Send completed form to:
Equitable, EB Claims
8501 IBM Dr, Suite 150-C
Charlotte, NC 28262
Fax Number: (315) 477-2499
ebclaims@equitable.com



Equitable Financial Life Insurance Company of America
For Assistance Call (866) 274-9887

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS (NY DBL) INSTRUCTIONS

How to request Disability Benefits

Do not submit this form prior to your first date of disability. You must submit your completed claim form within 30 calendar days of your first day of disability to avoid losing benefits. Keep a copy of all forms and documentations for your records.

1. If you are using this form because you became disabled **while employed** or you became disabled **within four (4) weeks after termination of employment**, your completed claim should be submitted to your **Equitable Financial Life Insurance Company (Equitable)** at the address above.

2. If you became **disabled after having been unemployed for more than four (4) weeks after termination of employment**, download Form DB-450 from the Workers' Compensation Board's website, www.wcb.ny.gov. You must complete and mail the form to: **Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029**. If you answered "Yes" to question 13.B.4., please complete and attach Form DB-450.1.

Note: This form has a section to be filled out by your healthcare provider, and a section to be completed by your employer. Before providing the form to your employer, fill out your section and make a copy to keep.

- The health care provider is required to return the form to you with Part B completed within seven days. If there is a delay, you must wait to submit the form to **Equitable**. If Part B is not complete (or has incomplete answers) there may be delay in the payment of benefits.

- Your employer is required to return the form to you with Part C completed within three business days. If there is a delay, you do not have to wait to proceed – you should send the form to **Equitable**. They cannot deny your request for disability benefits solely because your employer failed to fill out their section.

Important to know:

You will receive a response within 18 days of your first day of disability leave or the employer or carrier's receipt of your completed claim, whichever is later. If your claim is rejected, you will receive either a Notice of Denial of Claim for Disability Benefits (Form DB-DEN) or a Notice of Total or Partial Rejection of Claim for Disability Benefits (Form DB-451, EBNYDB451). If you receive a Form DB-DEN, you will receive a Form DB-451, EBNYDB451 with additional information within 45 days of your first day of disability leave or the employer or carrier's receipt of your completed claim, whichever is later.

If you do not receive a response within 18 days (or the Form DB-451 within 45 days) or if you have questions about your disability benefits claim, please call **Equitable**. For general information about disability benefits, please visit ebclaims@equitable.com or call at (866) 274-9887.

Equitable is the brand name of the retirement and protection subsidiaries of Equitable Holdings, Inc., including Equitable Financial Life Insurance Company (NY, NY); Equitable Financial Life Insurance Company of America, an AZ stock company with an administrative office located in Charlotte, NC; and Equitable Distributors, LLC. The obligations of Equitable Financial Life Insurance Company and Equitable Financial Life Insurance Company of America are backed solely by their claims-paying abilities.

Notice and Proof of Claim for Disability Benefits (Form DB-450) Instructions

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

You must answer all questions in this part.

Question 9: Enter the best estimate of average gross weekly wage. Fill out the table using your gross wages from your last employer prior to disability. If you had more than one employer in the previous 8 weeks prior to your disability, include all wage information from those employer(s) as well.

Step 1: Add all gross wages received (before any deductions) over the last eight weeks prior to the first day of disability, including overtime and tips earned. (See Step 3 for instructions for calculating bonuses and/or commissions.)

Step 2: Divide the gross wages calculated in step one by eight (or the number of weeks worked if less than eight) to calculate the average weekly wage.

Step 3: If you received bonuses and/or commissions during the 52 weeks preceding the first day of disability, add the prorated weekly amount to the average weekly wage. To determine the prorated weekly amount, add all bonuses/commissions earned in the preceding 52 weeks and then divide by 52.

PART B - HEALTH CARE PROVIDER'S STATEMENT (to be completed by the health care provider)

The health care provider must fill in this statement completely and return it within seven days of receipt of this form.

PART C - EMPLOYER INFORMATION (to be completed by the employer)

The employer must complete and return to the employee within three business days of receipt.

Question 6: If wages were continued during disability, specify how wages were paid – through salary continuation, use of paid time off, sick time, etc.

Question 8: Enter the wages earned by the employee during the last eight weeks preceding the first day of disability. The gross amount paid is the employee's gross weekly pay, including any overtime and tips earned for that week, plus the weekly prorated amount of any bonus or commission received during the preceding 52 weeks. (For detailed steps, see Question 9 in the Part A instructions). Calculate the gross average weekly wage by adding up the gross amounts paid, and then dividing the total by eight (or number of weeks worked if less than eight).

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EQUITABLE

Equitable Financial Life Insurance Company
For Assistance Call (866) 274-9887

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS (NY DBL)

PART A - CLAIMANT'S INFORMATION (Please Print or Type)

1. Name: _____
first middle last

2. Mailing Address (Street & Apt. #): _____
street city state zip code

3. Daytime Phone #: _____ Email Address: _____

I consent to receiving ☐ cell phone ☐ email communications from Equitable related to my claim(s) at the email address and/or cell phone number provided above.

4. Social Security #: _____ 5. Date of Birth: _____ 6. Gender: ☐ M ☐ F ☐ X

7. Describe your disability (if injury, also state how, when and where it occurred): _____

_____

8. Date you became disabled: _____ / ____ / _____ Did you work on that day?: ☐ Yes ☐ No
Have you recovered from this disability?: ☐ Yes ☐ No If Yes, date you were able to return to work: _____
Have you since worked for wages or profit?: ☐ Yes ☐ No If Yes, list dates: _____

9. Name of last employer prior to disability. If more than one employer in previous eight (8) weeks, name all employers. Average Weekly Wage is based on all wages earned in last eight (8) weeks worked.

LAST EMPLOYER(S) PRIOR TO DISABILITY				PERIOD OF EMPLOYMENT	
Firm or Trade Name	**Address**	**Phone Number**	**First Day (MM/DD/YYYY)**	**Last Day Worked (MM/DD/YYYY)**	**Average Weekly Wage (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)**

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Enter total wages earned in the last 8 weeks prior to the first day of disability below (Include wages for all employers listed above)

Week No.	Last Day Worked (MM/DD/YYYY)	No. of Days Worked	Gross Amount Paid
1			
2			
3			
4			
5			
6			
7			
8			
		Calculated average gross weekly wage:	

10. My job is or was: _____ 11. Union Member: ☐ Yes ☐No If "Yes": _____
Occupation Name of Union or Local Number

12. Were you claiming or receiving unemployment prior to this disability? ☐ Yes ☐ No

If you did **not** claim or if you claimed but did **not** receive unemployment insurance benefits *after* LAST DAY WORKED, explain reasons fully: _____

_____

If you did receive unemployment benefits, provide all periods collected: _____

_____

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PART A - CLAIMANT'S INFORMATION (Please Print or Type)

13. For the period of disability covered by this claim:
    A. Are you receiving wages, salary or separation pay? ☐ Yes ☐ No
    B. Are you receiving or claiming:
        1. Unemployment Benefits? ☐ Yes ☐ No 2. Paid Family Leave? ☐ Yes ☐ No
        3. Workers' compensation for work-connected disability? ☐ Yes ☐ No
        4. No-Fault motor vehicle accident? or personal injury involving third party? ☐ Yes ☐ No
        5. Long-term disability benefits under the Federal Social Security Act for *this* disability? ☐ Yes ☐ No

    IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 13, COMPLETE THE FOLLOWING:

    I have: ☐ received ☐ claimed from: _____ for the period: ____ / ____ / ____ to: ___ / ____ / _____
14. In the year (52 weeks) before your disability began, have you received disability benefits for other periods of disability? ☐ Yes ☐ No
    If yes, Paid by: _____ from: ____ / _____ / _____ to: ____ /_____ / _____
15. In the year (52 weeks) before your disability began, have you received Paid Family Leave? ☐ Yes ☐ No
    If yes, Paid by: _____ from: ____ / _____ / _____ to: ____ / _____ / _____
16. If you became disabled while employed or within four weeks of your last day worked, did your employer provide you with your rights under Disability Law within 5 days of your notice or request for disability forms? ☐ Yes ☐ No

---

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. I have read the instructions of this form and certify that the foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

_____ _____

Claimant's Signature **Date**

An individual may sign on behalf of the claimant only if they are legally authorized to do so and the claimant is a minor, mentally incompetent or incapacitated. If signed by other than claimant, print information below and complete and submit Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records.

_____ _____ _____

On behalf of Claimant **Address** **Relationship to Claimant**

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PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY. THE ATTENDING HEALTH CARE PROVIDER SHALL COMPLETE AND RETURN TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF RECEIPT OF THIS FORM. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 7-e. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS.**

1. Last Name: _____ First Name: _____ MI: _____
2. Gender: ☐ M ☐ F ☐ X 3. Date of Birth: _____ / _____ / _____
4. Diagnosis/Analysis: _____ Diagnosis Code: _____
   a. Claimant's symptoms: _____
   _____
   b. Objective findings: _____
   _____
5. Claimant hospitalized?: ☐ Yes ☐ No From: _____ / _____ / _____ To: ____ / _____ / _____
6. Operation indicated?: ☐ Yes ☐ No a. Type _____ b. Date _____ / _____ / _____

7. ENTER DATES FOR THE FOLLOWING	MONTH	DAY	YEAR
a. Date of your first treatment for this disability			
b. Date of your most recent treatment for this disability			
c. Date Claimant was unable to work because of this disability			
d. Date Claimant will again be able to perform work (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)			
e. If pregnancy related, please check box and enter the date ☐ estimated delivery date OR ☐ actual delivery date			

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease?:
   ☐ Yes ☐ No If "Yes", has medical been filed with the Board? ☐ Yes ☐ No

I certify that I am a:

_____ _____ _____
(Physician, Chiropractor, Dentist, Podiatrist, Psychologist, Nurse-Midwife) **Licensed or Certified in the State of** **License Number**

_____ _____ _____
Health Care Provider's Printed Name **Health Care Provider's Signature** **Date**

_____ _____
Health Care Provider's Address **Phone #**

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PART C - EMPLOYER INFORMATION (to be completed by the employer)

1. Business's full legal name and mailing address

Business Name _____

Mailing Address _____

City, State _____

Zip Code _____

Country (if not U.S.A.) _____

2. Employer's FEIN: _____

3. Contact Information:

Employer's contact name for questions relating to disability: _____

Employer's contact telephone number: _____

Employer's contact email address: _____

4. Is the employee a member of a union that provides the statutory disability benefits? ☐ Yes ☐ No

*If yes, provide Union name, address, and contact information _____

_____

5. Employee Information:

Employee's role: ☐ Employee ☐ Proprietor ☐ Partner ☐ Spouse of Employer ☐ Owner ☐ Co-Owner

Employee's date of hire (MM/DD/YYYY): _____

Date employee last worked: _____

Date employee returned to work (if applicable): _____

6. Were wages continued during disability? ☐ Yes ☐ No

If yes, what type? (PTO, sick time, other): _____

If yes, is reimbursement requested by employer? ☐ Yes ☐ No

*Reimbursement is only available if employer continued salary during disability or employee used sick time

7. Is the employee's disability work-related? ☐ Yes ☐ No

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8. Enter the last 8 weeks of gross wages for the employee immediately prior to the disability starting with the week the disability began, and calculate the average gross weekly wage (include bonuses, tips, commissions, reasonable value of board, rent, etc. and see instructions for more information)

Week No.	Week Ending Date (MM/DD/YYYY)	No. of days worked	Gross amount paid
1			
2			
3			
4			
5			
6			
7			
8			
		Calculated average gross weekly wage:	

9. In the preceding 52 weeks has the employee taken leave for:

☐ NYS Disability ☐ PFL ☐ Both Disability and PFL ☐ None

Disability: Please provide specific dates for disability _____

PFL: Please provide specific dates for PFL _____

10. Is employee still in your employment? ☐ Yes ☐ No

If no, date employment was terminated: _____

11. If employee received unemployment benefits, date the benefit was last received: _____

12. Employee's normal work schedule:

M _____ T _____ W _____Th _____F _____Sat _____Sun _____

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PART C - EMPLOYER INFORMATION (to be completed by the employer)

I have read and acknowledge the fraud information below and affirm that to the best of my knowledge and belief, the information I have provided is true and accurate.

Employer Name and Title: _____

Employer Signature: _____

Employer Contact Phone Number: _____

Date: _____

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a). The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law

HIPAA NOTICE - In order to adjudicate a workers' compensation claim or disability benefits claim, WCL 13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the insurance carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

Disclosure of Information: The Board will not disclose any information about your case to any unauthorized party without your consent. If you choose to have such information disclosed to an unauthorized party, you must file with the Board an original signed Form OC-110A "Claimants Authorization to Disclose Workers' Compensation Records." This form is available on the WCB website (**www.wcb.ny.gov**) and can be accessed by clicking the "Forms" link. If you do not have access to the internet please call (877) 632-4996. In lieu of Form OC-110A, you may also submit an original signed, notarized authorization letter.

FRAUD ACKNOWLEDGEMENT - An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

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Fax Number: (315) 477-2499
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EQUITABLE

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For Assistance Call (866) 274-9887

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS (NY DBL)

Employer Addendum for NY DBL - To Be Completed by the Employer

Information Needed for Withholding and Reporting Taxes.

What percent of this employee's NY DBL benefit is taxable? _____ %

What percentage, if any, do you contribute towards the cost of the NY DBL premium?_____%

Does the employee contribute towards the cost of the NY DBL premium? ☐ Yes ☐ No If yes, at what percent? _____%

If yes, is it on a ☐ Pre-Tax basis or ☐ Post-Tax basis

Lack of response will result in the benefit being treated as 100% taxable.

Please refer to IRS Publication ***15-A Employer's Supplemental Tax Guide, Section 6, Sick Pay Reporting*** and/or ***IRS Revenue Ruling 2004-55*** for information on calculating the taxable percent.

I affirm that to the best of my knowledge and belief, the information I have provided is true and accurate.

Employer Name and Title: _____

Employer Signature: _____

Employer Contact Phone Number: _____ **Date:** _____

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EQUITABLE

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NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS (NY DBL)

NY Supplemental Coverage Certification - To Be Completed by the Employer

If you participate in NYS DBL and Short Term Disability, please complete the DB450 form and provide the below information.

Policy/ Plan Holder Name: _____ Policy Number: _____

Claimant Name: _____ SSN: _____

Job Title: _____ Date of Hire: _____

Is this employee covered under your Equitable Non-Statutory STD plan? ☐ Yes ☐ No. If Yes, please provide details below.

What STD class is this employee a member of? _____

STD Coverage Effective Date: _____

Was this employee covered by a prior STD plan? ☐ Yes ☐ No

If Yes, when was their prior STD coverage effective**:** _____

What percentage, if any, do you contribute towards the cost of the STD premium?_____%

Is the Employer-paid premium added to the Employee's taxable wages? "Gross-Up" ☐ Yes ☐ No

Does the employee contribute towards the cost of the STD premium? ☐ Yes ☐ No

If Yes, at what percent? _____% ☐ Pre-Tax basis or ☐ Post-Tax basis

What percent of this employee's STD benefit is taxable? _____ %

Lack of response will result in the benefit being treated as 100% taxable.
Please refer to IRS Publication ***15-A Employer's Supplemental Tax Guide, Section 6, Sick Pay Reporting*** and/or ***IRS Revenue Ruling 2004-55*** for information on calculating the taxable percent.

What is this employee's weekly or hourly rate of pay? $ _____☐ Weekly ☐Hourly

What was the employee's regularly scheduled work week?

Hours per Week: _____ Scheduled workdays: ☐ Monday-Friday ☐Other: _____

What are the employee's physical job demands (pushing, pulling, standing, sitting, etc.) or attach a job description:

_____

_____

Are you able to offer job accommodations to facilitate a return to work? ☐ Yes ☐ No

What is the expected return to work date for this employee? _____

I affirm that to the best of my knowledge and belief, the information I have provided is true and accurate.

Employer Name and Title: _____

Employer Signature: _____

Employer Contact Phone Number: _____ **Date:** _____

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New York State Disability Benefits
STATEMENT OF RIGHTS

NEW YORK STATE | Workers' Compensation Board

If you are unable to work due to a non-occupational illness or injury, you may be entitled to disability benefits.

1. You may be entitled to statutory disability benefits for a non-work-related injury or illness (including disability due to pregnancy) beginning with the eighth consecutive day of disability. Disability benefits are paid **directly to you** by your EQH, **not** through your employer, unless your employer is an approved self-insurer. You can take up to 26 weeks of disability at 50% of your average weekly wage, capped at $170 per week. Generally, your average weekly wage is the average of your last eight weeks of pay prior to starting disability. Your employer or union may provide different benefits, at least as favorable as statutory, under an approved disability benefits plan or agreement.

2. If you also take New York State (NYS) Paid Family Leave (PFL), your combined total disability leave and PFL in any consecutive 52-week period may not exceed 26 weeks. You cannot take PFL and disability leave at the same time.

3. You can be treated by any physician, podiatrist, chiropractor, dentist, nurse midwife, or psychologist who can certify your disability. Your medical bills are not covered, unless your employer and/or union provides for the payment of medical bills under an approved disability benefits plan or agreement.

4. Your employer may **not** ask you to waive your right to disability benefits. Employers may collect a maximum contribution of 60 cents/week to offset the insurance premium (unless the additional contribution is part of an approved plan). **You cannot be discriminated or retaliated against for requesting or taking disability benefits.**

5. Your employer or EQH is required to begin payment or issue a ***Notice of Denial (Form DB-DEN)*** or ***Notice of Rejection (Form DB-451)*** within 18 days of your first day of disability leave or receipt of your completed claim, whichever is later. If you receive ***Form DB-DEN***, you will also receive ***Form DB-451*** with additional information within 45 days of your first day of disability leave or the receipt of your completed claim, whichever is later. If after these 45 days, you have not received benefits or ***Form DB-451***, promptly contact the NYS Workers' Compensation Board (Board) at **(877) 632-4996**. NOTE: If you receive ***Form DB-451*** and disagree, you may request a review by writing to the Board at the bottom right address.

To file a claim:

1. Obtain a ***Notice and Proof of Claim for Disability Benefits (Form DB-450)***, either from your employer or Equitable:

Equitable, EB Claims
8501 IBM Dr, Suite 150-C
Charlotte, NC 28262
Fax Number: (315) 477-2499
ebclaims@equitable.com

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2. Follow instructions to complete/submit the form, which includes sections your employer and health care provider must complete.

3. Submit the form to **Equitable** within 30 days of your first day of disability. If your claim is not paid promptly, contact your employer or **Equitable**. If you file late, you may not be paid for any disability period more than two weeks before the date you filed. Late filings may be excused if you can show it wasn't reasonably possible to file earlier. No benefits are payable if you file more than 26 weeks after your disability begins, or after you return to work.

Do not assume that your employer has filed a claim on your behalf; filing a claim is your responsibility.

Note: If your disability is the result of an automobile accident, and you have filed a claim for no-fault benefits, **you must** also file a ***Form EBNYDB450, DB-450*** for disability benefits. If you do not file for disability benefits, the no-fault insurer may reduce your no-fault payments.
IMPORTANT: In such cases, if you are not entitled to disability benefits, immediately advise the no-fault insurer.

FOR HELP OBTAINING A CLAIM FORM OR FILLING IT OUT, OR OTHER QUESTIONS ABOUT BENEFITS FOR YOUR NON-WORK-RELATED INJURY OR ILLNESS, PLEASE CALL (877) 632-4996. A BOARD REPRESENTATIVE WILL HELP.

This information is a simplified presentation of your rights as required by Section 229 of the Disability and Paid Family Leave Benefits Law. Your employer's disability benefits insurance carrier is:

Equitable Financial Life Insurance Company

Send completed form to:
Equitable, EB Claims
8501 IBM Dr, Suite 150-C
Charlotte, NC 28262
Fax Number: (315) 477-2499
ebclaims@equitable.com

Phone number: (866) 274-9887

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PRESCRIBED BY THE CHAIR,
WORKERS' COMPENSATION BOARD
NYS Workers' Compensation Board
Disability Benefits Bureau
PO Box 9029, Endicott, NY 13761-9029

WCB.NY.GOV

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Clear Form

Federal Income Tax Withholding and Electronic Funds Transfer (EFT) Request Form

NY DBL – Federal Income Tax Withholding:

If you want us to withhold federal income tax, please indicate the dollar amount to be withheld per benefit check.

Whole dollars only (minimum is $20.00 per week): $_____.00

Please Note: If $20.00 Federal Income Tax withholding reduces your benefit to less than $10.00 per week, we can no longer withhold taxes.

EFT Instructions:

1. Read the Terms and Conditions listed below.
2. Enter your name, address, home telephone number and Employee ID.
3. Complete the bank account information for your Electronic Funds Transfer request.
4. You and all other parties to the account specified must sign this form.
5. Return the completed form to Claims Office.

Attn: EB Claims
8501 IBM Drive
Suite 150-C
Charlotte, NC 28262
Fax: (315) 477-2499
ebclaims@equitable.com

Note: Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the EFT Program.

Name:_____ Address: _____

Telephone Number: _____

Employee ID: _____

Name of Bank:_____

Bank Address: _____

Bank Telephone Number: (_____) _____ - _____

Type of Account (select one):

☐ **Checking:** Account Number:_____

☐ **Saving:** Account Number:_____

Bank Routing Number: _____

Attach a voided blank personal check. Indicate any other names on the account selected:

_____

AUTHORIZATION

I / We authorize Equitable Financial Life Insurance Company, hereinafter called "The Insurance Company", and/or its Third Party Administrator, hereinafter called "TPA", and affiliated companies, to initiate credit entries (and to initiate, if necessary, debit entries and adjustments for credit entries made in error) to my (our) account indicated above and the Depository named above, hereinafter called Depository, to credit and/or debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until The Insurance Company and /or its TPA has received written notice from me (us) of its termination in such time and in such manner as to afford The Insurance Company and /or its TPA and Depository a reasonable opportunity to act on it.

_____ _____

Signature(s): **Date(s):**

_____ _____

Signature(s): **Date(s):**

Equitable is the brand name of the retirement and protection subsidiaries of Equitable Holdings, Inc., including Equitable Financial Life Insurance Company (NY, NY); Equitable Financial Life Insurance Company of America, an AZ stock company with an administrative office located in Charlotte, NC; and Equitable Distributors, LLC. The obligations of Equitable Financial Life Insurance Company and Equitable Financial Life Insurance Company of America are backed solely by their claims-paying abilities.

TERMS AND CONDITIONS

Receiving benefits by direct deposit or electronic funds transfer is voluntary. If at any time during your leave you wish to revoke this EFT request, you can do so by contacting our office.

The Insurance Company and /or its TPA will not be responsible for any banking fees charged for direct deposit or electronic funds transfer; however, The Insurance Company and /or its TPA will not charge you any fees for depositing your benefits into this account.

I understand that this agreement may be terminated by me upon written notice to The Insurance Company and /or its TPA.

The cancellation will be processed for the time period following receipt of the notice.

I understand that a change in the title of this account which alters the interest of any party terminates this authorization and that a new authorization must then be submitted to continue direct deposit/EFT.

I understand that it is my responsibility to inform The Insurance Company and /or its TPA of any address changes immediately.

I further understand that any benefit payment forwarded to the financial institution covering a period of time after my death will be refunded to The Insurance Company and /or its TPA. I agree that the financial institution shall have the right of offset for such a refund.

I authorize the financial institution specified in this authorization to provide The Insurance Company and /or its TPA with my home address and the names of any joint account holders for the account specified herein.

I understand that I am responsible for verifying the accuracy of my account data and for promptly notifying The Insurance Company and /or its TPA of any errors or changes including termination of my EFT request.

SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT

As a party to this account, I understand that I am personally liable, both individually and as a member of the group of parties to this account, for the full amount of all benefit payments covering any period after of the disability benefit recipient. This is a liability to The Insurance Company and /or its TPA. If I am entitled to any benefit as the beneficiary of the disability benefit recipient, the amount of my liability may be deducted from the amount payable to me. I agree that the financial institution shall have the right of offset for such a refund, and I authorize the financial institution to provide The Insurance Company and /or its TPA with my home address.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to The Insurance Company and /or its TPA or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/ she is doing so. The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately notify The Insurance Company and /or its TPA if the authorization is cancelled by the financial institution. The financial institution can not cancel the authorization by advice to The Insurance Company and /or its TPA.

Signature:_____ Date:_____

I certify that I have read and understand the Terms and Conditions of this EFT Agreement, including the **SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT**.

Signature(s) of Other Persons on Account:

Signature:_____ Date:_____

Signature:_____ Date:_____