LIFE INSURANCE

AUTHORIZATION TO RELEASE INFORMATION (HIPAA)

Express Mail:
Equitable Financial Life Insurance Company
Life Operations
8501 IBM Drive, Suite 150
Charlotte NC 28262
Regular Mail:
Equitable Financial Life Insurance Company
Life Operations
P.O. Box 1047
Charlotte, NC 28201-1047
Toll-Free Fax Number:
(855) 268-6373

EQUITABLE

Equitable Financial Life Insurance Company
Equitable Financial Life Insurance Company of America (EFLOA)
Equitable Financial Life and Annuity Company
Equitable Financial Life Insurance and Annuity Company (CA)

For Assistance: Call (800) 777-6510
Monday–Thursday, 8:30 a.m. – 7:00 p.m. EST
and Friday, 8:30 a.m. – 5:30 p.m. EST

AUTHORIZATION TO RELEASE INFORMATION PROTECTED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) IN CONNECTION WITH A CLAIM FOR LIFE INSURANCE BENEFITS ONLY

I am the next of kin or executor/administrator of the estate of ____
(PLEASE PRINT INSURED'S NAME)

TO OBTAIN HEALTH INFORMATION. Pursuant to HIPAA, as personal representative of the individual named above, I authorize any physician, hospital, clinic, medical practitioner, medical testing laboratory, pharmacy, pharmacy benefits manager, medically related facility or other health care provider, health plan or insurance company (including Equitable/EFLOA; with respect to other Equitable/EFLOA coverages) and the Medical Information Bureau to disclose to Equitable/EFLOA and its authorized representatives (collectively hereinafter the "Companies") any and all information, including medical reports, pharmaceutical records or prescription history, whether fact or opinion, they may have about any diagnosis, treatment, medication or drug history, and prognosis regarding physical or mental conditions of the individual listed above.

I understand and acknowledge that the requested health information may contain information regarding HIV test results or the diagnosis, treatment of AIDS or AIDS-related conditions as well as information regarding sexually transmitted diseases, mental health, alcohol and/or drug abuse, unless otherwise restricted by state law.

RE-DISCLOSURE OF HEALTH INFORMATION. I understand that any disclosure of information to the Companies for the purpose of determining eligibility for benefits or the continuance of coverage carries with it the potential for re-disclosure, meaning the information may no longer be protected by HIPAA. However, please note that such information may be protected by other state and federal privacy laws such as the Gramm-Leach Bliley Act.

PURPOSE OF AUTHORIZATIONS. I understand that the information obtained will be used by the Companies to process claims under the policy, determine eligibility for life insurance benefits, or the continuance of coverage. In addition, information obtained may be used in connection with reinsurance and may be disclosed to the Medical Insurance Bureau (MIB) who, upon request, may disclose such information about me in its file to another member company with whom I apply for life or health insurance or to whom a claim for benefits may be submitted; when requested by a government agency; in connection with legal or arbitration proceeding; or for other purposes as required or permitted by applicable law.

COVERAGE CONDITIONS. I understand that the Companies are conditioning the possible payment of benefits on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in the denial of a claim for benefits.

DURATION. Unless otherwise revoked, I agree that this authorization will expire 24 months from the date below. I understand that I may revoke my authorization at any time. No termination or revocation shall affect (1) any action that the Companies have taken in reliance on this authorization or (2) any right granted by law to contest a claim under the policy or the policy items. If I choose to revoke any authorization, any claim made under the policy may be denied. My revocation must be submitted in writing to: Equitable Financial Life Insurance Company or Equitable Financial Life Insurance Company of America (EFLOA) Director of Claims, 8501 IBM Drive, Suite 150, Charlotte, NC, 28262.

COPY OF AUTHORIZATIONS. I have a right to ask for and receive true copies of this Authorization Form and all other authorizations signed by me. I agree that reproduced copies will be as valid as the original.

x ____
Signature of Authorized Personal Representative

x ____
Print Name of Authorized Personal Representative

x ____
Description of Authorized Personal Representative's Authority or Relationship to Proposed Insured/Patient

Dated at City, State ______________________________ on ______________________________