



# GROUP APPLICATION

INSURANCE AND BENEFITS TRUST OF THE PEACE OFFICERS RESEARCH  
ASSOCIATION OF CALIFORNIA

## Group Long Term Disability Program

**MEMBER'S Name** \_\_\_\_\_

**SS#:** \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

**Home Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone Number** (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home Work

**Sex** \_\_\_\_ **Male** \_\_\_\_ **Female** \_\_\_\_ **Place of Birth** \_\_\_\_\_

**Full Name of Your Employer:** \_\_\_\_\_

**Association Name** \_\_\_\_\_ **Assoc Number** \_\_\_\_\_

**Monthly Salary \$** \_\_\_\_\_ **Date of PORAC Membership** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

**Date Employed** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Prior PORAC #** \_\_\_\_\_  
Month Day Year (if available)

**I am a:** \_\_\_\_ **Safety Employee**  
\_\_\_\_ **Non-Safety Employee**  
\_\_\_\_ **In the Academy graduation date:** \_\_\_\_\_

As a member in good standing of PORAC and having read the attached brochure describing the benefits. I hereby apply for coverage under my association's disability plan which is subject to the provisions of the Insurance and Benefits Trust of the Peace Officers Research Association of California Group Long Term Disability Plan. I certify that I am working full-time and able to perform all the required duties of my occupation. Upon approval of this application, **I authorize my employer to make the necessary deductions from my wages or salary to cover my contribution (if any) for the cost of this coverage.**

**MEMBER'S**  
**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

### HOW TO APPLY:

1. Complete this application including attached health questions, if required.
2. Return the completed form to your Department/Local Association.
3. Don't send money now: Your premiums will be paid through payroll deduction (if applicable), once coverage is issued.



26101 Marguerite Parkway  
Mission Viejo, CA 92692-3203  
(949) 348-0656 Fax (949) 348-2630  
CA License #0425842

**Be sure to read carefully and include your signature and date as indicated.**

SHADED AREA FOR INSURANCE COMPANY USE ONLY.

Approved DATE ___/___/___		Denied DATE ___/___/___	Denied Due to Lack of Information DATE ___/___/___
Medical Underwriter Signature _____		Medical Underwriter Signature _____	Evidence Processor Signature _____
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.)

- |   | 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"/> |
| 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"/> |
| 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"/> |
| 4. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medical for you for any of the following:  |                          |                          |
| *High blood pressure, cardiovascular disease, heart ailment, arteriosclerosis, or stroke?   | <input type="checkbox"/> | <input type="checkbox"/> |
| *Mental condition, depression, epilepsy, or nervous system disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |
| *Cancer, diabetes, or nephritis?  | <input type="checkbox"/> | <input type="checkbox"/> |
| *Arthritis, strained or injured back, slipped disc, or any bone, joint, or muscle disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| *Lung, kidney, stomach, genital, urinary, or intestinal ailment?  | <input type="checkbox"/> | <input type="checkbox"/> |
| *Blindness or deafness?   | <input type="checkbox"/> | <input type="checkbox"/> |
| *Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or an immune System disorder?  | <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"/> |
| 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"/> |
| 7. Do you take medication for any physical, mental or emotional condition, injury, or sickness?   | <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"/> |
| 9. Are you now pregnant?  | <input type="checkbox"/> | <input type="checkbox"/> |

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

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 (on the back of the form) 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.

Upon approval of this application, I authorize my employer to make the necessary deductions from my wages or salary to cover my contribution for the cost of this insurance, underwritten by The Standard Insurance Company of Portland, Oregon.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date