

## Individual Disability Insurance

# Telephone Interview

## What to Expect



Thank you for your interest in individual disability insurance from The Standard.<sup>†</sup> Your insurance representative has ordered a telephone interview, or "TeleApp," as part of the application process.

Your appointment is scheduled for:

\_\_\_\_\_ a.m./p.m. on \_\_\_\_\_  
(time) (date)

If you don't have an appointment scheduled yet, a LifePlans representative will contact you to set up a convenient time for your interview.

## What to Expect During Your Interview

A highly trained interviewer will ask you about your activities and health, including your work and medical history. Please allow 30 to 40 minutes for your interview.

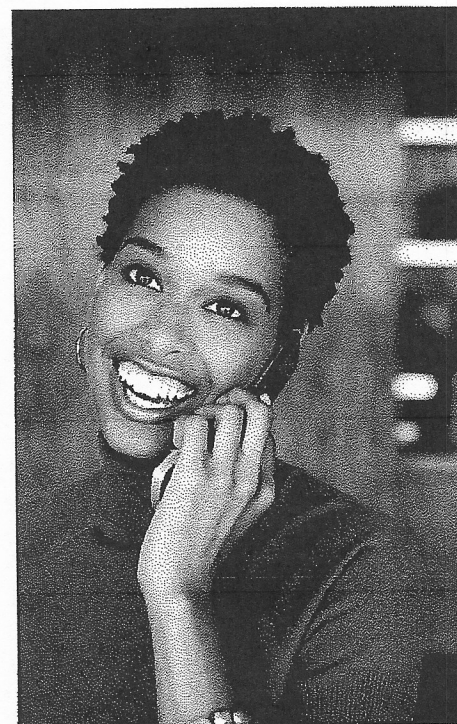
Be prepared to provide the following information during your interview:

- Names, addresses and phone numbers of medical providers you have visited in the last 10 years
- Approximate dates of injuries, surgeries, emergency room visits, hospitalization(s), illnesses and/or conditions
- Prescription history over the last three years, including medication names, dosages, dates taken and reasons for use
- Foreign travel history for the last five years
- Name(s) of employer(s) and dates of employment

## What to Expect After Your Interview

After your interview, LifePlans will send your completed interview to your insurance representative and The Standard. If approved, the final application and resulting policy with The Standard will include information you provide during your telephone interview.

When you receive your policy, review it carefully for completeness and accuracy. Incomplete, incorrect or untrue statements could affect your eligibility for benefits.



Standard Insurance Company  
The Standard Life Insurance  
Company of New York

[www.standard.com](http://www.standard.com)

<sup>†</sup> The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company, 1100 SW Sixth Avenue of Portland, Oregon, in all states except New York, where insurance products are offered by The Standard Life Insurance Company of New York of 360 Hamilton Avenue, Suite 210, White Plains, New York. 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 is licensed to solicit insurance business in all states except New York. The Standard Life Insurance Company of New York is licensed to solicit insurance business in only the state of New York.

TeleApp Information for Customers  
16459 (10/16) SI/SNY

# Standard Insurance Company

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

## Application for Individual Disability Insurance

### Proposed Insured

Full Name (First, Middle, Last) <b>Scott Grand</b>		Gender <b>Male</b>	Social Security No. <b>474-74-7689</b>	
Home Address <b>16958 68th Place North</b>		City <b>Maple Grove</b>		State <b>MN</b>
ZIP <b>55311</b>				
Birth Date <b>06/07/1976</b>	State of Birth <b>MN</b>	Driver's License No. <b>R350145629916</b>	Driver's License Issue State <b>MN</b>	
Primary Phone No. <b>651-261-1736</b>	Secondary Phone No.	Email Address <b>scott@yournarrative.com</b>	<input type="checkbox"/> Check to request electronic policy delivery.	
Current Primary Occupation/Duties <b>Principal Owner</b>				

### Insurance Applied For

Plan Type & Features:	<b>Disability Income</b> (Application Supplement required) Basic Monthly Benefit \$ <b>8000</b> Benefit Waiting Period <b>90</b> days Benefit Period <b>67</b>	<b>Business Buy-out Expense</b> (Application supplement required) Waiting period _____ days Aggregate Benefit Limit \$ _____
	<input checked="" type="checkbox"/> <b>Platinum Advantage</b> <input checked="" type="checkbox"/> Noncancelable <input type="checkbox"/> Indexed Cost of Living: <input type="checkbox"/> 3% <input type="checkbox"/> 6% <input checked="" type="checkbox"/> Own Occupation <input type="checkbox"/> Catastrophic Disability \$ _____ <input checked="" type="checkbox"/> Benefit Increase <input type="checkbox"/> Automatic Increase Benefit <input checked="" type="checkbox"/> Residual Disability Benefit Rider (select one): <input type="checkbox"/> Enhanced <input checked="" type="checkbox"/> Basic <input type="checkbox"/> Short Term <input type="checkbox"/> Student Loan Benefit Maximum monthly benefit \$ _____ Rider period: <input type="checkbox"/> 10 Years <input type="checkbox"/> 15 Years	Funding method (select and complete one): <input type="checkbox"/> Lump sum amount \$ _____ <input type="checkbox"/> Monthly amount \$ _____ For _____ years <input type="checkbox"/> Down payment amount \$ _____ Lump sum; and \$ _____ Monthly for _____ years
	<b>Business Overhead Expense</b> (Application supplement required) Base amount \$ _____ Waiting Period _____ days Benefit multiple _____ months <input type="checkbox"/> Residual Disability <input type="checkbox"/> Future Purchase Option units \$ _____ Number of units: _____	<input type="checkbox"/> Future Buy-out Expense Rider Aggregate Benefit Limit \$ _____ Funding method (must be same as base) (Select and complete one): <input type="checkbox"/> Lump sum amount \$ _____ <input type="checkbox"/> Monthly amount \$ _____ <input type="checkbox"/> Down payment amount/mo. \$ _____ <input type="checkbox"/> Extended Benefit Option

### Premium Payment

Premium mode: <input type="checkbox"/> EFT (monthly) <input type="checkbox"/> List bill (monthly) <input checked="" type="checkbox"/> Annual <input type="checkbox"/> Other _____ Payer name and address if other than proposed insured: _____ _____ _____
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# Standard Insurance Company

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

## Application for Individual Disability Insurance

### Other Insurance Coverage

1. Explain Yes answers in the table below. Use status and type codes provided:

- a. Have you applied for any disability insurance in the last 12 months? ☒ Yes ☐ No  
b. Will you become eligible for any disability insurance in the next 24 months? ☐ Yes ☒ No  
c. Is there any other individual or group disability insurance currently in force or pending on you? ☒ Yes ☐ No

Status Codes: N - now in force with any company; P - pending; A - applied for in the last 12 months;  
F - will become eligible in the next 24 months

Type Codes: I - individual; G - group; X - association; OE - overhead expense; L - loan repayment; O - other

Company	Status	Type	Who pays premium?	Benefit amount or % of income	If group:		Benefit period	Waiting period	Will coverage be replaced or reduced?
					Benefit cap maximum	Bonus covered?			
Unum	N	I	Insured	2,000		<input type="checkbox"/> Yes <input type="checkbox"/> No	67	90	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No

### Financial Information

2. How many hours per week do you work in your primary occupation? \_\_\_\_\_ hours per week

3. What is your annual earned income from your primary occupation?

Current year \$ 475,000 Last year \$ 475,000

If you are self-employed, earned income is after business expenses.

Do not include investment or other passive income.

4. Currently, is your passive income greater than 25% of your earned income or \$50,000? (Passive income includes: capital gains, interest, dividends, net rental income, pensions, annuities, royalties, etc.) ☐ Yes ☐ No  
If Yes, please provide sources and amounts:

5. Is your net worth, excluding primary residence, greater than \$8,000,000? ☐ Yes ☐ No  
If Yes, please provide sources and amounts:

6. Will your employer pay for any part of this requested insurance? ☐ Yes ☒ No  
If Yes, please answer a, b and c.

a. What percent of premium will your employer pay? ☐ None ☐ 100% ☐ Other \_\_\_\_\_ %

b. Will your employer's contribution be included in your taxable income? ☐ Yes ☐ No

c. Will you reimburse your employer for any premium? ☐ Yes ☐ No

7. Do you own any part of, or are you an independent contractor for, the business where you work? ☒ Yes ☐ No  
If Yes, please answer a, b and c.

a. Business entity: ☐ C Corp ☐ S Corp ☐ LLC ☐ LLP ☐ Sole Proprietor ☐ Partnership  
☐ Other \_\_\_\_\_

b. Number of employees: Full-time \_\_\_\_\_ Part-time \_\_\_\_\_

c. Percent of business entity owned \_\_\_\_\_ % Years owned \_\_\_\_\_

If TeleApp complete 8a and 8b.

8. a. Enter your Height \_\_\_\_\_ Weight \_\_\_\_\_

b. In the last 5 years have you been treated for, or been diagnosed by a medical professional as having any heart condition, back or neck disorder, anxiety or depression; cancer, diabetes or neurological disorder? ☐ Yes ☐ No

If Yes, please provide details. Include dates, diagnoses and treatments; also include health care provider name(s) and address(es).

Standard Insurance Company

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

Application for Individual Disability Insurance

Agreement and Signatures

I, the undersigned, understand and agree to the following:

In this application, "you" and "your" mean the proposed insured unless otherwise specified.

This application will be attached to, and made part of, a policy that is issued to you. The application includes all pages of this form, the Full Underwriting Application Supplement, and all other application supplements and amendments that may be attached to the application. If an application was completed by using the TeleApp interview process, this application also includes all questions Standard Insurance Company (Standard) or its representatives will ask the proposed insured; and it includes all answers given in response to those questions. The TeleApp answers will be included with the application if a policy is delivered and should be carefully reviewed when signing for acceptance of a policy.

Standard will rely on the information given in this application in considering the proposed insured's eligibility for insurance and for various premium rates. By obtaining and using this information, or information from other authorized sources, Standard is not giving a medical opinion about the proposed insured's health. I will not rely on any inquiry or decision by Standard as a statement regarding, or evaluation of, the proposed insured's health.

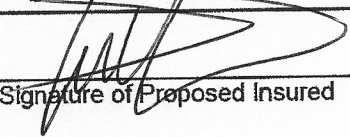
This application will not be effective unless it is signed and dated by the proposed insured and owner, if different. No insurance will be in force until: (a) the date a policy has been issued, delivered to and accepted by the owner; and (b) the first full premium is paid while all answers in this application remain true and complete. The only exceptions are as provided in a Disability Insurance Conditional Receipt, issued at the same time as this application. Premium will be calculated to begin on the Policy Effective Date.

No sales representative, medical examiner, or TeleApp interviewer is authorized: to determine insurability; or to change any of Standard's requirements; or to waive any rights Standard may have. No corrections or amendments to this application will be made without the owner's written consent.

Standard may require that any disability policy(s) listed in answer to question 1 be permanently terminated or reduced as a condition of issuing the insurance applied for herein. Standard will rely on the information in this answer in determining the amount, if any, of disability insurance it will issue. If such insurance is not terminated or reduced as required by Standard, any policy issued and accepted pursuant to this application may be rescinded and considered void from the beginning, and all premiums returned. If any insurance applied for is intended to replace other insurance in force with Standard, the Standard policy being replaced will end the moment the insurance applied for becomes effective.

I have read this application. I understand that if any answers are false, incorrect or untrue, Standard may have the right to deny benefits or rescind my insurance policy. I Represent That: all answers in this application are correctly recorded, true and complete to the best of my knowledge and belief; and any and all answers I have provided verbally to a Standard producer or other Standard representative have also been correctly recorded. No knowledge of any fact on the part of any sales representative, medical examiner or TeleApp interviewer shall be considered to be knowledge of Standard unless such fact is stated in the application.

**NOTE: A person who knowingly presents false information or conceals material information in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.**

 Signed at Maple Grove, MN on 10/18/18  
City, State Date

Signed at \_\_\_\_\_ on \_\_\_\_\_  
Signature of Policyowner (If other than Proposed Insured) City, State Date  
If a company is policyowner, signature of authorized representative.

Print Name of Policyowner \_\_\_\_\_ Owner's Tax ID Number (If other than Proposed Insured) \_\_\_\_\_  
If a company is policyowner, also print title of authorized representative and company name.

Owner's Address \_\_\_\_\_ City, State \_\_\_\_\_ ZIP \_\_\_\_\_ Email Address \_\_\_\_\_

I declare and affirm that: (1) any answers provided to me by the proposed insured have been truly and accurately recorded on this application; and (2) no changes, additions or alterations of any kind have been made to this form after it was signed by the proposed insured and owner, if different.

Signed at \_\_\_\_\_ on \_\_\_\_\_  
Signature of Soliciting Producer City, State Date



## Standard Insurance Company

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

## Authorization to Obtain and Disclose Information

### 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 this personal information may be in paper or electronic format and may include information about my age, occupation, avocations, driving record, travel, aviation, character, general reputation, personal characteristics and activities, mode of living, income and finances and other insurance. I also understand that personal information may include medical records, in paper or electronic format, containing health information related to medical history, examinations, diagnoses, prognoses, test results, prescriptions and treatments of any physical or mental conditions.

### Authorization to Obtain Personal Information

I authorize MIB, Inc., and any licensed physician, medical professional, health care provider, hospital, medical or medically-related facility, clinic, pharmacy, alcohol or drug treatment facility, insurance or reinsurance company, insurance sales representative, consumer reporting agency, government department or agency, employer, and any other person, organization or institution having records or knowledge of me, to release personal information about me, to Standard, its reinsurers, and any insurance support organization acting on behalf of Standard Insurance Company. I further authorize Standard to request and obtain an investigative consumer report about me from a consumer reporting agency, as described in the Disclosure Notice - Information Practices.

### Authorization to Use Personal Information

I authorize Standard to use personal information obtained about me for the purposes of evaluating eligibility for insurance and reinsurance, 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 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. I understand that any health information that is disclosed pursuant to this Authorization may be subject to redisclosure as permitted or required by law and may no longer be protected by federal laws governing privacy and confidentiality of health information.

### Certain Types of Health Information

I understand that certain health information cannot be released without my specific consent, in accordance with federal and state laws. I hereby expressly consent to the release of information related to my use of alcohol, drugs and tobacco; diagnosis or treatment of Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and sexually transmitted diseases; and diagnosis and treatment of psychological or mental illness (excluding psychotherapy notes). I also understand that blood, urine, saliva or other medical tests or examinations may be required to determine my insurability.

This authorization excludes the use of results of bloodborne pathogen tests (including HIV antibody tests) performed on: (1) a criminal offender or crime victim who was exposed to or had contact with an offender's bodily fluids during the commission of a crime that was reported to law enforcement officials; (2) an individual who has had contact with an emergency medical services person; (3) an inmate who has had contact with a corrections employee; or (4) a patient who has had contact with an employee of a secure treatment facility.

### Expiration and Revocation

This Authorization will expire automatically twenty-four (24) months following the date of my signature below. 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 97204-1093. 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.

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 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

Scott Grand

Name (please print)

9935(9/16)MN

Date of Signature

6-7-1970

Date of Birth

Authorization to Obtain and Disclose Information - Submit with Application

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

**Authorization for Release  
of Personal Psychotherapy Notes  
to Standard Insurance Company**

Scott Guard  
Name of (Proposed) Insured/Patient (please print)

6-7-1976  
Date of Birth

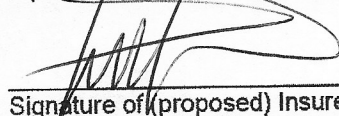
I authorize any licensed physician, medical professional, health care provider, hospital, medical or medically-related facility, laboratory, clinic, pharmacy, alcohol or drug treatment facility that has provided medical treatment, care or services to me to disclose my entire medical record and any other health information **solely relating to psychotherapy notes** to Standard Insurance Company ("Standard") or an insurance support organization acting on behalf of Standard. Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of my medical record.

By my signature below, I acknowledge that any agreements that I have made to restrict my health information do not apply to this Authorization and I instruct my health care providers to release and disclose my entire medical record relating to psychotherapy notes without restriction.

I understand that the health information to be disclosed to Standard will be used for the purposes of evaluating eligibility for insurance and reinsurance, determining appropriate premium rates, evaluating claims for insurance benefits and conducting other legally permissible activities that relate to my application and insurance coverage. I also understand that any health information that is disclosed pursuant to this Authorization may be subject to redisclosure as permitted or required by law and may no longer be protected by federal laws governing privacy and confidentiality of health information.

This Authorization will expire automatically twenty-four (24) months following the date of my signature below. 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 Underwriting, 1100 SW Sixth Avenue, Portland, Oregon 97204-1093. 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 collection, use or disclosure of information prior to Standard's receipt of my revocation and any action taken before Standard receives my written revocation will be valid.

I acknowledge that I have read this Authorization and that I have the right to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization is as valid as the original.

  
Signature of (proposed) Insured/Patient

10/18/18  
Date



**NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN  
INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH  
INSURANCE GUARANTY ASSOCIATION LAW**

If the insurer that issued your life, annuity or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, **SUBJECT TO LIMITS AND EXCLUSIONS**, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life & Health Insurance Guaranty Association  
4760 White Bear Parkway  
Suite 101  
White Bear Lake, Minnesota 55110  
(651) 407-3149

The maximum amount the Guaranty Association will pay for all policies issued on one life by the same insurer is limited to \$500,000. Subject to this \$500,000 limit, the Guaranty Association will pay up to \$500,000 in life insurance death benefits, \$130,000 in net cash surrender and net cash withdrawal values for life insurance, \$500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, \$250,000 in annuity net cash surrender and net cash withdrawal values, \$410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be \$500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to \$250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the Association shall not be responsible for more than \$10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed \$10,000,000, the \$10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the Guaranty Association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The Guaranty Association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

STANDARD INSURANCE COMPANY  
P.O. Box 711  
Portland, Oregon 97207

Standard Insurance Company

Individual Policy Issue  
1100 SW Sixth Avenue Portland OR 97204-1093

Minnesota Guaranty Association Notice  
Delivery Receipt

Name of Applicant: Scott G. Gindl  
(please print)

Signature of Applicant: [Signature] Date 10/19/18

To all producers completing a Minnesota application:

Minnesota law requires documentation of the fact that Minnesota's guaranty association notice is given to the applicant at the time of application. For your convenience, we are providing you with this delivery receipt to assist in your compliance with this law.

Please complete this receipt and forward it with the completed application to the home office.

I, the undersigned producer, declare that I provided a copy of Minnesota's required guaranty association notice at the time of application to the above applicant.

\_\_\_\_\_  
Date

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





## AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

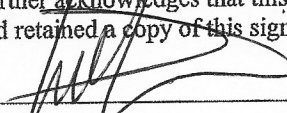
I, \_\_\_\_\_ (the "Insured"), hereby authorize Halvorson Company, Inc. and any of its affiliates, agents, employees or representatives, and their respective successors and assigned (collectively, "HCI"), to use, and to deliver, disclose, give, provide and release, as may be necessary to effect the placement of a life insurance policy insuring the Insured's life (a "Life Insurance Policy"), any and all Non-Public Information (as defined below) to HCI and any of its affiliates (of which a limited list is provided below), and any of their respective agents, employees and representatives (each an "Authorized Recipient") as may be necessary to effect the placement of a Life Insurance Policy.

"Non-Public Information" means information, including, without limitation, non-public personal, financial, health and medical information about the Insured and the Insured's identity as an insured under a Life Insurance Policy that is obtained, whether from the Insured, any of the Insured's agents or representatives, any insurance company, health care or medical provider, professional or facility or any other source.

The Insured hereby further authorizes each Authorized Recipient to deliver, disclose, give, provide and release any and all Non-Public Information in connection with the placement of a Life Insurance Policy to any entity or person for the purposes of health or medical information review or underwriting.

The Insured agrees and consents that this Authorization to Obtain and Disclose Information (the "Authorization") shall be effective from the date hereof until the earlier of (a) the date that is (2) years after the date hereof, or (b) such earlier date, if any, as may be required by applicable law or regulation. The Insured agrees that any photocopy, facsimile or other reproduction of this authorization shall be as valid as the original hereof and may be relied upon by any insurance company and any of his/her agents, designees, successors, or assigns.

The Insured certifies that he or she is executing and delivering this Authorization freely and unilaterally as of the date written below. The Insured further acknowledges that this Authorization is written in plain language and acknowledges that he or she has received and retained a copy of this signed Authorization for future reference.

Proposed Insured Signature:  Date: 10/16/18  
Print Name: Scott Grand Birthdate: 7-6-76 Soc. Sec. #: 474-74-7689

Allianz  
American General/AIG  
AXA/MONY  
Banner Life  
Genworth Financial  
Genworth Life & Annuity  
Great West Life & Annuity  
Guardian Life  
Hallett Financial Group  
John Hancock  
John Hancock USA  
Lincoln Benefit Life  
Lincoln Financial

Lion Street Inc  
Lion Street Financial  
Mass Mutual  
MetLife Investors  
Metropolitan Life Ins Co.  
Midland National  
Minnesota Life  
Mutual of Omaha  
National Benefits Group  
National Life  
Nationwide  
New York Life  
North American Life

Ohio National Life  
Pacific Life  
Penn Mutual  
Principal  
Protective  
Pruco Life Ins Co  
Prudential  
PRS LLC  
Symetra  
Transamerica  
VOYA  
e4 Brokerage LLC

I understand that any Insurer or Agency named afore, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect such information for proposed insurance coverage. The Insurers and Agencies named afore and their reinsurers will use the information in order to determine whether I am insurable or to assist in the application and underwriting process. The insurance producer may also use this information to help update and improve my insurance program.

I hereby authorize any medical practitioner, including my primary care physician, any medical facility, health plan, health care professional, laboratory, other medical entity, insurance support organization, financial institution, consumer reporting agency and my employer, to give the information described above to the Insurers and Agencies listed afore.

I understand that my information will be kept confidential, and will not be disclosed to other persons or organizations without this written permission for the purposes referenced herein, except to the extent that it is necessary for (1) the Insurers and Agencies named afore and their reinsurers and other entities required to conduct business; (2) other insurers to which I have applied or may apply; (3) reinsurers; or (4) other persons whom perform business, professional or insurance services for them. They may also disclose this information as allowed by law. I understand that the Agencies and Insurers listed afore may use secured internet-based systems to store and access some or all of the confidential and personal medical information.

I understand that when information is used or disclosed pursuant to this Authorization, it may be subject to redisclosure by the insurance company and may no longer be protected by the federal and state laws and regulations that may have applied in the first instance. This Authorization will remain in effect for 24 months from the date of my signature below.

I understand I may revoke this Authorization at any time by requesting such of my agent/broker in writing and sent to the healthcare provider, if required. I understand that such revocation would not be effective to the extent any of the parties herein have already relied upon this authorization.

A photocopy of this Authorization is as valid as an original. I acknowledge that I have received a copy of this Authorization and the Notice to Proposed Insured(s). If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.

I understand that I am not required to sign this Authorization. I understand, however, that if I do not sign this Authorization to release my records and information that the insurers and agencies listed herein may not be able to evaluate and place my application for insurance. I understand that any health care provider who receives this authorization will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.

Signed at Maple Grove, MN (city, state) this 18<sup>th</sup> day of October, 2018 (year)

Proposed Insured's Signature: \_\_\_\_\_

Print name of Proposed Insured: Scott Grant

Social Security #: 474-74-7689

**Complete if Minor Child is Proposed for Coverage:**

Name of Minor Child: \_\_\_\_\_

Relationship of Representative to Minor: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Signature(s) of Policy Owner(s): \_\_\_\_\_