Group Voluntary Short Term Disability Insurance

For Employees of Employers Participating in the Washington Counties Insurance Fund

Answers To Your Questions About Coverage From The Standard

Booklet Includes

- Coverage Highlights
- Enrollment Form
- Medical History Statement

Standard Insurance Company

TheStandard®

Standard Insurance Company
Voluntary Short Term Disability Coverage Highlights
Washington Counties Insurance Fund

Voluntary Short Term Disability (STD) Insurance

Short Term Disability insurance pays a weekly benefit in the event you cannot work because of a covered illness or injury. An STD benefit replaces a portion of your weekly income, providing funds directly to you to help pay your bills and living expenses. Standard Insurance Company (The Standard) has developed this document to provide you with information about the optional coverage you may select through your employer, who must be participating in Washington Counties Insurance Fund (WCIF).

Eligibility Requirements

Policy # 645273-D

- Group policy effective date is January 1, 2009

Employee

- A citizen or resident of the United States or Canada, and one of the following:
  - A regular employee of an employer participating in WCIF, who is actively working at least the minimum amount of hours required by your employer to be eligible under the group policy and who meets any and all other employer-specific requirements necessary to be eligible under the group policy*; or
  - An elected official of an employer participating in WCIF
- Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible

Premium

- You pay 100 percent of the premium for the buy-up portion of this coverage through easy payroll deduction

Class

- Class 1 - A member who is insured for Long Term Disability insurance Plan 2 (90-day Benefit Waiting Period) under group policy 645273-A
- Class 2 - A member who is not insured for Long Term Disability insurance Plan 2 (90-day Benefit Waiting Period) under group policy 645273-A

*Please ask your human resources representative for more information about eligibility requirements

Benefit Amount and Duration

Benefit Percentage

Your weekly STD benefit is 60 percent of the first $1,667 of your weekly insured predisability earnings, reduced by deductible income

Plan Maximum Weekly Benefit

$1,000

Plan Minimum Weekly Benefit

$15

Maximum Benefit Period:

Class 1

Option 1 - 90 days. However, STD benefits will end on the date Long Term Disability benefits become payable to you under a group plan provided by your employer, even if that occurs before the 90 days.

Class 2

You may choose one of the following options:

Option 1 - 90 days. However, STD benefits will end on the date Long Term Disability benefits become payable to you under a group plan provided by your employer, even if that occurs before the 90 days.

Option 2 - 180 days. However, STD benefits will end on the date Long Term Disability benefits become payable to you under a group plan provided by your employer, even if that occurs before the 180 days.

Note:

- All late applications (applying 31 days after becoming eligible), requests for coverage increases and reinstatements are subject to medical underwriting approval. To submit a medical history statement online, visit: http://www.standard.com/mybenefits/mhs_ho.html.

Employee Coverage Effective Date

To become insured, you must satisfy the eligibility requirements listed above, serve an eligibility waiting period (if applicable), receive medical underwriting approval (if applicable), and be actively at work (able to perform all normal duties of your job) on the day before the scheduled effective date of insurance. If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

Please contact your human resources representative for more information regarding the requirements that must be satisfied for your insurance to become effective.

Understanding Your Plan Design

Benefit Waiting Period

If your claim for STD Benefits is approved by The Standard, benefits become payable after you have served continuously the applicable days noted below for your disability and you remain disabled. Benefits are not payable during the benefit waiting period.

Accidental Injury, physical disease, pregnancy or mental disorder: After 30 days

Definition of Disability

You will be considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder:

- You are unable to perform with reasonable continuity the material duties of your own occupation, and
- You suffer a loss of at least 20 percent in your predisability earnings when working in your own occupation

You are not disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license.

Deductible Income

Deductible income is income you receive or are eligible to receive while STD benefits are payable. Deductible income includes, but is not limited to:

- Sick pay, annual or personal leave pay, severance pay or other forms of salary continuation (including donated amounts)
- Amounts under an unemployment compensation law
- Amounts because of your disability under any other group insurance
- Disability or retirement benefits under your employer's retirement plan
- Amounts under any state disability income benefit law or similar law
- Earnings from work activity while you are disabled, plus the earnings you could receive if you worked as much as your disability allows
- Earnings or compensation included in your predisability earnings which you receive or are eligible to receive while STD benefits are payable
- Amounts due from or on behalf of a third party because of your disability, whether by judgment, settlement or other method
- Any amount you receive by compromise, settlement or other method as a result of a claim for any of the above

Additional Features

Please see your human resources representative for additional information about the features and benefits below.

Reasonable Accommodation Expense Benefit

If your employer makes an approved work-site modification that enables you to return to work while disabled, The Standard will reimburse your employer up to a pre-approved amount for some or all of the cost of the modification.

Exclusions

Subject to state variations, you are not covered for a disability caused or contributed to by any of the following:

- Your committing or attempting to commit an assault or felony, or your active participation in a violent disorder or riot
- An intentionally self-inflicted injury
- War or any act of war (declared or undeclared, and any substantial armed conflict between organized forces of a military nature)
- The loss of your professional or occupational license or certification
- A disability arising out of or in the course of any employment for wage or profit

Limitations

STD benefits are not payable for any period when you are:

- Not under the ongoing care of a physician in the appropriate specialty as determined by The Standard
- Not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by The Standard, unless your disability prevents you from participating
- Confined for any reason in a penal or correctional institution
- Able to work and earn at least 20 percent of your predisability earnings in your own occupation, but you elect not to work
- Receiving sick-leave pay, annual or personal leave pay, or other salary continuation including donated amounts from your employer
- Eligible to receive benefits for your disability under a workers' compensation law or similar law

When Benefits End

STD benefits end automatically on the earliest of:

- The date you are no longer disabled
- The date your maximum benefit period ends
- The date you die
- The date benefits become payable under any other disability insurance plan under which you become insured through employment during a period of temporary recovery
- The date you fail to provide proof of continued disability and entitlement to benefits
- If applicable, the date long term disability benefits become payable to you under a long term disability plan

When Insurance Ends

Insurance ends automatically on the earliest of the following:

- The date the last period ends for which a premium was paid
- The date your employment terminates
- The date the group policy terminates
- The date you cease to meet the eligibility requirements (insurance may continue for limited periods under certain circumstances)
- If applicable, the date your employer ceases to participate under the group policy

Group Insurance Certificate

If coverage becomes effective, and you become insured, you may retrieve a group insurance certificate containing a detailed description of the insurance coverage including the definitions, exclusions, limitations, reductions and terminating events from www.wcif.net or by calling (800) 344-8570. The controlling provisions will be in the group policy. Neither the information presented in this summary nor the certificate modifies the group policy or the insurance coverage in any way.

Rates

If you have questions regarding how to determine your monthly earnings, please contact your human resources representative. Premiums for this coverage will be deducted directly from your paycheck.

Monthly Earnings*	Rate per member, per month *90 days*	Rate per member, per month *180 days*
$999 or under	$9.30	$10.80
$1,000 – $1,499	$10.30	$12.30
$1,500 – $1,999	$11.30	$14.80
$2,000 – $2,499	$12.80	$16.80
$2,500 – $2,999	$14.30	$19.30
$3,000 – $3,499	$15.30	$20.80
$3,500 – $3,999	$16.30	$23.30
$4,000 – $4,499	$17.80	$25.30
$4,500 – $4,999	$18.80	$26.80
$5,000 – $5,499	$19.80	$28.80
$5,500 – $5,999	$21.30	$30.80
$6,000 – $6,499	$22.30	$32.80
$6,500 – $6,999	$23.80	$34.80
$7,000+	$24.80	$37.30

*Monthly earnings means 4.333 times your predisability earnings. Monthly earnings as of the preceding December 31, or the date you become insured, whichever is later.

Standard Insurance Company

Reset

Enrollment and Change Form

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

APPLICANT

Your Name (Last, First, Middle)	Group Name	Group Number(s)	
	Washington Counties Insurance Fund (WCIF)	**645273**	
Your Address	City	State	ZIP
Your Soc. Sec. No.	Date of Birth	☐ Male	☐ Female
Employer		Job Title/Occupation	

DISABILITY

Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.

Voluntary Short Term Disability

☐ Option 1, 90 days

☐ Option 2, 180 days

CHANGE

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

☐ Name Change 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 amount will change if my coverage or costs change.

Member/Employee Signature Required	Date (Mo/Day/Yr)

Human Resources Department - Complete this section. Retain form for your records.

Dvsn ID	Billing Cat.	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings $_____ Per: ☐ Hour ☐ Wk ☐ Mo ☐ Yr
0001	**0100**			

DIRECTIONS FOR APPLYING FOR COVERAGE

Read the Information Practices Notice(s) on page 4. A separate form must be submitted for each applicant (Employee/Member, Spouse and/or Child) when Evidence Of Insurability or Proof of Good Health is required to apply for coverage. Complete all items, date and sign in the space at the bottom of page 3. Keep a copy for your records, and send the original to Standard Insurance Company at the address given above.

MEMBER/EMPLOYEE INFORMATION

Name of Group and Group Number	Employer Name and Location	Check who is Applying (One per form)
Washington Counties Insurance Fund - 645273		☐ Member/Employee ☐ Spouse ☐ Child

Member/Employee Name	Birth Date (Mo/Day/Year)	Date Hired (Mo/Day/Year)

Occupation	Salary	Social Security Number	Member/Employee Identification No.

APPLICANT INFORMATION

Applicant's Name (Person to be insured)	Email Address

Street Address	City	State/Province	ZIP/Postal Code

Sex	Birth Date (Mo/Day/Year)	Birthplace	Social Security Number	Work Phone ( )
☐ M ☐ F				Home Phone ( )

APPLICATION INFORMATION

Check the type and provide details on the amount of coverage you are requesting.

☐ Short Term Disability

☐ Long Term Disability _____ (Current Amount In Force, if any) + _____ (Additional Amount Requested) = _____ (Total Amount Requested)

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

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

PHYSICIAN INFORMATION *(Physician name or medical facility with Applicant's complete medical records—provide name and full mailing address)*

Doctor First Name	Doctor Last Name		

Clinic Name	Doctor Phone

Doctor Address	City	State/Province	ZIP/Postal Code

Date Last Consulted

Reason Last Consulted

Applicant Name	Social Security Number

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. Have you been absent from work for a period of 5 or more consecutive days during the last 2 years due to any sickness, surgery, injury, mental or emotional condition? ☐ 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 disorder, or digestive system disorder? ☐ Yes ☐ No
   - B. Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, deafness, or another neurological or muscle disorder? ☐ Yes ☐ No
   - C. Cancer (malignancy or growth), leukemia, lymphoma, chronic anemia, or blood clotting (thrombophlebitis, pulmonary embolism)? ☐ Yes ☐ No
   - D. Cardiovascular disease, heart ailment, arteriosclerosis, chest pain, high blood pressure, heart murmur, valve, circulatory or vascular disorder? ☐ Yes ☐ No
   - E. Emphysema, asthma, chronic bronchitis, sleep apnea, or other lung disease? ☐ Yes ☐ No
   - F. Lupus, scleroderma, vasculitis, connective tissue disease, or other immune system disorder not related to Human Immunodeficiency Virus (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, or arthritic conditions? ☐ Yes ☐ No
   - H. Endocrine (including thyroid or adrenal), diabetes? ☐ Yes ☐ No
   - I. Drug, alcohol or nicotine use or abuse, or have you used drugs, alcohol or nicotine in a manner that resulted in you having to obtain advice, counseling or treatment? ☐ Yes ☐ No
   - J. Psychiatric or mental condition, depression, adjustment disorder, affective disorder, or obsessive-compulsive disorder? ☐ Yes ☐ No
3. 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) or HIV antibodies? ☐ Yes ☐ No
4. During the past five years have you been in a hospital or other institution for observation, rest, diagnosis, or treatment of any disease, disorder, condition or injury? ☐ Yes ☐ No
5. Do you plan any operation or visit to a doctor or practitioner for an existing physical or mental condition, illness, injury, surgery or pregnancy? ☐ Yes ☐ No
6. Do you currently have any disorder, condition or disease, or are you currently taking medication prescribed by a medical or other practitioner for any disorder, condition (including pregnancy) or disease other than cold or allergies not disclosed above? ☐ Yes ☐ No

Height _____ **Weight** _____

DETAILS OF ANY "YES" ANSWERS ABOVE

Include diagnosis, start and end dates, duration, type and frequency of treatment, hospitalization, physician visits, cause, location of disorder, residuals, acute or chronic status, work loss, and operations.

Question #	Diagnosis/Description	Month/Year	Details/Current Status	Physicians Consulted, City and State

Applicant Name	Social Security Number

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 supplemental information, 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 MIB, 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 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 authorize The Standard to release information it has about me to 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 I am entitled to receive a copy of this authorization. This authorization will remain valid six months 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.
- 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/Employee: 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 understand that insurance on a Spouse or other Dependent, if any, is payable to the Member/Employee, if living, or as provided under the terms of the Group Policy(ies).
- I acknowledge that I have read and received the Information Practices Notice and Fraud Notice (if applicable), and I have made a copy of this Medical History Statement.

Signature of Applicant (or Member/Employee for Dependent Child)	**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	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. (MIB), formerly known as Medical Information Bureau. We will use the authorization you signed on this form when we seek this information.
- MIB – 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 (including short and long term disability) 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: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

  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 (including short and long term disability) insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.
- 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.

FRAUD NOTICE

- ARKANSAS, MAINE, OHIO: Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.
- COLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who kindly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- LOUISIANA, NEW MEXICO: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- MARYLAND, RHODE ISLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- PUERTO RICO: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or any other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.
- TENNESSEE, VIRGINIA, WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For more than 100 years we have been dedicated to our core purpose: to help people achieve financial security so they can confidently pursue their dreams. We have earned a national reputation for quality products and superior service by always striving to do what is right for our customers.

Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group Disability, Life, Dental and Vision insurance. We provide insurance to nearly 26,000 groups covering more than 8.5 million employees nationwide.* Our first group policy, written in 1951 and still in force today, stands as a testament to our commitment to building long-term relationships.

To learn more about The Standard, visit us at **www.standard.com**. For more information about group Voluntary STD insurance from The Standard, contact your human resources department.

* As of January 31, 2010, based on internal data developed by Standard Insurance Company.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

GP399-STD, GP899-STD, GP309-STD, GP209-STD,
GP399-STD/ASSOC, GP399-STD/TRUST

Group Voluntary Short Term Disability Insurance
SI **10388d-645273** (8/14) EE