

New Hampshire Insurability Information Request

Standard Insurance Company
P.O. Box 2753

Portland, OR 97208-9803

Phone: 800-551-7265 Fax: 614-433-8880

AL-MedicalUnderwriting@standard.com

Complete this form and email it to AL-MedicalUnderwriting@standard.com

Please keep a copy of this form/notice for your records.

Group no.	Evidence required because of: <input type="checkbox"/> Over guaranteed issue amount <input type="checkbox"/> Late entrant <input type="checkbox"/> Change of benefits This evidence is provided for: <input type="checkbox"/> An effective date under a new group <input type="checkbox"/> A post group effective date addition
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Section 1: General information

Last name		First name		M.I.	Date of birth (MMDDYYYY)			
Identification no.		Work phone no.		Home phone no.		Email address		
Employee address		City		State	ZIP code	State of birth	Height	Weight
Requested amount \$	Name of employer			Employer address				

Section 2: Dependent information — Complete for all dependents (if any) to be covered under this program.

Last name, first name, M.I.	Sex	Date of birth (MM/DD/YYYY)	State of birth	Social Security no.	Relationship	Height	Weight
	<input type="checkbox"/> M <input type="checkbox"/> F				Spouse		
	<input type="checkbox"/> M <input type="checkbox"/> F						
	<input type="checkbox"/> M <input type="checkbox"/> F						
	<input type="checkbox"/> M <input type="checkbox"/> F						

Section 3: Medical and activities questionnaire

Complete the following medical questions for all persons to be covered: For the purpose of the following questions, the term "medical or social practitioner" includes but is not limited to: a doctor, nurse, psychologist, psychiatrist, social worker, chiropractor, podiatrist, therapist, pathologist, dentist, optometrist, osteopath, Christian Science practitioner, or any person affiliated with a self-help program such as Alcoholics Anonymous, a substance abuse program, or a weight loss program. Please explain "yes" answer(s) in the chart at the top of page 2.

<p>1. Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Expected due date: _____ (MMDDYYYY)</p> <p>2. Have you or any of your dependents smoked or used tobacco in the last five years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? _____ Type: _____ Quit date (if applicable): _____ (MMDDYYYY)</p> <p>3. In the past 10 years, have you or any of your dependents been treated or diagnosed by a member of the medical profession for:</p> <p>a. high blood pressure or high cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? _____ Last three readings: _____</p> <p>b. heart disease, cancer, diabetes, arthritis, or asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. counseling by a medical or social practitioner for an emotional, mental or nervous condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. alcoholism, substance abuse or chemical dependency? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. In the past 10 years, have you or any of your dependents been convicted for driving while intoxicated? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>5. Have you or any of your dependents been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. In the past three years have you or any of your dependents been prescribed medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. In the past 10 years have you or any of your dependents had an inpatient admission and/or outpatient surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. During the past three years, have you or any of your dependents sought medical treatment, or have been advised by a medical or social practitioner to seek treatment for a condition relating to a yes answer to the preceding seven questions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. In the past 10 years, have you or any of your dependents been rated or declined for, or refused reinstatement or renewal of, life or health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of person, date and reason: _____</p> <p>10. In the past three years, have you or any of your dependents been engaged in or contemplate during the next 12 months being engaged in sports or hobbies such as aviation, scuba diving, sky diving, racing, or similar activities? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list: _____</p>
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Important notice: No person, including an employee or agent of Standard Insurance Company has the authority to change or omit any of these medical questions.

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningún costo adicional llamando al número de servicio al cliente que se encuentra en este documento. The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of 1100 SW Sixth Avenue, Portland, Oregon in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

Section 3: Medical and activities questionnaire (continued)

Explain any "Yes" answers below. If additional space is necessary, attach a separate page including your signature and date.						
Question no.	Name of individual	Name of illness or injury	Dates of treatment	Any remaining effects	Name of medication and dosage	Name and address of physician/hospital

Section 4: Notice of exchange of information

To proposed Insured and other persons proposed to be Insured, if any — information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB Group, Inc., a non-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 may, upon request, 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. If you question the accuracy of this 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: P.O. Box 105, Essex Station, Boston, Massachusetts 02122; and telephone number is 866-692-6901. (TTY: 866-346-3642 for hearing impaired).

Section 5: Agreement and authorization

1. I authorize the release of any medical records or information concerning claims, conditions or treatment of myself and for any dependents listed herein, by any provider of health services, pharmacy related service organization, medical or medically-related facility, or the MIB Group, Inc., to Standard Insurance Company (The Standard), its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of The Standard. This information will be used for purposes which include but are not limited to: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims, and quality improvement programs. The Standard will advise such entities that such information must be kept confidential to the extent necessary or as otherwise provided by law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to HIV virus or AIDS, sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, prescription history, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. I understand that The Standard may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that The Standard collects about me, and that I may receive a more detailed description of my rights under this law by writing to The Standard.
2. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.
3. I am responsible for the timely notification to my employer of any changes that would make me or a dependent ineligible for coverage.
4. I understand that The Standard reserves the right to accept or decline the application and that no right whatsoever is created by this information request. I acknowledge that I have read the foregoing provisions and I expressly accept such provisions as a condition of coverage. I also acknowledge receipt and understanding of the Notice of Exchange of Information explained above. I represent that the answers given to all questions on this information request are true and accurate to the best of my knowledge and I understand they are being relied on by the insurer in reviewing the application for insurance. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this information request may result in denial of benefits or rescission or cancellation of my coverage(s). This authorization, for purposes of processing this information request form, is valid from the date signed for a period of twenty-four months unless revoked by me in writing, which I may do at any time by contacting The Standard. A photocopy is as valid as the original.

Applicant signature X	Date (MMDDYYYY)
Spouse signature (If to be covered) X	Date (MMDDYYYY)

This Authorization may be revoked at any time by the Applicant by sending a written revocation to us at: **Standard Insurance Company, P.O. Box 2753, Portland, OR, 97208-9830**. Such revocation must be signed and dated by the Applicant and spouse, if the spouse is to be covered. Revocation of this Authorization may result in denial of coverage or denial of a claim.

Refusal of authorization — I refuse authorization to disclose health care information. I understand that Anthem may not be able to conduct a proper review of my request for coverage without such information.

Applicant signature X	Date (MMDDYYYY)
Spouse signature (If to be covered) X	Date (MMDDYYYY)

Fraud Warning: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. §638:20.