

**Standard Insurance Company**

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

**Producer Instructions and Information Report  
On A Policy Increase Option Application**

**Producer Instructions**

Note: Any policy and riders issued will be those most comparable to the base policy and riders available at the time of the increase and will be subject to our underwriting rules and income limits in effect as of the applicable option date. Supplemental social insurance riders (Supplemental Social Insurance, Supplemental Income Benefit, Social Security Agreement, and Social Security Benefit) and increase option riders are not available on increase policies. The Waiting/Elimination Period, Benefit Period/Multiple, and premium mode for any increase will be the same as, or the most comparable to, the base policy.

1. Prior to completing this application, give the Disclosure Notice - Information Practices (Nonmedical) to the proposed insured to read carefully.
2. **Complete all questions.** Print all responses. If applying for an increase option on a Business Overhead Expense (BP) or Buy-Out (BEP) policy, include the appropriate Application Supplement.
3. Complete the Producer Information Report, below. Use REMARKS to note special instructions or requests.
4. Staple all pages together and submit to your Standard Insurance Company regional office or assigned agency. Include a copy of the sales illustration used as a basis for the sale and the proposed insured's most recent tax return with all schedules and W-2's.

**Producer Information Report**

1. Producer Name (Please Print)	2. Producer Number	3. Agency Number
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Home #(     )	Work #(     )	Other #(     )
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4. Telephone Numbers

\_\_\_\_\_ (     )

5. Fax Number

6. E-mail Address

7. Other Producer(s) to Receive Credit for this Application:

NAME (PRINT) _____	PRODUCER NO. _____	PERCENT _____
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NAME (PRINT) _____	PRODUCER NO. _____	PERCENT _____
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8. To the best of your knowledge, is replacement involved or intended to be involved with this application?  YES  NO

9. Give billing instructions (if other than bill to policyowner): \_\_\_\_\_

10. REMARKS: Note anything not disclosed on the application that might affect the insured's eligibility for an increase.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I DECLARE THAT: I gave the Disclosure Notice - Information Practices (Nonmedical) to the proposed insured. This application was read and signed by the proposed insured and owner, if different, after all questions were asked and answered. I have accurately recorded on this application all of the information that was given to me by the proposed insured and owner, if different. I know of nothing affecting the risk that is not recorded on this application or in any accompanying application supplement, written statement or letter.

\_\_\_\_\_  
Producer Signature

\_\_\_\_\_  
Date



# Understanding Income Documentation

Income documentation is required for all disability income insurance applications (except applications qualifying for Simplified Underwriting, and select Students and New Professionals). The documentation required depends on the applicant’s business entity, as shown in the table below.

Entity	Documentation <sup>1</sup> for			What Income Figure to Use	Employer - Paid Limits
	Protector Platinum, Protector+ and Protector Essential	Business Protector	Business Equity Protector		
<b>Students, Residents, New Professionals</b>	Not required unless requested by the underwriter	For new in private practice professionals, please contact your underwriter	Not available	See Student/New Professional Guidelines in the Special Occupations Section for benefit limits	Not eligible for employer - paid limits
<b>Non - owner employee</b>	Complete Form 1040 for most recent year including all schedules, W - 2s of the proposed insured <b>OR</b> If income is from salary only, provide copy of paystub showing a minimum of six months of YTD income <b>OR</b> If 1099 income, complete 1040 to include related Schedule C	Not available	Not available	W - 2 box #5 labeled “Medicare Wages and Tips” <b>OR</b> Project year to date salary to determine annual income. Do not project commissions or bonuses. <sup>2</sup> <b>OR</b> 1099’s report income from independent contractors. Most likely filed under a Schedule C, but may be reported as “other income”	May apply for employer - paid limits. <sup>3</sup> Independent contractors are not eligible for employer - paid limits
<b>Owner of Sole Proprietorship</b>	Complete Form 1040 and Schedule C	Schedule C from personal tax return	Not available	Schedule C line #31	Not eligible for employer - paid limits.
<b>C Corporation Owner</b>	Complete W - 2s of the proposed insured. Business Tax Form 1120 is required if 50%+ owner (non-medical occupations only)	Business tax form 1120	2 years’ complete business tax returns	W - 2 box #5 labeled “Medicare Wages and Tips”	May apply for employer - paid limits <sup>3</sup>
<b>S Corporation Owner</b>	Complete 1040, W - 2s, and Schedule E <b>OR</b> Corporate Tax Return Form 1120S and Schedule K - 1 (1120S)	Business tax form 1120S	2 years’ complete business tax returns	W - 2 box #5 plus Schedule E Nonpassive income, subtract Nonpassive loss, Section 179 Expense. <sup>4</sup> “Passive” may be counted as unearned income. <b>OR</b> Add 1120S line 7 (owner’s share shown on W - 2) and K - 1 box number 1, subtract line 11	May apply for employer - paid limits if the proposed insured owns 2% or less of the business <sup>3</sup>
<b>Partnership</b>	Complete 1040, Partnership Form 1065, Schedule K - 1 (1065)	Business tax form 1065	2 years’ complete business tax returns	Add K-1 lines 1 and 4, subtract line 12	Not eligible for employer - paid limits.
<b>LLC or LLP</b>	The type of business tax return filed for the LLC or LLP will govern the documentation required.	See appropriate business entity above	2 years’ complete business tax returns	Refer to the appropriate requirements above for regular corporations and partnerships	See appropriate business entity above

The Standard reserves the right to require additional financial information on any applications regardless of amount, if necessary to reach an underwriting decision or to secure reinsurance. The Standard also reserves the right to limit or modify the amount of insurance coverage offered regardless of earned income, other financial information or other insurance in force. Two years’ tax returns are required for business owners applying for the Business Owner Upgrade or Business Owner Discount.

- For some occupations The Standard requires documentation of more than one year’s earned income to qualify for an occupation classification. Examples include stockbrokers, real estate agents and insurance producers.
- For bonus or commission to be considered as income, at least two years’ documentation is required.
- To be eligible for employer - paid limits, the premium cannot be included in taxable income and the employee may not reimburse the employer for the premium.
- Up to 20 percent of Section 179 depreciation can be added to the income to allow for an additional benefit of up to \$1,000 a month.

**Standard Insurance Company**  
**The Standard Life Insurance Company Of New York**  
[standard.com/di](http://standard.com/di)

Understanding Income Documentation  
 14162 (8/13) SI/SNY

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Ore. in all states except New York, where insurance products are offered by The Standard Life Insurance Company of New York of White Plains, N.Y. Product features and availability 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**

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

**Application for Policy Increase**

**Insured**

1. Full Name (Last, First, Middle) \_\_\_\_\_ 2. Sex \_\_\_\_\_ 3. [Social Security Number] \_\_\_\_\_

4. Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ 5. Date of Birth \_\_\_\_\_  
HOME ( ) WORK ( )

6. Phone Numbers \_\_\_\_\_ 7. Email Address (optional) \_\_\_\_\_

**Insurance Applying For and Other Insurance**

8. **REQUEST POLICY INCREASE FOR POLICY NUMBER:** \_\_\_\_\_  
Check 9 or 10 for the type of increase you are requesting. Fill in the required information. Then complete questions 12-18.

9.  **INCREASE PURCHASE OPTION:**  
Plan Type and Features: Any policy and rider(s) issued will be those most comparable to the base policy and riders available at the time of the increase. No supplemental social insurance and no increase option riders are available on increase policies. The Waiting/Elimination Period, Benefit Period/Multiple, and premium mode for any increase will be the same as, or the most comparable to, the base policy.

**Disability Income** Increase in Basic Monthly Benefit: \$ \_\_\_\_\_  
**Business Buy-Out Expense\*** Increase in Aggregate Benefit Limit: \$ \_\_\_\_\_

**Business Overhead Expense\*** Increase in Base Amount: \$ \_\_\_\_\_  
**Other (specify):** \_\_\_\_\_  
\*Include the appropriate Application Supplement.

**ACCELERATED OPTION DATE:** Give reason(s): \_\_\_\_\_

10.  **ADDITIONAL AUTOMATIC INCREASE PERIOD** (Disability Income only).

11. Other than the policy shown in number 8 above: Is there any individual or group disability insurance currently in force or pending on you; or applied for; or for which you are or will become eligible? .....  YES  NO  
If yes, explain in the table below. Use status and type codes. List all individual and group disability policies with any company, including Standard Insurance Company; but do not list the policy shown in number 8 above.

**STATUS CODES:** NOW IN FORCE (N); PENDING (P); APPLIED FOR IN THE LAST 12 MONTHS (A); WILL BECOME ELIGIBLE IN THE NEXT 12 MONTHS (F).  
**TYPE CODE:** INDIVIDUAL (I); SOCIAL SECURITY SUBSTITUTE (S); GROUP (G); ASSOCIATION (X); OVERHEAD EXPENSE (OE); OTHER (O - EXPLAIN.)

COMPANY NAME: IF REPLACEMENT PLEASE GIVE POLICY NUMBER.	STATUS	TYPE	MONTHLY AMOUNT:	BENEFIT PERIOD:	WAITING PERIOD:	IF GROUP:			WILL COVERAGE BE REPLACED OR REDUCED?
						WHOPAYS PREMIUM?	BENEFIT CAP MAXIMUM?	% OF INCOME:	
									<input type="checkbox"/> Yes <input type="checkbox"/> No
									<input type="checkbox"/> Yes <input type="checkbox"/> No
									<input type="checkbox"/> Yes <input type="checkbox"/> No

**General Information**

12. Current Primary Occupation (include professional designation, specialty or degree) \_\_\_\_\_

13. Current Employer \_\_\_\_\_ 14. Employer Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip Code \_\_\_\_\_

15. How many hours a week do you work in your primary occupation? \_\_\_\_\_

16. How much of the premium for this increase will be paid by your employer?  NONE  100%  OTHER \_\_\_\_%

17. 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 18.  
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 (explain) \_\_\_\_\_

18. Your current earned income at an annual rate is \$\_\_\_\_\_. For last year it was \$\_\_\_\_\_.  
"Earned Income" means: salary, other compensation and commissions. Exclude investment income. If you are self-employed, earned income is after business expenses, but before personal income taxes. Do not include any income that is not reported to the IRS. Please explain any significant fluctuations between years. \_\_\_\_\_



**Standard Insurance Company**

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

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**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 MIB, Inc. (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 MIB, Inc., 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 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.

**MIB, Inc.**

Standard, or its 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 (TTY 866-346-3642). Information for consumers about MIB, Inc. may be obtained on its website at [www.mib.com](http://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  
1100 SW Sixth Avenue Portland OR 97204-1093

**Receipt for Payment**  
(Application to Exercise a Policy Increase Option)

Proposed Insured: \_\_\_\_\_  
(please print)

\* Amount Received: \$ \_\_\_\_\_

Standard Insurance Company (Standard) acknowledges receipt of the above amount paid with the Application to Exercise a Policy Increase Option (Application) having the same proposed insured, owner and date(s) as this receipt. No insurance or increase in insurance is provided by this receipt, and this receipt does not guarantee issuance of any insurance coverage or increase in coverage.

I, the undersigned owner, have read this receipt. I understand and agree that payment of the above amount, and issuance of this receipt, does not provide any disability insurance coverage or increase in coverage, and that any insurance coverage that may be issued pursuant to the Application will be subject to the terms, conditions, limitations and exclusions of whatever issued policy governs such increase. I ask that Standard apply this payment to the first premium due for the increase applied for, if the increase is issued. I understand Standard will return this payment to me if the increase is not issued. Each copy of this receipt is considered to be a duplicate original.

\_\_\_\_\_  
Signature of Owner  
If company owner, signature of authorized representative

Signed at \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_  
City State Date

\_\_\_\_\_  
Signature of Soliciting Producer

Signed at \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_  
City State Date

**\* INSTRUCTIONS FOR PAYMENT WITH APPLICATION:** Any amount paid with the Application must equal at least ONE MODAL PREMIUM, based on the premium mode for the base policy. All checks must be payable to Standard Insurance Company. Do not make checks payable to the producer. Do not leave the payee blank.

**PRODUCER INSTRUCTIONS:** Use this receipt if money is paid with the Application. The owner and producer must complete, sign and date both copies of this receipt on the same date the owner signs the Application. Each copy must be identical. Give one copy to the owner. Send the other copy with the Application and check to the home office.

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

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(Application to Exercise a Policy Increase Option)

Proposed Insured: \_\_\_\_\_  
(please print)

\* Amount Received: \$ \_\_\_\_\_

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\_\_\_\_\_  
Signature of Owner  
If company owner, signature of authorized representative

Signed at \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_  
City State Date

\_\_\_\_\_  
Signature of Soliciting Producer

Signed at \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_  
City State Date

**\* INSTRUCTIONS FOR PAYMENT WITH APPLICATION:** Any amount paid with the Application must equal at least ONE MODAL PREMIUM, based on the premium mode for the base policy. All checks must be payable to Standard Insurance Company. Do not make checks payable to the producer. Do not leave the payee blank.

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**Standard Insurance Company**

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

**Authorization to Obtain and Disclose  
Personal (Nonmedical) Information**

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**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)