed claim packet. Your claim packet consists of six forms. All questions on these forms are important. Please answer them to the best of your ability. If a section does not apply to you, or the information is unavailable, please indicate that in the space provided.

The five forms in your claim packet are:

1. Employee's Statement

You must fill out this Statement completely. If not enough space is given on the form, please use an additional sheet. Remember to sign and date the Statement. An unsigned Statement will be returned for your signature.

2. Spouse/Dependent's Statement

Your Spouse/Dependent must fill out this Statement completely. If not enough space is given on the form, please use an additional sheet. Your Spouse/Dependent should sign and date the Statement. An unsigned Statement will be returned for your Spouse/Dependent's signature. You must apply on behalf of a Child.

3. Payment Consent

The Payment Consent form will be needed if you live in a community property state.

4. Authorization to Obtain and Release Information

Please sign and date this form and attach it to the Spouse/Dependent's Statement. Your Spouse/Dependent's signature on this form enables Standard Insurance Company to obtain the information necessary to determine eligibility for this benefit. The Authorization also allows us to release this information to other parties for purposes specified on the Authorization. You will receive a copy of this Authorization upon your request.

5. Attending Physician's Statement

- Part A should be completed by Spouse/Dependent.
- Part B should be completed by a physician. If more than one physician has been seen for the disability, a statement should be completed by each physician. The physician(s) should mail the completed form directly to The Standard.

You are responsible for making sure all required forms are completed and returned to our office. Processing of the claim will begin when all completed forms are received. Should you have any questions, our office is available to assist you.

Standard Insurance Company
844.289.2306 Tel 971-321-5033 Fax
800 SW Jackson, Ste 1110, Topeka, KS 66612

Spouse/Dependent Accelerated Benefit
Employee's Statement

Please make sure that you have answered all questions completely and accurately. If there are unanswered questions, the review of your claim may be delayed. An Employer's Statement and Attending Physician's Statement must also be submitted to The Standard.

Please print clearly.

Employee's Full Name _____

Street Address _____

City _____ State _____ ZIP _____

Phone (_____) _____ Birthdate _____ Social Security No. _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Have you received a Certificate of Insurance, brochure or other written description of the Accelerated Benefit? ☐ Yes ☐ No

Name of Employer **KPERS**

Street Address _____

City _____ State _____ ZIP _____

Date Hired _____

Have you stopped working? ☐ Yes ☐ No If yes, last day at work _____

Are you self-employed at any activity? ☐ Yes ☐ No

Are you covered under more than one Group Life Insurance policy issued by Standard Insurance Company? ☐ Yes ☐ No

Are you now working at your occupation? ☐ Yes ☐ No

Have you applied for waiver of premium? ☐ Yes ☐ No

I certify the above answers are true and complete and to the best of my knowledge and belief form the basis of my Spouse/Dependent's claim for an Accelerated Benefit. I do understand that the receipt of an Accelerated Benefit may be taxable and affect my Spouse/Dependent's eligibility for Medicaid or other government benefits or entitlements. I also understand that if my Spouse/Dependent meets the definition of "terminally ill individual" of the Internal Revenue Code Section 101, the Accelerated Benefit may be non-taxable and these matters should be discussed with a tax and/or legal advisor before applying for an Accelerated Benefit. I further understand that this benefit provides for an accelerated payment of life insurance and is not intended nor designed to provide health, nursing home or long term care benefits.

Acknowledgment

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 3 of this form.

Employee's Signature _____ Date _____

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CALIFORNIA RESIDENTS

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COLORADO RESIDENTS

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DISTRICT OF COLUMBIA RESIDENTS

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA RESIDENTS

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NEW JERSEY RESIDENTS

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim, containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS

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Standard Insurance Company
844.289.2306 Tel 971-321-5033 Fax
800 SW Jackson, Ste 1110, Topeka, KS 66612

Spouse/Dependent Accelerated Benefit
Spouse/Dependent's Statement

This form is to be completed by the recipient of the Accelerated Benefit. Please make sure that you have answered all questions completely and accurately. If there are unanswered questions, the review of your claim may be delayed. An Employer's Statement and Attending Physician's Statement must also be submitted to The Standard.

Please print clearly.

Spouse/Dependent's Full Name _____

Street Address _____

City _____ State _____ ZIP _____

Phone (_____) _____ **Birthdate** _____ **Social Security No.** _____

Relationship to Employee ☐ Spouse ☐ Child

Employee's Full Name _____

Name of Employer **KPERS**

Street Address _____

City _____ State _____ ZIP _____

Date Hired _____

Are you covered under more than one Group Life Insurance policy issued by Standard Insurance Company? ☐ Yes ☐ No

Describe your present medical condition.

Please provide the following information regarding any physicians who have treated you. Attach a separate sheet for additional physicians.

Physician's Name _____ Specialty _____

Street Address _____

City _____ State _____ ZIP _____

Phone (_____) _____ Date first consulted _____ Date last consulted _____

Please indicate if you are currently confined to a hospital ☐ Yes ☐ No Nursing Home ☐ Yes ☐ No

If you answered yes, please provide the date confinement began _____ Is confinement permanent? ☐ Yes ☐ No

Please provide the name and address of hospital or nursing home.

_____
Name

_____
Street City State ZIP

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Spouse/Dependent Accelerated Benefit
Spouse/Dependent's Statement

Spouse/Dependent's Name _____

Are you currently receiving in-home care? ☐ Yes ☐ No If yes, care is ☐ Full-time ☐ Part-time

Please describe type of care and by whom provided.

What amount of Accelerated Benefit are you claiming? _____ %

10% minimum*
25% minimum*
50% maximum*
75% maximum*

$_____

$5,000 minimum*
$250,000 maximum*
$500,000 maximum*

* *Subject to the terms in your policy, the minimums and maximums indicated here may vary. Please read the Accelerated Benefit provision in your Certificate of Insurance.*

Is part or all of your Life Insurance required to be paid to your children, spouse or former spouse as a part of a court-approved divorce decree, separate maintenance agreement or property settlement agreement? ☐ Yes ☐ No

Are you married and living in a community-property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin)? ☐ Yes ☐ No
If yes, your spouse must complete the attached written consent for payment of an Accelerated Benefit.

Have you made an assignment of all or part of your insurance? ☐ Yes ☐ No
If yes, the assignee must complete the attached written consent for payment of an Accelerated Benefit.
(An assignment is a transfer of your rights under this policy; it does not refer to your beneficiary designation.)

Have you filed for bankruptcy? ☐ Yes ☐ No
If yes, the trustee in bankruptcy or other official of the Bankruptcy Court must complete the attached written consent for payment of an Accelerated Benefit.
(If you are covered under a policy issued in Connecticut, Illinois, or Texas, you are not required to respond.)

Are you required by a government agency to use the Accelerated Benefit to apply for, receive, or continue a government benefit or entitlement? ☐ Yes ☐ No
(If you are covered under a policy issued in Connecticut, you are not required to respond.)

Have you previously applied for or received an Accelerated Benefit under the Group Policy? ☐ Yes ☐ No

Have you made application to convert or have you converted all or part of your coverage under the Group Policy to an individual policy? ☐ Yes ☐ No

I certify the above answers are true and complete and to the best of my knowledge and belief form the basis of my claim for an Accelerated Benefit. I do understand that the receipt of an Accelerated Benefit may be taxable and affect my eligibility for Medicaid or other government benefits or entitlements. I also understand that if I meet the definition of "terminally ill individual" of the Internal Revenue Code Section 101, the Accelerated Benefit may be non-taxable and these matters should be discussed with my tax and/or legal advisor before applying for an Accelerated Benefit. I further understand that this benefit provides for an accelerated payment of Life Insurance and is not intended nor designed to provide health, nursing home or long term care benefits.

Acknowledgment

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 6 of this form.

Signature of Spouse (or Parent signing for Dependent) _____ Date _____

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DISTRICT OF COLUMBIA RESIDENTS

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Spouse/Dependent Accelerated Benefit Payment Consent

STATE OF _____)
) ss.
County of _____)

The undersigned, on oath being first duly sworn, depose and say:

My relationship to _____ is:
(Name of Spouse/Dependent)

- ☐ Spouse living in a community property state
- ☐ Assignee under an assignment
- ☐ Trustee in bankruptcy or other official of the Bankruptcy Court

I understand that the Spouse/Dependent is making application to Standard Insurance Company (The Standard) for the payment of an Accelerated Benefit in the amount of $_____ under a Group Term Life Insurance policy. I consent to the payment by The Standard to the Spouse/Dependent of the Accelerated Benefit should The Standard determine the Spouse/Dependent to be eligible.

_____
Signature

Subscribed and sworn to before me this _____ day of _____

_____
Notary Public for the
State of _____

My commission expires _____

Authorization to Obtain and Release Information

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically related facility or association.
- Kaiser Permanente.
- Any insurance company or annuity company.
- Any employer, policyholder or plan sponsor.
- Any organization or entity administering a benefit or leave program (including statutory benefits) or an annuity program.
- Any educational, vocational or rehabilitation counselor, organization or program.
- Any consumer reporting agency, financial institution, accountant, or tax preparer.
- Any government agency *(for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, Workers' Compensation Board, etc.).*

TO GIVE THIS INFORMATION:

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of any physical or mental condition, including:
  - Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
  - Any communicable disease or disorder.
  - Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.
  - Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.

and:

- Any non-medical information requested about me, including such things as education, employment history, earnings or finances, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions, etc.

TO STANDARD INSURANCE COMPANY, THE STANDARD LIFE INSURANCE COMPANY OF NEW YORK, THE STANDARD BENEFIT ADMINISTRATORS AND THEIR AUTHORIZED REPRESENTATIVES (referred to as "The Companies", individually and collectively), AND MY EMPLOYER'S ABSENCE MANAGEMENT PROGRAM ADMINISTRATOR ("Absence Manager").

- I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct the persons and organizations identified above to release and disclose my entire medical record without restriction.
- I understand that each of The Companies and Absence Manager will gather my information only if they are administering or deciding a claim(s) under my life, dismemberment and/or disability insurance, or leave of absence claim, and will use the information to determine my eligibility or entitlement for benefits or leave of absence.
- I understand that I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The Companies and Absence Manager, except to the extent the authorization has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Companies' and Absence Manager's ability to evaluate or process my claim(s), and may be a basis for denying or closing my claim(s) for benefits or leave of absence.
- I understand that in the course of conducting its business The Companies and Absence Manager may disclose to other parties information about me. They may release information to a reinsurer, a plan administrator, plan sponsor, or any person performing business or legal services for them in connection with my claim(s). I understand that The Companies and Absence Manager will release information to my employer necessary for absence management, for return to work and accommodation discussions, and when performing administration of my employer's self-funded (and not insured) disability plans.
- I understand that The Companies and Absence Manager comply with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to them pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. Information retained and disclosed by The Companies and Absence Manager may not be protected under the Health Insurance Portability and Accountability Act [HIPAA].
- I understand and agree that this authorization as used to gather information shall remain in force from the date signed below:
  - For Standard Insurance Company, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Life Insurance Company of New York, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Benefit Administrators, the duration of my claim(s) administered by The Standard Benefit Administrators or 24 months, whichever occurs first.
  - For Absence Manager, 24 months.
- I understand and agree that The Companies and Absence Manager may share information with each other regarding my life, dismemberment and/or disability insurance claim(s) and leave of absence claim. This authorization to share information shall remain valid for 12 months from the date signed below.
- I acknowledge that I have read this authorization and the New Mexico notice on page 9. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (please print) _____ Social Security No. _____

Signature of Spouse (or Parent signing for Dependent) _____ Date _____

If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.

Standard Insurance Company is a licensed insurance company in all states except New York. The Standard Life Insurance Company of New York is an insurance company licensed only in New York. An absence manager may be hired by your employer and may be one of The Companies.

FOR RESIDENTS OF NEW MEXICO

The state of New Mexico requires Standard Insurance Company to provide you with the following information pursuant to its Domestic Abuse Insurance Protection Act.

The Authorization form allows Standard Insurance Company to obtain personal information as it determines your eligibility for insurance benefits. The information obtained from you and from other sources may include confidential abuse information. "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. With respect to confidential abuse information, you may revoke this authorization in writing, effective ten days after receipt by Standard Insurance Company, understanding that doing so may result in a claim being denied or may adversely affect a pending insurance action.

Standard Insurance Company is prohibited by law from using abuse status as a basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating a policy, restricting or excluding coverage or benefits of a policy or charging a higher premium for a policy.

Upon written request you have the right to review your confidential abuse information obtained by Standard Insurance Company. Within 30 business days of receiving the request, Standard Insurance Company will mail you a copy of the information pertaining to you. After you have reviewed the information, you may request that we correct, amend or delete any confidential abuse information which you believe is incorrect. Standard Insurance Company will carefully review your request and make changes when justified. If you would like more information about this right or our information practices, a full notice can be obtained by writing to us.

If you wish to be a protected person (a victim of domestic abuse who has notified Standard Insurance Company that you are or have been a victim of domestic abuse) and participate in Standard Insurance Company's location information confidentiality program, your request should be sent to Standard Insurance Company.

Standard Insurance Company
844.289.2306 Tel 971-321-5033 Fax
800 SW Jackson, Ste 1110, Topeka, KS 66612

Spouse/Dependent Accelerated Benefit Attending Physician's Statement

The Spouse/Dependent is responsible for the completion of this form at their own expense. We require comprehensive medical information in order to evaluate the insured's claim for Accelerated Benefit. Please print clearly.

Part A. To Be Completed By Spouse/Dependent

Spouse/Dependent's Full Name _____ Phone (_____) _____

Street Address _____

City _____ State _____ ZIP _____

Birthdate _____ **Social Security No.** _____ Sex: ☐ Male ☐ Female

Policy Number 753781

Part B. To Be Completed By Physician

The purpose of this form is to help us determine whether your patient is eligible for accelerated payment of life insurance proceeds. We need to evaluate the clinical condition of your patient. Please advise of any clinical findings including laboratory data and results of special tests such as X-rays, CAT scan, EKG, etc. Copies of any surgical reports, hospital discharge summaries, chart notes, or narrative reports will be helpful.

Weight _____ Height _____ Blood pressure on last visit _____ Pulse _____

Diagnosis
Primary _____

Secondary _____

ICDA Classification _____

Course of treatment, including medications _____

_____

Prognosis _____

In your opinion, does the patient have a terminal condition? _____

What is the terminal condition? _____

In your professional opinion, what is the patient's life expectancy?
- ☐ Less than 6 months
- ☐ 6 to 12 months
- ☐ Greater than 12 months
- ☐ Other _____

Objective Findings – Objective documentation must be included to support life expectancy _____

_____

_____

Symptoms _____

_____

_____

When did symptoms first appear? _____

Date you recommended patient should stop working _____ Why? _____

_____

Standard Insurance Company
844.289.2306 Tel 971-321-5033 Fax
800 SW Jackson, Ste 1110, Topeka, KS 66612

Spouse/Dependent Accelerated Benefit Attending Physician's Statement

Spouse/Dependent's Name _____

Dates and Nature of Treatment

(a) Date of first visit _____ Date of last visit _____

(b) Frequency ☐ Weekly ☐ Monthly ☐ Other *Specify* _____

(c) Will treatment substantially improve function and employability? ☐ Yes ☐ No *If yes, specify* _____

(d) Have you made referrals? ☐ Yes ☐ No *If yes, specify* _____

Name _____ Specialty _____ Phone (_____) _____

Progress

(a) Has patient: ☐ Retrogressed ☐ Unchanged ☐ Improved ☐ Recovered

(b) Is patient: ☐ Hospital confined ☐ Bed confined ☐ House confined ☐ Ambulatory

(c) If patient has been hospitalized, please provide the name, address, and phone number of the hospital.

_____

Admitted _____ Discharged _____ Phone (_____) _____

Limitation *If there is a limitation, check and describe below.*

Are the limitations permanent? ☐ Yes ☐ No

☐ Sitting ☐ Climbing ☐ Bending ☐ Use of left hand/arm ☐ Use of right hand/arm ☐ Sitting ☐ Walking

☐ Stooping ☐ Lifting ☐ Pushing/Pulling ☐ Other clarify _____

Physical Impairment **as defined in Federal Dictionary of Occupational Titles*

☐ Class 1 – No limitation of functional capacity; capable of heavy work*; No restrictions

☐ Class 2 – Medium manual activity*

☐ Class 3 – Slight limitation of functional capacity; capable of light work*

☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity

☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity

☐ Remarks _____

Do you believe the patient is competent to manage insurance benefits? ☐ Yes ☐ No

If no, is the patient competent to appoint someone to help manage the Insurance benefits? ☐ Yes ☐ No

List Other Treating or Referring Physicians

NAME	ADDRESS
1. _____	_____ City _____ State _____ ZIP _____
2. _____	_____ City _____ State _____ ZIP _____

Name of Physician _____ Specialty _____

Address _____ City _____ State _____ ZIP _____

Phone (_____) _____ Taxpayer Identification No. _____

Acknowledgment

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 12 of this form.

Signature _____ Date _____

Standard Insurance Company
844.289.2306 Tel 971-321-5033 Fax
800 SW Jackson, Ste 1110, Topeka, KS 66612

Some states require us to provide the following information to you:

ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA RESIDENTS

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO RESIDENTS

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DISTRICT OF COLUMBIA RESIDENTS

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA RESIDENTS

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

NEW JERSEY RESIDENTS

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim, containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ALL OTHER RESIDENTS

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.