



Group Term Life Insurance Program Application

California State Firefighters' Employee Welfare Benefits Corporation

DIRECTIONS: This form must be completed when Evidence of Insurability is required under your plan. To apply for coverage (as a Member) read the notice(s) on page 4. Then complete all items, sign, and date below. When finished, send original to Myers-Stevens & Toohy & Co., Inc. and keep a copy for your records.

Name of Department		Medical History Statement		
Name of Policy Owner CSFEWBC		Policy # 633835	Type of Application (Check One) <input type="checkbox"/> Initial <input type="checkbox"/> Increase in Coverage	I am an active: <input type="checkbox"/> Safety Member <input type="checkbox"/> Non-Safety Member
Applicable Coverage <input type="checkbox"/> Member's Voluntary Life <input type="checkbox"/> Spouse's Voluntary Life <input type="checkbox"/> Children's Life <input type="checkbox"/> \$100,000 G.I.				
Member's Name		Social Security Number	Date Employed	Member Since

Applicant Section *Directions: To apply for coverage (as a Member, Spouse or Child), read the Information Practices Notice on back of this form. Then complete, sign and date all the items below.*

Check who is applying: Member Spouse Child

For Member Applicant: Address (Street, City, State, Zip)				Work Phone () -
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date / /	Birthplace	E-Mail Address	Home Phone () -
For Spouse or Child Applicant: Name				Work Phone () -
Address (Street, City, State, Zip)				Home Phone () -
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date / /	Birthplace	E-Mail Address	Social Security Number
Applicants for Voluntary Life Insurance: Voluntary Amount Requested				
Member \$		Spouse: \$		Child(ren) \$
Applicants for AD&D Insurance: Voluntary Amount Requested				
Member \$		Spouse: \$		Child(ren) \$
This designation supersedes any previous beneficiary designation. The member is the beneficiary of any coverage in effect on his/her eligible spouse or children.			Member's Beneficiary	Beneficiaries SSN
				Relationship
Height	Weight	Physician or Medical Facility with Applicant's Complete Medical Records (Name & Full Mailing Address)		Membership #

For approved applicants, premiums shall be paid in accordance with the provisions of the Group Policy(ies). Declinations do not affect either Guarantee Issue Amounts not subject to Evidence of Insurability or other coverages already in force with Standard Insurance Company. Coverage will be subject to all applicable terms and conditions of the Group Policy(ies) and state limitations.

Check yes or no for each of these questions, and give details for any "yes" answers after #9.

(Attach a separate sheet if more room is required)

	Member		Spouse/Child	
	YES	NO	YES	NO
1. Have you had any physical, mental or emotional condition, injury, sickness, or surgery in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you consulted or been attended by a physician or practitioner for any cause in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you now unable to work full time because of any physical, mental or emotional condition, injury or sickness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:				
A. High blood pressure, cardiovascular disease, heart ailment, arteriosclerosis, or stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Mental condition, depression, epilepsy, or nervous system disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Cancer diabetes, or nephritis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Arthritis, strained or injured back, slipped disc, or any bone, joint, or muscle disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Lung, kidney, stomach, genital, urinary, or intestinal ailment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Blindness or deafness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or immune system disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you sought or received advice or treatment for the use of alcohol or drugs in the past 10 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. In the past 10 years have you had a persistent cough, unintentional weight loss of 10 pounds or more, persistent fatigue, persistent lymph node enlargement, prolonged night sweats, pneumonia, lesions, or growths?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you take medication for any physical, mental or emotional condition, injury or sickness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you plan any operation or visit to a doctor or practitioner for an existing physical, mental or emotional condition, injury or sickness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#	Member/Spouse/Child	Description of injuries, disorders and operations	Month/Date	Duration	Final Result	Physicians Consulted, City & State

Acknowledgment and Authorization for Release of Information *(Please read carefully)*

I represent that the statements contained herein, including those made above (as this refers to the boxes above this section) and any attachments, are true and complete, to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by Standard, the effective date of any coverage will be determined in accordance with the terms of the group Policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, Standard's liability is limited to the return of any premium which may have been paid.

I acknowledge that I have read and received the information Practices Notice (on page 11) and I have kept a copy of this Medical History Statement.

To any physician, health care provider, hospital, insurance or reinsurance company, the Medical Information Bureau, Inc. (MIB), or any employer: I authorize you to release to Standard or its reinsurers all medical information you have about me including medical history, diagnosis, prognosis and treatment of any physical, mental or emotional condition. I understand that Standard will use the information obtained by this authorization to determine my eligibility for group insurance coverage. I further authorize Standard to release this information to its reinsurers, MIB, and to other insurance companies to which I have applied for insurance coverage or benefits.

I understand a copy of this authorization will be provided upon request. This authorization will remain valid one year from the date below. A photocopy of this authorization shall be as valid as the original.

I understand that I have the right to revoke this authorization at any time by sending a written statement to Standard. I understand that the revocation of the authorization, or the failure to sign the authorization, may impair Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.

Signature of Member (or member for child)	Date	Signature of Spouse	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

As member in good standing of CSFA and having read the attached brochure describing benefits, I hereby apply for insurance under the provisions of the California State Firefighters' Employee Welfare Benefits Corporation Group Life Insurance Plan. Upon approval of this application, I authorize my employer (if applicable) to make the necessary deductions from my wages or salary to cover my contribution for the cost of this insurance, written by Standard Insurance Company of Portland, Oregon.

Send this copy to:

Myers-Stevens & Toohy & Co., Inc. | 26101 Marguerite Parkway | Mission Viejo | CA 92692
phone **800.827.4695** | fax **949.348.2630** | CSFA@myers-stevens.com | CA Lic #0425842

Information Practices Notice

To help us determine your eligibility for group insurance, we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or MIB, Inc. (Medical Information Bureau). We will use the authorization you signed on the front side of this form when we seek this information.

MIB (MEDICAL INFORMATION BUREAU) - Information we collect about you is confidential. However, Standard Insurance Company or its reinsurers may make a brief report to the MIB. MIB is a nonprofit corporation. It exchanges information among its member life insurance companies. If you later apply to another MIB member company for life or health insurance coverage, or if you submit a claim for benefits to such member company, MIB will supply the member company with any information it has about you in its files. This will be done only upon the member company's request. Standard or its reinsurers may also release information about you to Standard's reinsurers or to other insurance companies to whom you have applied for life or health insurance or made claim for benefits.

MIB will disclose any information it has about you at your request. If you believe that the information MIB has about you is incorrect, you may contact MIB and request a correction. Your request for correction will be handled by MIB in accordance with the procedures outlined in the federal Fair Credit

Reporting Act. The address of the MIB information office is: P.O. Box 105, Essex Station, Boston, Massachusetts 02112. MIB's telephone number is (617) 426- 3600.

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.

Group Underwriting Department
Standard Insurance Company
900 SW Fifth Ave.
Portland, Oregon 97204-1282
800/843-7979

This brochure is intended to summarize the main features of the coverage provided in the group insurance master policy. Each insured member will receive a Certificate of Insurance which contains a more detailed description of the benefits provided. Neither this brochure nor the Certificate of Insurance modify in any way the provisions of the group master policy.