STANDARD INSURANCE COMPANY

Group Policies 608011 and 641095

Check who is applying **(one per form)**
☐ Member ☐ Spouse ☐ Child
☐ New Application ☐ Application for Increase

MUST BE COMPLETED IN INK

MEMBER'S NAME	MEMBER'S SS#	DATE OF EMPLOYMENT WITH THE STATE OF CALIFORNIA	DATE OF MEMBERSHIP IN C.A.P.S.

APPLICANT'S FULL NAME (PERSON TO BE INSURED)	DATE OF BIRTH	PLACE OF BIRTH	BASE MONTHLY EARNINGS FROM STATE OF CALIFORNIA $	SEX ☐ M ☐ F

HOME ADDRESS *(NO. AND STREET)*	CITY	STATE	ZIP

APPLICANT'S SS#	HOME PHONE	WORK PHONE

FULL NAME OF BENEFICIARY - APPLIES TO MEMBER COVERAGE ONLY. *(EXAMPLE: MARY A. DOE, NOT MRS. JOHN J. DOE.)*	RELATIONSHIP

MAILING ADDRESS *(NO. AND STREET)*	CITY	STATE	ZIP

Please Check Plan Desired: You may request up to $520,000

PLAN	COVERAGE	NOTE
☐ 1. "Supplemental Plan" *(Member Only)*	$30,000	The MEDICAL HISTORY STATEMENT must always be completed if you have been employed by the State of California more than 90 days. A physical examination may be required and forms will be forwarded upon receipt of your application.
☐ 2. Basic "Dependent Benefit" *(Spouse & Children)*	$5,000	You may request the DEPENDENT COVERAGE only if you have requested the "SUPPLEMENTAL" Insurance coverage.
☐ 3. "Supplemental Plus" Plan *(Member Only)* $10,000, $25,000 or any additional Multiple of **$15,000**, up to $490,000 (E.g. $40,000, $55,000, $70,000, $85,000, $100,000, etc.) Amount Requested $ _____		The MEDICAL HISTORY STATEMENT must always be completed. A physical examination may be required and forms will be forwarded upon receipt of your application. You may request "SUPPLEMENTAL PLUS" coverage only if you have requested "SUPPLEMENTAL" coverage.
☐ 4. "Life only" *(Excludes Accidental Death Benefits)*		Do not check if you want Accidental Death Benefits included with Life Insurance.
☐ 5. "Long Term Disability" *(Member Only)* Select one of the following Benefit Waiting Periods: ☐ 60 days ☐ 90 days ☐ 180 days Premium rates are based on whether or not you smoke tobacco. Check one of the following: ☐ I smoke tobacco. ☐ I do not smoke tobacco.		The MEDICAL HISTORY STATEMENT must always be completed. A physical examination may be required and forms will be forwarded upon receipt of your application.

You are not eligible for "SUPPLEMENTAL PLUS" Insurance or "DEPENDENT" Benefits unless you have requested "SUPPLEMENTAL" coverage (No. 1 above).

X _____
SIGNATURE OF MEMBER DATE

FOR THOSE TRANSFERRING FROM C.S.E.A.: If you are transferring life insurance from C.S.E.A. you do not need to complete the Medical History Statement. But, you must complete the following:

I am a member of C.S.E.A. ☐ Yes ☐ No If Yes, I am insured for $ _____ of life insurance. Please attach a copy of the Controllers payroll deduction information which accompanies your Salary Warrant.

MEDICAL HISTORY STATEMENT

To apply for coverage, read the Information Practices Notice on the back of this form. Then complete, sign and date all items below ***If this form is not completed properly, processing time will be delayed.*** *When finished, send to Standard Insurance Company, Sacramento Group Office (address on back).*

HEIGHT	WEIGHT	PHYSICIAN OR MEDICAL FACILITY WITH APPLICANT'S COMPLETE MEDICAL RECORDS
		NAME FULL MAILING ADDRESS MEMBERSHIP NUMBER

Check yes or no for each of these questions, and give details for any "yes" answers after #10 (Attach a separate sheet if more room is required)

1. Have you had any physical, mental or emotional condition, injury, sickness, or surgery in the past 5 years? ☐ Yes ☐ No
2. Have you consulted or been attended by a physician or practitioner for any cause in the past 5 years? ☐ Yes ☐ No
3. Are you now unable to work full time because of any physical, mental or emotional condition, injury, or sickness? ☐ Yes ☐ No
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? ☐ Yes ☐ No
   - B. Mental condition, depression, epilepsy, or nervous system disorder? ☐ Yes ☐ No
   - C. Cancer, diabetes or nephritis? ☐ Yes ☐ No
   - D. Arthritis, strained or injured back, slipped disc, or any bone, joint, or muscle disorder? ☐ Yes ☐ No
   - E. Lung, kidney, stomach, genital, urinary, or intestinal ailment? ☐ Yes ☐ No
   - F. Blindness or deafness? ☐ Yes ☐ No
   - G. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or an immune system disorder? ☐ Yes ☐ No
5. Have you sought or received advice or treatment for the use of alcohol or drugs in the past 10 years? ☐ Yes ☐ No
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? ☐ Yes ☐ No
7. Do you take medication for any physical, mental or emotional condition, injury, or sickness? ☐ Yes ☐ No
8. Do you plan any operation or visit to a doctor or practitioner for an existing physical, mental or emotional condition, injury, or sickness? ☐ Yes ☐ No
9. Have you ever been declined for insurance or offered a rated or restricted policy, either as a new policy or reinstatement? ☐ Yes ☐ No
10. Are you now pregnant? ☐ Yes ☐ No

#	*Description of injuries, Disorders and Operations*	*Month/Year*	*Duration*	*Final Result*	*Physicians Consulted, City & State*

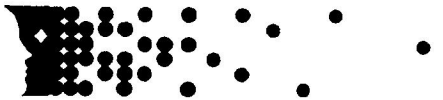
I represent each of the above answers to be true and complete to the best of my knowledge and belief.

X _____
SIGNATURE OF MEMBER DATE

SIGNATURE REQUIRED ON BOTH SIDES

Application For:

Life Insurance, Accidental Death & Dismemberment, and Long Term Disability Insurance



CALIFORNIA ASSOCIATION OF PROFESSIONAL SCIENTISTS

MAIL ALL APPLICATIONS TO:
Standard Insurance Company

MEDICAL UNDERWRITING
900 SW FIFTH AVE
PORTLAND, OR 97204-1282

TheStandard®

6284-809011 (1/09)

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 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: PO Box 105, Essex Station, Boston, Massachusetts 02112. MIB's telephone number is (617) 426-3660.

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.

Acknowledgement and Authorization for Release of Information (Please read carefully.)

I represent that the statements contained herein 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 and I have received 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.

SIGNATURE OF APPLICANT
(OR MEMBER FOR DEPENDENT CHILD) _____ DATED _____