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, read the notice(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.*

NAME OF GROUP	GROUP NUMBER	TYPE OF APPLICATION	CHECK APPLICABLE COVERAGE
City of San Jose - Retirement Services	645765	☐ INITIAL ☐ INCREASE IN COVERAGE	☐ ADDITIONAL/OPTIONAL LIFE

RETIREE'S NAME	BIRTHDATE	DATE RETIRED

CHECK WHO IS APPLYING	RETIREE'S ADDRESS (STREET, CITY, STATE, ZIP)
☐ RETIRED MEMBER	

SEX ☐ M ☐ F	BIRTHPLACE	SOCIAL SECURITY NUMBER	WORK PHONE ( )
			HOME PHONE ( )

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 either 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 nephritis? . . . . . ☐ 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	WEIGHT	PHYSICIAN OR MEDICAL FACILITY WITH APPLICANT'S COMPLETE MEDICAL RECORDS
		NAME FULL MAILING ADDRESS

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**

Describe below any "yes" answers which were given for questions on page 1. (Please provide the entire question number.)

Question #	*Description of Injuries, Disorders and Operations*	*Month/Year*	*Duration*	*Final Result*	*Physicians Consulted, City & State*

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 97204-1282 or call 1-800-843-7979.

PLEASE RETAIN A COPY FOR YOUR RECORDS.