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)

Life Insurance

Third-Party Release of Life Insurance Policy Information Authorization

Traditional and Variable Life Series

Policy information may be released directly to a third party, authorized by the Policyowner(s) to receive contract information. This authorization must be completed, currently dated and signed by the Policyowners(s). Provided that this form is completed in its entirety, it will be valid for three years from the date of the signature unless limited in duration upon written notification or, if undated, the date received at our administrative office.

We reserve the right to deny the release of policy information to a third-party contact authorized by the Policyowner(s). Former Associates of Equitable Advisors or Equitable Financial Advisors (MI & TN) cannot be designated as third party recipients of life insurance information. This authorization is void after any change in ownership.

I (We) hereby authorize 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) to release the information specific to the policies listed below to my designated third-party contact for a period of three years.

Changes to the policy are not permitted under the authority of this authorization. All requests to make policy changes must be submitted by the Policyowner(s) to our administrative office. The Policyowner(s) can at any time during this period terminate the third-party authorization by writing to our administrative office.

Return:

Express Mail:
Equitable Financial Life Insurance Company
Life Operations
8501 IBM Dr, Suite 150
Charlotte NC 28262-4333

Regular Mail:
Equitable Financial Life Insurance Company
Life Operations
P.O. Box 1047
Charlotte, NC 28201-1047

Toll-free Fax Number:
(855) 268-6378

For Assistance:

Call:
(800) 777-6510
Monday - Thursday:
8:30 AM to 7:00 PM EST
Friday: 8:30 AM to 5:30 PM EST

To Sign Up For eDelivery:

Visit us at
www.equitable.com

1. Type of Request

Please complete the sections listed below if you are requesting a:

- Third-Party Release of Information — sections 2, 3, 4 and 5

2. Owner's Information (Please Print)

Policy Number(s) (Required): _____ _____

Insured's Name: _____
First Middle/MI Last

Owner's Name (if other than insured): _____
First Middle/MI Last

Owner's Daytime Phone Number: _____
xxx-xxx-xxxx

Owner's Email Address: _____

Joint Owner's Name: _____
First Middle/MI Last

Owner's Address: _____
Number and Street Apt. / Suite / Floor

_____
City State Zip Code

For Addresses Outside the United States:

Country: _____ Country Postal code: _____

☐ Please check if this is an address change.

3. Type of Information to be released

Please select the information you are authorizing to be released to the third-party upon their request:

- ☐ Policy values (Face Amount, Death Benefit, Cash Values, Loan Values)
- ☐ Inforce Illustration *(A projection of the policy's future values and earnings [if applicable]. You may request illustrations created without any changes, or you may request an illustration that shows features being removed or added as well as changes in the premium amounts.)* We reserve the right to charge an administrative fee per illustration requested.
- ☐ Loan information.
- ☐ Premium information.
- ☐ Other: _____
  (The Policyowner(s) must be specific as to the information the third-party is to receive)

  Please note: this authorization is not valid for the release of any medical information.

4. Information about the Third-Party

To release information to a third-party, the following information is required:

Name of Authorized Party(ies): _____
(Please print)

Note: Former Associates of Equitable Advisors or Equitable Financial Advisors (MI & TN) cannot be designated as third-party recipients of life insurance information.

Relationship to Policyowner(s): _____
(Please print)

Entity name (if applicable) _____
(Please print)

Address of Authorized Party(ies): _____
(Required for phone verification purposes) Address Number and Street

_____
City **State** **Zip code**

Daytime Phone Number of Authorized Party(ies): _____
xxx-xxx-xxxx

Please select how this information is to be released to the third party contact:

- ☐ Verbally – The third-party must contact the Life Operations Center to obtain the selected information. The information provided above will be verified at the time of the call.
- ☐ Fax to : ( ) _____. The Policyowners(s) should specify the fax number of the third-party.
- ☐ Written correspondence (mailed to the third-party's address indicated above)
- ☐ Email to _____. The Policyowner(s) should specify the email address of the third-party.
- ☐ By checking this box, I authorize the third-party shown above to provide Equitable with a fax number, email address or physical address at the time information is requested.

Note: We reserve the right to release requested information directly to the Policyowner(s) if we consider a previously established authorized third-party presents risks to upholding Equitable's Privacy Policy or otherwise jeopardizes the policy remaining in effect.

5. Signatures

Signature: _____ _____

Signature of Owner — Current Date (mm/dd/yyyy)

Signature: _____ _____

Signature(s) of Joint Owner(s) — Current Date (mm/dd/yyyy)

Signature: _____ _____

Signature of Corporation Officer, Partner or Trustee — Title (Required)

_____

Current Date (mm/dd/yyyy)

_____

Print Name of Corporation, Partnership or Trust (Required)

General Information about Signature Requirements

Multiple/Joint Owners: Must be signed by all Owners.

Corporation: One officer other than the Insured on behalf of the corporation.

Attorney-in-Fact/Guardian: Must be signed by either the Attorney-in-Fact or Guardian with their title listed. A copy of the appointment is needed if it is not already on file.

Individual/Pension Trust: Must be signed by Trustee(s).

Partnerships: Requests must be submitted in the name of the Partnership and signed by a partner other than the Insured, or two partners if Insured signs.

Other: For cases such as minor owners, contact the Life Operations for appropriate signature requirements.

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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