Standard Insurance Company
900 SW Fifth Avenue Portland OR 97204-1235

Long Term Disability Insurance
Residency Continuation Application

Reset

Shaded area for administrative purposes; do not fill in this section.

Group Name	Division	Billing Category	Date of Residency
AMA-Med Plus Advantage	**ISG**		

To Be Completed By Applicant *Check all boxes and complete all sections that apply.*

Your Name (Last, First, Middle)		Your Social Security Number	Birth Date		☐ Male ☐ Female
Your Address		City	State	ZIP	Phone Number
Current Medical School	Graduation Date	Resident Program			
Residency Start Date	Projected Residency Completion Date	Email Address			

Choose One Payment Method

☐ Please submit a check for $240.45
made payable to: **Standard MPA Program**

Application for Resident Continuation can be sent to:
Professional Benefit Consultants Inc.
7525 SE 24th St., Suite 350
Mercer Island, WA 98040

You can also return your application by submitting to: medplus@profbci.com. You can send your check in the mail to the address above.

☐ PayPal - Enter Amount Due $_____

* Go to www.medplusepay.com
* Enter the policy number
* Enter the amount due from the balance due on the invoice or the premium due on the enrollment form
* You can return your application by submitting to: medplus@profbci.com

Coverage Information may be found at www.medplusadvantage.com or contact the Med Plus Advantage program manager at 888-627-6618

Change

Complete this section only when you wish to make a change after insurance becomes effective.

☐ Name Change Former name _____
☐ Other _____

Signature I verify the above information is correct. I understand that by completing this form I am applying for Long Term Disability insurance and I am responsible for paying annual premiums. **I understand that my annual premium amount will change if my coverage or costs change.**

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

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