TheStandard®

School Administrators
Special Services

Voluntary Life Insurance

SCHOOL ADMINISTRATORS SPECIAL SERVICES FOR MEMBERS OF ACSA AND ACCCA

ASSOCIATION OF CALIFORNIA COMMUNITY COLLEGE ADMINISTRATORS

STANDARD INSURANCE COMPANY

Voluntary Group Life Insurance

Standard Insurance Company has developed this document to provide you with information about the optional coverage you may select through your Association. Written in non-technical language, this is not intended as a complete description of the coverage. If you have additional questions, please request a copy of the Certificate of Coverage from the Plan Administrator.

Protecting What's Priceless

It's not easy to think about, but what if you or your spouse were to die suddenly? Your family would be faced with house payments, unpaid bills, child care and other expenses just to maintain the lifestyle they have currently. Could your family live on one income? Would your family be able to cover the medical expenses associated with a terminal illness or with burial and funeral expenses?

You make a great investment in your family. You spend time with them. You care for them. You work for them. And if you're not there for them, you want them protected. School Administrators Special Services (SASS) offers you an excellent opportunity to help protect your loved ones by sponsoring Group Life and Accidental Death and Dismemberment (AD&D) Insurance, and Dependents Life and AD&D Insurance, from Standard Insurance Company (The Standard).

From the coverage options described below, you can apply for the right amount of protection you need for yourself and your family.

Payroll Deduction - If you are an active member and you elect to become insured, the cost of coverage may be deducted from your paycheck. You don't have to worry about mailing monthly payments

Choice - You decide how much coverage you need from the range of amounts available, and you can choose to insure yourself only, or yourself, your spouse and/or your dependent children.

Flexibility - If your needs change you can request to change the amount of coverage. Increases in coverage require proof of good health.

Peace of Mind - You will take comfort and satisfaction in knowing that you have done something positive for your family's future.

The Specifics

This section answers the most frequently asked questions about this insurance plan.

Coverages Available

- Life and AD&D Insurance for Active Members and their Spouses
- Life Insurance for Dependent Children
- Life Insurance for Retired Members and their Spouses

The information that follows contains a brief description of the Group Life and AD&D Insurance plans offered by The Standard. You can refer to your Certificate which contains more detailed information.

Life and AD&D Insurance for Members: If you meet the eligibility requirements as described below, you may apply for Life Insurance in amounts as shown in the following tables. The amount of your AD&D insurance equals the amount of Life Insurance you elect for yourself. The amount payable for certain losses is less than 100 percent of the AD&D Insurance Benefit. AD&D insurance is not included for Retired Members.

Dependents Life and AD&D Insurance for your Spouse: You can apply for the Dependents Life Insurance for your Spouse in amounts as shown in the following tables (but not to exceed 50 percent of the total amount of your Life Insurance). The amount of your Spouse's AD&D insurance equals the amount ($10,000 or more) of life insurance you elect for your Spouse. The amount payable for certain losses is less than 100 percent of the AD&D Insurance Benefit. Spouse coverage is not available if the Spouse is enrolled for Member coverage. AD&D Insurance is not included for Spouses of Retired Members. A Spouse is defined as a person to whom you are legally married, or an individual recognized as your domestic partner under California state law.

Dependents Life Insurance for your Children: You can apply for life insurance for your Dependent Children in amounts as shown in the following tables (but not to exceed 50 percent of the total amount of your Life Insurance). All your eligible children will be insured for the same amount. AD&D Insurance is not included. Children may only be insured by one member. Dependent children eligible for coverage are defined as unmarried natural or adopted children, or the unmarried children of your spouse living in your home. Dependent Children may be covered from live birth through age 18, or through age 22 if registered full-time students at an accredited education institution.

Spouses and Children who are full-time members of the armed forces of any country are not eligible for coverage.

Eligibility

To be eligible for this plan:

- You must be a member in good standing of School Administrators Special Services (SASS).
- If you are a regular, consolidated, student, associate, or other member of SASS, then you may elect from Class 1 (Active Members) benefits.
- If you are a SASS member age 60 or over and working less than 20 hours for a School District, Community College, State College, State University, County Office of Education, Department of Education or a private school; or a SASS member receiving California State Teachers' Retirement System or California Public Members' Retirement System (CalSTRS/ CalPERS) retirement benefits; or a SASS member paying Association of California School Administrators or Association of California Community College Administrators retirement dues, then you may elect from Class 2 (Retired Members) benefits.
- Full-time members of the armed forces of any country are not eligible for coverage.

Active Member Coverage Amount

You may elect Voluntary Life coverage in units of $10,000 to a maximum of $500,000. The minimum amount you can elect is $10,000.

If you wish to become insured for an amount in excess of the lesser of two times your annual earnings or $200,000, the excess will be subject to medical underwriting approval provided you apply within 90 days of first becoming an Association member. All late applications and requests for coverage increases are also subject to medical underwriting approval.

Accidental Death and Dismemberment Insurance (AD&D) is also included in this plan.

Active Member Rates

If you elect Voluntary Life insurance, your monthly premium rate for this plan is indicated in the table below. Premiums for this coverage may be deducted directly from your paycheck.

Age As of 1/1/2010	Rate (Per $1000 of Total Coverage)
<35	$0.09
35-39	$0.10
40-44	$0.13
45-49	$0.17
50-54	$0.27
55-59	$0.32
60-64	$0.39
65-69	$0.73
70+	$1.02

To calculate your premium:

1. Amount Elected: Write this amount on the Life Requested Amount line on your Enrollment and Change Form. Line 1: _____
2. Line 1 divided by $1,000 = Line 2. Line 2: _____
3. Rate (from chart). Line 3: _____
4. Line 2 multiplied by Line 3 = Your monthly cost. Line 4: _____

Active Member's Spouse Coverage Amount and Rates

The Level benefit coverage is available in units of $10,000 to a maximum of $250,000, but not to exceed 50 percent of your Voluntary Life coverage. All Spouse coverage for $10,000 or more will be subject to medical underwriting approval. The Level benefit also includes Accidental Death & Dismemberment coverage equal to the life coverage.

Option 1 - Basic Life coverage in the flat amount of $2,500 is available for your Spouse and $2,000 for your dependent child for $0.40 per month.

Option 2: Active Member's Spouse Rates – Level Benefit - If you elect Level Benefit Voluntary Life insurance for your Spouse, your monthly premium rate for this coverage is indicated in the table below. Premiums for this coverage may be deducted directly from your paycheck.

Age As of 1/1/2010	Rate (Per $1000 of Total Coverage)
<35	$0.09
35-39	$0.10
40-44	$0.13
45-49	$0.17
50-54	$0.27
55-59	$0.32
60-64	$0.39
65-69	$0.73
70+	$1.02

To calculate the premium for your spouse:

1. Amount Elected: Write this amount on the Dependent Life Spouse Requested Amount line on your Enrollment and Change Form. Line 1: _____
2. Line 1 divided by $1,000 = Line 2. Line 2: _____
3. Rate (from chart). Line 3: _____
4. Line 2 multiplied by Line 3 = Your monthly cost. Line 4: _____

Coverage Amount for Children and Rates

Your choice of one of the following Options:

	Term Life Insurance	
Child's Age	Option 1	Option 2
Under 6 months	$200	$750
6 months through 18 years	$2,000	$7,500
18 years through 22 years	$2,000	$7,500
Monthly Premium	$0.40	$0.70

Children will be covered through age 18 (or through age 22 if a full-time student at an accredited institution.)

Accelerated Benefit

If you become terminally ill, you may be eligible to receive up to 75 percent of the Life Insurance benefit, provided you meet certain conditions.

Member Coverage Effective Date

If you have applied for and we have approved your application for coverage, you will receive confirmation that tells you the scheduled effective date of your insurance.

When Does Your Coverage as an Active Member End?

- The date you start receiving CalSTRS/CalPERS retirement benefits.
- The date you start working less than 20 hours for a School District, Community College, State College, State University, County Office of Education, Department of Education or a private school and you are age 60 or over.
- The date you start paying Association of California School Administrators or Association of California Community College Administrators retirement dues.

What Happens If My Active Members Coverage Ends?

If your Life Insurance is scheduled to end because you no longer meet the Active Member requirements, but you meet the requirements for Retired Member coverage, you will be automatically enrolled in the Retired Member's plan with the highest plan coverage amount, which does not exceed your current benefit. You may elect to reduce or terminate this coverage with a full premium refund by notifying your Plan Administrator within 120 days after your coverage as an Active Member ends.

Retired Members Insurance Amounts and Monthly Premiums

Retired Member Life Insurance – Your choice of one of the following Plans:

	Reducing Term Life Insurance			
Member's age	Plan 1	Plan 2	Plan 3	Plan 4
Under 60	$12,500	$25,000	$37,500	$50,000
60 through 64	8,000	16,000	24,000	32,000
65 through 69	5,250	10,500	15,750	21,000
70 through 74	3,500	7,000	10,500	14,000
75 or over	1,750	3,500	5,250	7,000
Monthly Premium	$13.10	$26.10	$39.10	$52.10

Retired Member's Spouse Life Insurance – Your choice of one of the following Options:

	Reducing Term Life Insurance			
Spouse's Age	Option 1	Option 2	Option 3	Option 4
Under 60	$625	$3,125	$6,250	$9,375
60 through 65	625	1,550	3,125	4,700
66 through 69	625	N/A	N/A	N/A
70 or over	300	N/A	N/A	N/A
Monthly Premium	$0.40	$2.30	$4.90	$7.50

Your Spouse Life insurance may not exceed 50% of your Voluntary Life insurance amount.

Dependents Life Insurance for your Children – See the table on the preceding page

When Does Coverage End For All Members?

Your Life and AD&D Insurance automatically ends the earliest of these dates.

- The date the last period ends for which you made a premium contribution for the coverage.
- The date the Group Policy terminates.
- The date you cease to be a member of SASS.
- The date you become a full-time member of the armed forces of any country.

Coverage for Dependents automatically ends on the earliest of these dates.

- Five months after the date you die (no premium contribution is required).
- The date your Life Insurance ends.
- The date the last period ends for which you made a premium contribution for the coverage.
- The date the Group Policy terminates, or the date Dependents Life Insurance terminates under the Group Policy.
- For your Spouse, the date your divorce is final or the date of dissolution of your domestic partnership.
- For any Dependent, the date the Dependent ceases to be an eligible Dependent.

What happens If My Insurance Ends?

If your Insurance or Dependents Life Insurance ends or is reduced, you (or your Dependents) may be able to convert coverage to an individual life insurance policy without submitting Evidence of Insurability, provided application for the individual policy is made within 31 days after insurance ends.

Accidental Death & Dismemberment (AD&D) Insurance

AD&D Insurance is included with any Active Member Life coverage you elect as well as Active Member Spouse Life coverage of $10,000 or more you elect. The amount of the AD&D insurance benefit for loss of life is equal to the amount payable for Life Insurance coverage. AD&D insurance is not available to Retirees or their spouses.

The amount of this AD&D Insurance Benefit for other covered losses is a percentage of the amount payable for Life Insurance coverage on the date of the accident, as shown in the following table:

Loss:	Percentage Payable:
One hand or one foot	50%
Sight in one eye, speech, or hearing in both ears	50%
Two or more of the Losses listed above	100%

Limitations

The loss must occur solely by an accident and independently of all other causes within 365 days after the accident. Loss of life must be evidenced by a certified copy of the death certificate. All other losses must be certified by a physician in the appropriate specialty as determined by The Standard.

Exclusions

AD&D Insurance Benefits are not payable for death or dismemberment caused or contributed to by:

- War or act of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature
- Suicide or other intentionally self-inflicted injury, while sane or insane
- Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot
- Voluntary use or consumption of any poison, chemical compound, or drug, unless used or consumed according to the directions of a physician
- Sickness or pregnancy existing at the time of the accident
- Heart attack or stroke
- Medical or surgical treatment for any of the above

When Coverage Ends

AD&D Insurance for you and your Spouse will automatically end on the earliest of the following:

- The date your Active Member Life Insurance ends
- The date AD&D Insurance terminates under the group policy
- For your Spouse, the date your Spouse's Option 2 Life Insurance ends

Group Insurance Certificate

If you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage. The information presented above is controlled by the group policy and does not modify it in any way. The controlling provisions are in the group policy issued by Standard Insurance Company.

Additional Questions?

If you have any additional questions, please contact Plan Administrator.

Plan Administrator:
Mestmaker & Associates
P.O. Box 2302, Bakersfield, CA 93303 – (877) 472-6722

Sponsored by:
School Administrators Special Services
1575 Bayshore Highway Burlingame CA 94010-1613

Member Associations:
Association of California School Administrators
Association of California Community College Administrators

Arranged by:
Schaefer-Curry Insurance Associates, Inc.
1625 El Camino Rd Belmont CA 94002

Underwritten by:
Standard Insurance Company

Reset

Standard Insurance Company

SASS Group Voluntary Life Enrollment and Change Form

Mark all boxes and complete all sections that apply. Return completed form to the address below.

APPLICANT

Your Name (Last, First, Middle)			Group Name	Group Number(s)
			School Administrators Special Services (SASS)	**641419**
Your Address				
City	State	ZIP	Email	
Employer	Your Soc. Sec. No.		Work Phone No.	Home Phone No.
Employer Address			City	State / ZIP

LIFE

☐ New Coverage ☐ Change in Coverage ☐ I am a new member of the Association and never before eligible for membership.

Life Insurance

Member Life Coverage: Annual Salary $_____ Coverage Amount $_____ Rate Per $1,000_____

Spouse Life Coverage: ☐ Option 1 ☐ Option 2 Coverage Amount $_____ Rate Per $1,000_____

Child(ren) Life Coverage: ☐ Option 1 ☐ Option 2

If you have never been eligible for Association membership and apply for coverage within 90 days of becoming a member, you are guaranteed to be accepted for the Member Life Plan in the amount of 2x salary (coverage limited to $200,000). Evidence of good health is required for any amount of Spouse Life coverage, but not for Child coverage.

FAMILY MEMBERS TO BE INSURED

Member Name (Last, First, Middle)	Relationship **Member**	☐ M ☐ F	Date of Birth	State of Birth
Spouse Name (Last, First, Middle)	Relationship **Spouse**	☐ M ☐ F	Date of Birth	State of Birth
Name (Last, First, Middle)	Relationship	☐ M ☐ F	Date of Birth	State of Birth
Name (Last, First, Middle)	Relationship	☐ M ☐ F	Date of Birth	State of Birth
Name (Last, First, Middle)	Relationship	☐ M ☐ F	Date of Birth	State of Birth

BENEFICIARY

This designation applies to Member Life Insurance available through the SASS. Designations are not valid unless signed, dated, and delivered to the Plan Administrator during your lifetime. See page 2 for further information.

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

CHANGE

Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.

☐ Add Dependent ☐ Delete Dependent ☐ Name Change ☐ Beneficiary Change

Date of add/delete _____ Former name _____ ☐ Other _____

SIGNATURE

☐ I wish to make the choices indicated on this form. If electing coverage I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction will change if my coverage or costs change.

☐ I wish to make the choices indicated on this form. If electing coverage, I wish to authorize electronic payment (Credit Card or ACH) to cover my contribution toward the cost of insurance. I understand that my deduction will change if my coverage or costs change. (Please contact plan administrator for electronic authorization forms.)

Member Signature Required	Date (Mo/Day/Yr)

INSTRUCTIONS

Medical History Statement is required from the member if applying for more than guaranteed acceptance coverage and from the spouse for any amount of coverage. Check to see that the Enrollment Form and each Medical History Statement, if required, are signed before mailing to the Plan Administrator. Additional forms are available from the Plan Administrator.

Plan Administrator: MWG Mestmaker & Associates, PO Box 2302, Bakersfield CA 93303 877.472.6722 Tel

Beneficiary Information

- Your designation revokes all prior designations.

- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).

- If you name two or more Beneficiaries in a class:

    1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.

    2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.

    3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.

- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."

- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.

- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.

Standard Insurance Company
Medical Underwriting, 900 SW Fifth Avenue Portland OR 97204

Medical History Statement
For Residents of California

Reset

DIRECTIONS FOR APPLYING FOR COVERAGE

FOR RESIDENTS OF CALIFORNIA. *DIRECTIONS: This form must be completed when Evidence Of Insurability is required under your plan. To apply for coverage (as a Member or Spouse), read the notice(s) on page 2. Then complete all items, sign, and date below. When finished place the original signed Medical History Statement in a sealed envelope (for privacy) with your name on the outside of the envelope and return it along with the Group Voluntary Life Enrollment Form to* ***Plan Administrator, Mestmaker & Associates, PO Box 2302, Bakersfield, CA 93303 (Phone: 877-472-6722)****. Please keep a copy for your records.*

MEMBER INFORMATION

Name of Policyowner		Policy Number	Check who is Applying
School Administrators Special Services		**641419**	☐ Member ☐ Spouse
Member Name		Birthdate (Mo/Day/Year)	Date Hired (Mo/Day/Year)
Occupation	Salary	Social Security Number	Member Identification No.

APPLICANT INFORMATION

Applicant's Name (Person to be insured)			Street Address City State Zip	
Sex ☐M ☐F	Birthdate (Mo/Day/Year)	Birthplace	Social Security Number	Work Phone ( ) Home Phone ( )

APPLICATION INFORMATION

Type of Application *(check one)* ☐ Initial ☐ Increase in Coverage ☐ Late Application

Check the insurance coverage you are requesting.

☐ Life Insurance _____ (Current Amount In Force, if any) + _____ (Additional Amount Requested) = _____ (Total Amount Requested)

MEDICAL HISTORY STATEMENT QUESTIONS

Check yes or 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? ☐ Yes ☐ 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. Disease of the liver, pancreas, kidney, ulcers, stomach, intestinal ailment, or digestive system disorder? ☐ Yes ☐ No
   - B. Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, blindness, deafness, or any other neurological or muscle disorder? ☐ Yes ☐ No
   - C. Cancer, tumor, lesions, leukemia, lymphoma, blood clotting or other malignancy or growth? ☐ Yes ☐ No
   - D. Cardiovascular disease, heart ailment, arteriosclerosis, abnormal pulse, high blood pressure, heart murmur, valve, circulatory, or vascular disorders? ☐ Yes ☐ No
   - E. Emphysema, asthma, bronchitis, sleep apnea, or other respiratory or lung disease? ☐ Yes ☐ No
   - F. Lupus, scleroderma, vasculitis, connective tissue disease, or other immune system disorder not related to Human Immunodeficiency Disorder (HIV)? ☐ Yes ☐ No
   - G. Osteoarthritis, rheumatoid arthritis, osteoporosis, pain in the joints, amputations, or other disease or disorder of the bones, joints, back, or spine, arthritic or disc conditions? ☐ Yes ☐ No
   - H. Diabetes, thyroid, gland, spleen, or nephritis? ☐ Yes ☐ No
   - I. Drug or alcohol abuse, or have you used alcohol, drugs or nicotine in a manner that has resulted in medical treatment? ☐ Yes ☐ No
   - J. Psychiatric or mental condition, depression, adjustment disorder, affective disorder, anxiety disorder, or obsessive-compulsive disorder? ☐ Yes ☐ No
3. 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? ☐ Yes ☐ No
4. 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)? ☐ Yes ☐ No
5. Are you currently pregnant? ☐ Yes ☐ No

Height	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: 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 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 (Member)	**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.

Print and Sign

Standard Insurance Company

Standard Insurance Company has earned a solid reputation for its quality products, expert resources, superior service, steady growth, innovation and strong financial performance. Founded in 1906, Standard Insurance Company is a leader in the group disability, life and dental insurance market, while also offering individual disability and retirement plans for groups and individuals.

For more information about group Voluntary Life insurance coverage, or for assistance, please contact SASS.

TheStandard®

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

A subsidiary of StanCorp Financial Group, Inc.

School Administrators Special Services
1575 Bayshore Highway
Burlingame CA 94010
(650) 692-4300 (800) 672-3494

Arranged by:

Schaefer-Curry
Insurance Associates Inc.
1625 El Camino Real
Belmont CA 94002
(650) 593-8503

SI **12505-641419** (10/17)