Group Voluntary Life 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

Standard Insurance Company
Voluntary Life Coverage Highlights
Washington Counties Insurance Fund

Voluntary Life Insurance

Life insurance coverage can help your family meet daily expenses, maintain their standard of living, pay off debt, secure your children's education, and more in the event of your passing. Standard Insurance Company (The Standard) has developed this document to provide you with information about the elective coverage you may select through your employer, who must be participating in Washington Counties Insurance Fund (WCIF).

Eligibility Requirements

Policy # 645273-C
- The group policy effective date is January 1, 2009

Employee
- You must be enrolled in Basic Life insurance under group policy 645273-B, and one of the following:
  - An active employee of an employer participating in WCIF, who is working at least the minimum amount of hours required by your employer to be eligible under the group policy*; or
  - An active 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

Dependent
- You must elect Voluntary Life insurance for yourself in order to elect Dependents Life insurance
- Spouse means a person to whom you are legally married or if your employer offers domestic partner coverage, your domestic partner as recognized by law
- Child means your child from live birth through age 25
- Your spouse or children must not be full-time member(s) of the armed forces

Premium
- You pay 100 percent of the premium for this coverage through easy payroll deduction

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

Coverage Amount Guidelines

Within the coverage amount guidelines shown below, you select the amount of Voluntary Life and Dependents Life insurance for which you are interested in applying.

	Minimum	Incremental Unit	Guarantee Issue Amount	Maximum
Employee	$10,000	$10,000	$50,000	$500,000*
Spouse	$10,000	$10,000	$20,000	$250,000
Child	$2,000	$2,000	$10,000	$10,000

*When combined with your Basic Life insurance under group policy 645273-B, but not to exceed 6 times your Annual Earnings

Note:

- Amounts of coverage elected above the Guarantee Issue amount are subject to medical underwriting approval. To submit a medical history statement online, visit: http://www.standard.com/mybenefits/mhs_ho.html.
- All late applications (applying 31 days after becoming eligible), requests for coverage increases and reinstatements are subject to medical underwriting approval. Employees and Dependents eligible but not insured under the prior life insurance plan are also subject to medical underwriting approval.
- The coverage amount for your spouse cannot exceed 100 percent of your Voluntary Life coverage.
- The coverage amount for your child(ren) cannot exceed 100 percent of your Voluntary Life coverage.

Coverage Amount Needed

Your family has a unique set of circumstances and financial demands. To help you figure out the amount of Voluntary Life insurance you may need to protect your loved ones, The Standard has created a Life Insurance Needs Calculator found at: http://www.standard.com/lifeneeds.

Employee Coverage Effective Date

To become insured, you must satisfy the eligibility requirements listed above, receive medical underwriting approval (if applicable), agree to pay premium, 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, including Dependents Life 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 these requirements that must be satisfied for your insurance to become effective.

Life Insurance Age Reductions

Under this plan, your coverage amount reduces based on your age as follows: by 35 percent at age 70, by 55 percent at age 75, and by 70 percent at age 80.

Your spouse's coverage amount terminates the date your spouse reaches age 70.

If you are age 70 or over, ask your human resources representative for the amount of coverage available.

Life Insurance Features and Benefits

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

Waiver of Premium If you become totally disabled while insured under this plan and under age 60, and complete a waiting period of 180 days, your Voluntary Life insurance may continue without premium payment until age 65 provided you give us satisfactory proof that you remain totally disabled.

Accelerated Benefit If you become terminally ill, you may be eligible to receive up to 75 percent of your Voluntary Life benefit to a maximum of $500,000.

Portability If your insurance ends because your employment terminates, you may be eligible to continue your group insurance coverage under the Portability of Insurance provision. The cost of this insurance is paid for by you.

Conversion If your insurance ends or reduces, you may be eligible to convert your Voluntary Life insurance to an individual life insurance policy without submitting proof of good health.

Travel Assistance* This service provides you and your dependents with access to appropriate medical care and other emergency services when traveling at least 100 miles from home or in foreign countries for up to 180 days. Travel Assistance also offers a range of professional, 24-hour medical, legal and trip assistance information and coordination services to help your travel go smoothly.

*Travel Assistance is provided through an arrangement with FrontierMEDEX, Inc., which is not affiliated with The Standard. Travel Assistance is not an insurance product, in all states except Oregon and Washington.

When Insurance Ends

Coverage ends automatically on the earliest of the following:

- The last date the last period ends for which a premium was paid
- The date your employment terminates (This date may vary based on your employer's specifications as written in the Group Policy. Please contact your human resources representative for more information.)
- The date you cease to meet the eligibility requirements (coverage may continue for limited periods under certain circumstances)
- The date the group policy, or your employer's coverage under the group policy, terminates
- For each elective insurance coverage, the date that coverage terminates under the group policy

When Insurance Ends (Continued)

In addition to the above requirements, your Dependents Life coverage ends automatically on the date your dependent ceases to meet the eligibility requirements for a dependent, and for your spouse, the date your spouse reaches age 70.

For more details on when insurance ends, contact your human resources representative.

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.

Employee Rates

If you elect Voluntary Life insurance, your monthly rate for this plan is indicated in the table below. Premiums for this coverage will be deducted directly from your paycheck.

Employee's Age (as of last Dec 31)	Rate (Per $10,000 of Total Coverage)
<20	$0.56
20-24	$0.66
25-29	$0.71
30-34	$0.82
35-39	$0.98
40-44	$1.45
45-49	$2.35
50-54	$3.91
55-59	$5.81
60-64	$8.74
65+	$12.53

To calculate your premium:

1. Amount Elected: Write this amount on the Voluntary Life requested amount line on your Enrollment and Change Form. Line 1: ____________
2. Line 1 divided by $10,000 = Line 2. Line 2: ____________
3. Select your rate from the rate table and enter on Line 3. Line 3: ____________
4. Line 2 multiplied by Line 3 = Your monthly cost. Line 4: ____________

Spouse Rates

If you elect Dependents Life insurance for your spouse, your monthly rate for this coverage is indicated in the table below. Premiums for this coverage will be deducted directly from your paycheck.

Spouse's Age (as of last Dec 31)	Rate (Per $10,000 of Total Coverage)
<20	$0.60
20-24	$0.70
25-29	$0.75
30-34	$0.90
35-39	$1.05
40-44	$1.55
45-49	$2.45
50-54	$4.09
55-59	$5.87
60-64	$9.57
65-70	$13.53

To calculate the premium for your spouse:

1. Amount Elected: Write this amount on the Spouse Life requested amount line on your Enrollment and Change Form. Line 1: ____________
2. Line 1 divided by $10,000 = Line 2. Line 2: ____________
3. Select your rate from the rate table and enter on Line 3. Line 3: ____________
4. Line 2 multiplied by Line 3 = Your monthly cost. Line 4: ____________

Child Rates

If you elect Dependents Life insurance for your eligible child(ren), your monthly rate for this coverage is $0.44 per $2,000 regardless of the number of eligible children covered. Premiums for this coverage will be deducted directly from your paycheck.

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

LIFE

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

Voluntary Life

☐ Employee Voluntary Life Your requested amount $_______________

Dependents Life

☐ Spouse requested amount $_______________ Spouse Name ___________________ Spouse Date of Birth _______________

☐ Child requested amount $_______________

BENEFICIARY

This designation applies to Life Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Contingent - Full Name	**Address**	**Soc. Sec. No.**	**Relationship**	**% of Benefit**

CHANGE

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

☐ Add Dependent ☐ Delete Dependent ☐ Name Change ☐ Beneficiary Change

Date of add/delete ___________________ 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
01	**0100**			

Beneficiary Information

- Your designation revokes all prior designations.

- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).

- If you name two or more Beneficiaries in a class:

  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.

  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.

  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.

- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated ____ ."

- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.

- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.

Medical History Statement

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	Phone
☐ M ☐ F				Work Phone ( ) 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 one hundred years we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. 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 more than 25,500 covering nearly 8.4 million employees.* 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 Voluntary Life Insurance from The Standard contact your human resources department or visit us at **www.standard.com**.

* As of June 30, 2012, based on internal data developed by Standard Insurance Company.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

GP190-LIFE/S399, GP399-LIFE/TRUST,
GP899-LIFE, GP190-LIFE/A997/S399

Group Voluntary Life Insurance
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