



TheStandard®  
Positively different.

# Medical History Statements



TheStandard™

STANDARD INSURANCE COMPANY 

## Medical History Statements

### Frequently Asked Questions



### Getting Started

This site will guide you through the steps to complete and submit a Medical History Statement. This form is required for your application to obtain new or enhanced insurance coverage with The Standard. The Medical History Statement may be specific to your state of residence.

Completing the form will take approximately 15 minutes. You will need to have the following information available before you begin:

- Types and amounts of coverage you are requesting
- Physician names and addresses
- Personal identification information (Social Security Number, Date of Birth, etc.)
- Group name and six-digit policy number

Once you have the required information, select the "Get Started" button to begin the process.



To view some site content, you will need the [Adobe® Acrobat® Reader\(TM\)](#) browser plug-in.



## Medical History Statements

Frequently Asked Questions

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### Initial Questions

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Initial Questions	2. Demographic Questions	3. Employment Questions	4. Coverage Questions	5. Medical Questions

#### Enter the applicant's name.

First Name	Middle Initial	Last Name	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

#### Where is the applicant's current residence?

U.S.       Other

#### Enter the applicant's address.

Street Address:

City:

State:

Zip:

#### Enter the applicant's home phone number. (10 digit)

Continue



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## Medical History Statements

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Completed

## Submit Form

- Please review your Medical History Statement.
- Print or save a copy of the application for your own records.
- Remember to submit your form by clicking the "submit" button at the bottom of the page.

Save a Copy



97%



Sign

Signatures

Pages

ments

Standard Insurance Company

Medical Underwriting, 900 SW Fifth Avenue Portland OR 97204-1282

## Medical History Statement

**DIRECTIONS FOR APPLYING FOR COVERAGE**

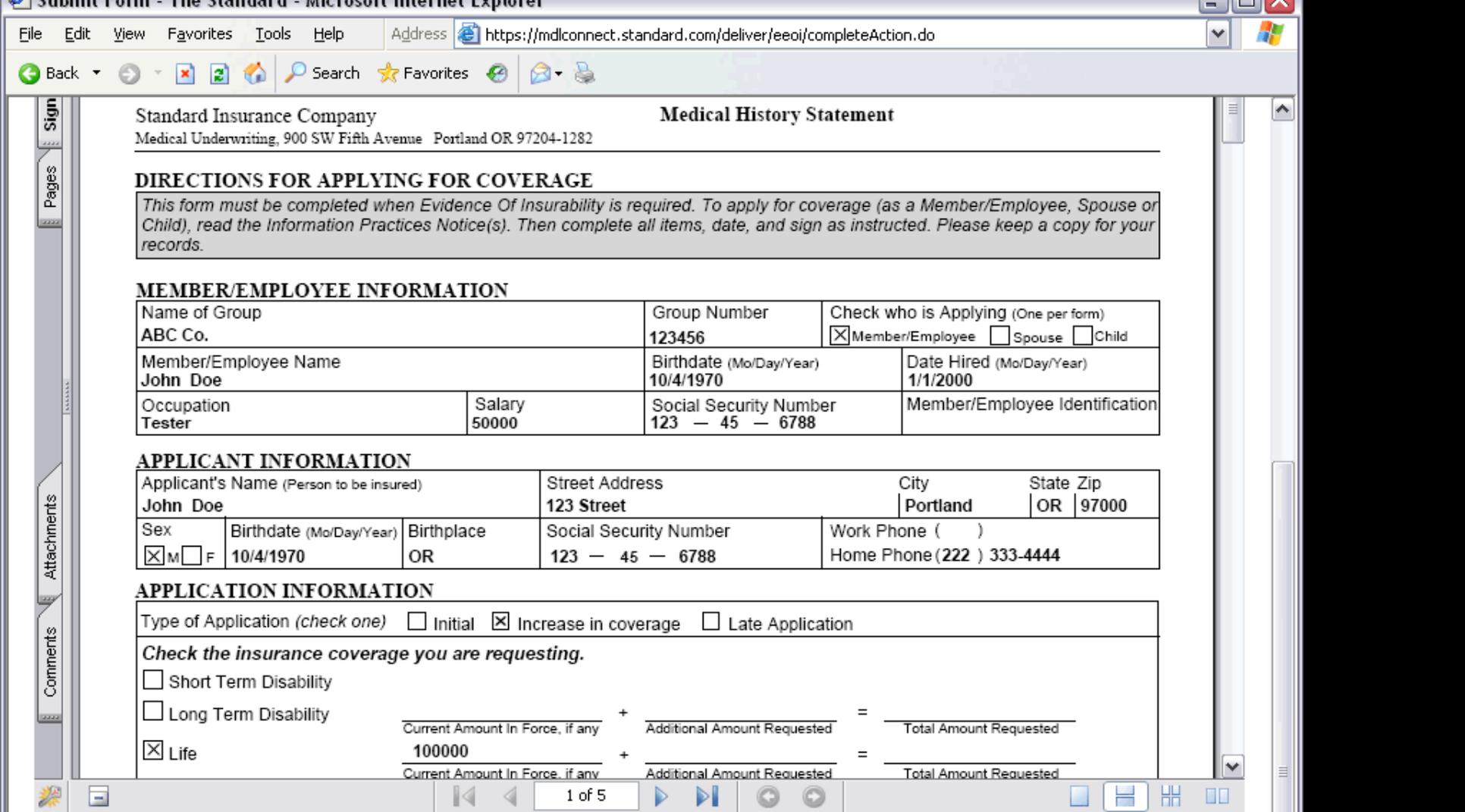
*This form must be completed when Evidence Of Insurability is required. To apply for coverage (as a Member/Employee, Spouse or Child), read the Information Practices Notice(s). Then complete all items, date, and sign as instructed. Please keep a copy for your records.*

**MEMBER/EMPLOYEE INFORMATION**

Name of Group ABC Co.		Group Number 123456	Check who is Applying (One per form) <input checked="" type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
Member/Employee Name John Doe		Birthdate (Mo/Day/Year) 10/4/1970	Date Hired (Mo/Day/Year) 1/1/2000	
Occupation Tester	Salary 50000	Social Security Number 123 - 45 - 6788	Member/Employee Identification	

**APPLICANT INFORMATION**

Applicant's Name (Person to be insured) John Doe		Street Address 123 Street	City Portland	State Zip OR 97000
Sex	Birthdate (Mo/Day/Year)	Birthplace	Social Security Number	Work Phone ( )



**Standard Insurance Company**

Medical Underwriting, 900 SW Fifth Avenue Portland OR 97204-1282

**Medical History Statement**

**DIRECTIONS FOR APPLYING FOR COVERAGE**

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Member/Employee Name <b>John Doe</b>		Birthdate (Mo/Day/Year) <b>10/4/1970</b>	Date Hired (Mo/Day/Year) <b>1/1/2000</b>	
Occupation <b>Tester</b>	Salary <b>50000</b>	Social Security Number <b>123 - 45 - 6788</b>	Member/Employee Identification	

**APPLICANT INFORMATION**

Applicant's Name (Person to be insured) <b>John Doe</b>		Street Address <b>123 Street</b>		City <b>Portland</b>	State <b>OR</b>	Zip <b>97000</b>
Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Birthdate (Mo/Day/Year) <b>10/4/1970</b>	Birthplace <b>OR</b>	Social Security Number <b>123 - 45 - 6788</b>	Work Phone ( )		
				Home Phone <b>(222 ) 333-4444</b>		

**APPLICATION INFORMATION**

Type of Application (check one)  Initial  Increase in coverage  Late Application

**Check the insurance coverage you are requesting.**

Short Term Disability

Long Term Disability

Life

Current Amount In Force, if any	+	Additional Amount Requested	=	Total Amount Requested
<b>100000</b>				
Current Amount In Force, if any	+	Additional Amount Requested	=	Total Amount Requested

By clicking the "Submit" button I acknowledge that I have reviewed the PDF and that the content in the form accurately reflects the information I have entered.

To return to the questions and modify one or more answers click on the "Make Changes" button.

Submit

Make Changes

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### Application Confirmation

We have received your Medical History Statement.

Reminder, do not send us a hard copy of the Medical History Statement, this may lead to delays in processing your application.



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100% Completed



To view some site content, you will need the [Adobe® Acrobat® Reader\(TM\)](#) browser plug-in.

### Final Review

You must follow the steps below to complete your form.

1. Review your Medical History Statement.
2. Read the Acknowledgment and Authorization for Release of Information.
3. Print a copy of your form.
4. Sign and date the form.
5. Affix proper postage and mail it to The Standard Insurance Company.

**Mail form to:**  
 Standard Insurance Company  
 Medical Underwriting  
 900 SW Fifth Avenue  
 Portland, OR 97204-1282

1 If you need to return to the questions and answers, click the "Back" button.

Make Changes

<https://mdlconnect.standard.com/deliver/eeoi/renderAction.do?...>

Save a Copy Print Search Select Sign

52%

**Standard Insurance Company MEDICAL HISTORY STATEMENT** Medical Underwriting  
 900 SW Fifth Ave • Portland OR 97204-1282

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/Employee, Spouse or Child), read the notes(s) on page 2. Then complete all items, sign, and date below. When finished, send the original to Standard Insurance Company, and keep a copy for your records. If both the Member/Employee and Member/Dependent(s) (Spouse and/or Child) are applying, each must complete one of these forms.

NAME OF GROUP ABC Co.	GROUP NUMBER 123456	TYPE OF APPLICATION <input type="checkbox"/> NEW <input type="checkbox"/> RENEWAL <input type="checkbox"/> REINSTATEMENT	CHECK APPLICABLE COVERAGE <input type="checkbox"/> LIFE <input type="checkbox"/> ACCIDENT AND SICKLEAVE <input type="checkbox"/> DISABILITY
MEMBER/EMPLOYEE'S NAME John Doe	BIRTHDATE 05/15/1979	DATE HIRED 5/1/2000	IS THIS A LATE APPLICATION? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
CHECK WHO IS APPLYING FOR COVERAGE <input checked="" type="checkbox"/> MEMBER/EMPLOYEE <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD	APPLICANT'S NAME (PERSON YOU INSURE) John Doe	OCCUPATION Teacher	SALARY \$6000
SOCIAL SECURITY NUMBER 123 - 45 - 6789	APPLICANT'S ADDRESS (PRINT CITY, STATE, ZIP) 123 Street Sacramento CA 95816	WORK PHONE (408) 222-3333	HOME PHONE (229) 333-4444

ADDITIONAL/OPTIONAL LIFE APPLICANTS: PLAN OPTION (IF APPLICABLE): \_\_\_\_\_ AMOUNT OF COVERAGE REQUESTED: \$ \_\_\_\_\_

BENEFICIARY DESIGNATION: If you currently have a beneficiary designation on file with your plan administrator for Life coverage under Standard's Group Policy, that designation will also apply to any approved Additional/Optional Life, or other coverage increase. If you have no beneficiary designation on file or wish to change the name of the current designee, contact your plan administrator.

For approved applicants, premiums shall be paid in accordance with the provisions of the Group Policy(ies). Declinations do not affect their Guarantee (Issue Amounts not subject to Evidence Of Insurability or other coverages already in force with Standard Insurance Company. Coverage will be subject to all applicable terms and conditions of the Group Policy(ies) and state limitations.

Check yes or no for each of these questions, and give details as shown on page 2 for any "yes" answers. Attach a separate sheet if necessary.

1. Have you had any physical, mental or emotional condition, injury, sickness, or surgery in the past 5 years?  Yes  No
2. Have you consulted or been attended by a physician or practitioner for any cause in the past 5 years?  Yes  No
3. Are you now unable to work full-time because of any physical, mental or emotional condition, injury, or sickness?  Yes  No
4. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
  - A. High blood pressure, cardiovascular disease, heart ailment, arteriosclerosis, or stroke?  Yes  No
  - B. Mental condition, depression, epilepsy, or nervous system disorder?  Yes  No
  - C. Cancer, diabetes, or hepatitis?  Yes  No
  - D. Arthritis, strained or injured back, slipped disc, or any bone, joint, or muscle disorder?  Yes  No
  - E. Lung, kidney, stomach, genital, urinary, or intestinal ailment?  Yes  No
  - F. Blindness or deafness?  Yes  No
  - G. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or an immune system disorder?  Yes  No
5. Have you sought or received advice or treatment for the use of alcohol or drugs in the past 10 years?  Yes  No
6. In the past 10 years have you had a persistent cough, unintentional weight loss of 10 pounds or more, persistent fatigue, persistent lymph node enlargement, prolonged night sweats, pneumonia, lesions, or growths?  Yes  No
7. Do you take medication for any physical, mental or emotional condition, injury, or sickness?  Yes  No
8. Do you plan any operation or visit to a doctor or practitioner for an existing physical, mental or emotional condition, injury, or sickness?  Yes  No
9. Are you now pregnant?  Yes  No

HEIGHT 5ft. 0in.	WEIGHT 150	PHYSICIAN OR MEDICAL FACILITY WITH APPLICANT'S COMPLETE MEDICAL RECORDS (ALL APPLICANTS REQUIRED)
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**Acknowledgment and Authorization for Release of Information. (Please read carefully.)**  
 I represent that the statements contained herein, including those made on page 2 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 of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by 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, Standard's liability is limited to the return of any premium which may have been paid.  
 I acknowledge that I have read and received the Information Practices Notice (on page 2) and I have kept a copy of this Medical History Statement. To any physician, health care provider, hospital, insurance or reinsurance company, the Medical Information Bureau, Inc. (MIB), or any employer, I authorize you to release to Standard or its reinsurers all medical information you have about me including medical history, diagnosis, prognosis and treatment of any physical, mental or emotional condition. I understand that Standard will use the information obtained by this authorization to determine my eligibility for group insurance coverage. I further authorize Standard to release this information to its reinsurers, MIB, and to other insurance companies to which I have applied for insurance coverage or benefits.  
 I understand a copy of this authorization will be provided upon request. This authorization will remain valid one year from the date below. A photocopy of this authorization shall be as valid as the original. I understand that I have the right to revoke this authorization at any time by sending a written statement to Standard. I understand that the revocation of the authorization, or the failure to sign the authorization, may impair Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.

SIGNATURE OF APPLICANT (OR MEMBER/EMPLOYEE FOR DEPENDENT CHILD) \_\_\_\_\_ DATED \_\_\_\_\_  
 04/18/07/2006 1 of 2 6066