EQUITABLE

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

Connecticut Paid Leave
Connecticut Paid Family and Medical Leave for Care of a Family Member with a Serious Health Condition (CT PL)
Application Checklist

The Connecticut Paid Family Leave (CT PFL) program presents the opportunity for you to receive income-replacement benefits while you take time away from work to take care of yourself and your family's health needs. To apply for these benefits, you must tell us the reason you are applying for benefits and provide documentation supporting the leave reason as well as documentation verifying your identity.

Use this form if you are experiencing need to care for a family member experiencing a serious health condition

You are caring for a family member who is receiving treatment for or recovering from a serious health condition. A family member means a spouse, parent, spouse's parent, child (of any age), child's spouse, grandparent, spouse's grandparent, sibling, sibling in law or an individual related to you by blood or affinity whose close association with you is the equivalent to one of the listed family relationships.

In order to support your Paid Leave request, you must complete:

- **Statement of Family Relationship** form

In order to support your Paid Leave request, you and the healthcare provider of your family member who has a serious health condition must complete:

- **Certification for Care of a Family Member with a Serious Health Condition** form

Employment Verification

In order to support your Paid Leave request, you must have your employer complete the following:

- **Employment Verification** form
- **Employer Wage Verification** form

If you have more than one employer, each employer should complete the forms on your behalf.

Electronic Funds Transfer - optional

You have the option to have benefit payment deposited into your account. This is optional, if you do not submit the request form, any benefits will be paid via a check mailed to you.

- **Electronic Funds Transfer (EFT) Request** form

CT PFL Application Document Checklist – continued on next page

Identity Verification

In order to support your Paid Leave request, you must provide identification verification documents with your application. Please submit one stand-alone document OR two alternate documents. **Do not send original documents.**

Stand-alone documents:

The easiest way to provide proof of identity is a color copy of your Connecticut driver's license or ID. If you don't have a Connecticut driver's license or ID, you will need to provide **ONE** of the following documents for ID proofing:

☐ Valid United States government (federal or state) issued form of identification (i.e., passport, passport card, ID card, enhanced or standard driver's license)

☐ Valid United States Citizenship and Immigration Service ID.

- Form I-766 Employment Authorization
- Form I-551 Permanent Resident Card

☐ Valid foreign government issued form of identification (i.e., passport, consular ID card, national identification card)

Alternate documents:

Please provide one of the documents from Column A and one of the documents from Column B.

Column A	Column B
☐ A certified copy of your birth certificate filed with a State Office of Vital Statistics or equivalent agency in your state of birth. ☐ A certificate of Citizenship, Form N-560, or Form N-561, issued by DHS ☐ A certificate of Naturalization (Form N-550 or Form N-570)	☐ An SSN Card ☐ A W-2 Form ☐ An SSA-1099 Form ☐ A Non-SSA-1099 Form ☐ A pay stub with your full name and SSN on it ☐ An authorization letter from the IRS displaying your 9-digit individual tax identification number

Where do I send my application?

Equitable, EB Claims	Phone: (866) 274-9887
8501 IBM Dr, Suite 150-C	Fax: (315) 477-2499
Charlotte, NC 28262	Email: ebclaims@equitable.com

Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate, and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution. I further certify that if benefits are paid in excess of the amount to which I am entitled, I will return to the Authority the amount that was overpaid, and I acknowledge that failure to do so may result in the accrual of interest and other penalties.

Signature:	Date:

CONNECTICUT PAID FAMILY LEAVE (CT PFL)
Certification for Care of a Family Member with a Serious Health Condition

EQUITABLE

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

Send completed form to: Equitable, EB Claims 8501 IBM Dr, Suite 150-C Charlotte, NC 28262	Phone: (866) 274-9887 Fax: (315) 477-2499 Email: ebclaims@equitable.com

Applicant Information

First Name:	Middle Name:	Last Name:	Case Number (if known):
Last 4 digits of SSN		Date of Birth:	
Address:	City:	State:	Zip Code:
Cell Number:	Email:		

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.

Who is the Paid Leave for?

The Family Member is the Applicant's:

☐ Domestic Partner	☐ Stepchild	☐ Domestic partner's grandchild
☐ Sibling	☐ Grandparent	☐ Grandchild's domestic partner
☐ Sibling-in-law	☐ Domestic partner's grandparent	☐ Parent
☐ Stepsibling	☐ Grandparent's domestic partner	☐ Parent-in-law
☐ Child	☐ Grandchild	☐ Stepparent

☐ Person related by blood or affinity whose relationship with the applicant is the equivalent to one of the listed relationships

Family Member's Information

First Name:	Middle Name:	Last Name:	Date of Birth:
Address:	City:	State:	Zip Code:

Family Member's Health Care Provider Information

Health Care Provider's Name:		
Health Care Provider's Business Address:		
City:	State:	Zip Code:
Type of Practice/Medical Specialty:		
Certificate license number and state:		
Telephone:	Fax:	Email:

CONNECTICUT PAID FAMILY LEAVE (CT PFL)
Certification for Care of a Family Member with a Serious Health Condition

CT PFL Certification for Care of a Family Member with a Serious Health Condition – continued from prior page

Applicant First Name:	Applicant Middle Name:	Applicant Last Name:	Case Number (if known):

Form Instructions for the Health Care Provider

Please provide your contact information, complete all relevant parts of this Section, and sign the form. The applicant has requested paid leave benefits under Connecticut Paid Family Leave (CT PFL) to serve as a caregiver for your patient.

Limit your response to the medical condition(s) for which the applicant is seeking CT Paid Family Leave to serve as a caregiver. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For CT PFL purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the applicant's family members, as defined in 29 C.F.R. § 1635.3(b).

Part A: Patient Medical Information (to be completed by Family Member's Health Care Provider)

Below are a list of definitions outlining the areas that are considered a serious health condition for the purposes of CT PFL with area to provide supporting details. **Select all** that apply and provide as much detail as possible.

Inpatient Care

- An Overnight stay in a hospital, hospice, or residential medical care facility.
- Inpatient care included any period of incapacity or any subsequent treatment in connection with the overnight stay.

  Inpatient Care: The patient ☐ *has been* / ☐ *is expected to be* admitted for an overnight stay in a hospital, hospice or residential medical care facility on the following dates: _____ (mm/dd/yyyy)

Continuing Treatment by a Health Care Provider (any one or more of the following)

Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment of period of incapacity relating to the same condition, that also involves either:

- Two or more in-person or telemedicine visits to a health care provider for the treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,
- At least one in-person or telemedicine visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health care provider might prescribe a course of prescription medication or therapy requiring special equipment.

  Incapacity plus Treatment: The patient ☐ has been / ☐ is expected to be incapacitated for more than three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

  The patient ☐ *was* / ☐ *will be* seen on the following date(s):_____

CT PFL Certification for Care of a Family Member with a Serious Health Condition – continued in next page

CONNECTICUT PAID FAMILY LEAVE (CT PFL)
Certification for Care of a Family Member with a Serious Health Condition

CT PFL Certification for Care of a Family Member with a Serious Health Condition – continued from prior page

Continuing Treatment by a Health Care Provider (any one or more of the following) - continued

Details on continuing treatment:
Was medication, other than over-the counter medication prescribed? ☐ Yes ☐ No
Is it medically necessary for the patient to attend follow-up appointments for evaluation and or treatment because of the medical condition? ☐ Yes ☐ No
If yes, please describe and provide dates: _____
_____
_____

Pregnancy

- Any period of incapacity due to pregnancy or for prenatal care.
  ☐ Pregnancy: The condition is pregnancy.
  ☐ *Expected Due Date* / ☐ *Actual Delivery Date*: _____ *(mm/dd/yyyy)*
  If you advise(d) your patient to stop working prior to the expected or actual delivery date, what date do/did you advise your patient to stop working? _____ *(mm/dd/yyyy)*
  - If the start of the leave is earlier than 4 weeks prior to the due date, explain medical circumstances for such time off._____
    _____
    _____

Chronic Conditions

- Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health conditions is one which requires visits to a health care provider) or nurse or physician's assistant supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
  ☐ **Chronic Condition**: It is medically necessary for the patient to receive treatment from a health care provider for this condition at least twice per year. Please provide the dates of the last two appointments and the next scheduled appointment.
  Last two appointments: _____ *(mm/dd/yyyy),* and _____ *(mm/dd/yyyy)*
  Next scheduled appointment: _____ *(mm/dd/yyyy)*

Permanent or Long-term Condition

- A period which is permanent or long-term due to condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
  ☐ **Permanent or Long-Term Conditions:** Due to the condition, incapacity is permanent or long-term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

CT PFL Certification for Care of a Family Member with a Serious Health Condition – continued in next page

CONNECTICUT PAID FAMILY LEAVE (CT PFL)
Certification for Care of a Family Member with a Serious Health Condition

CT PFL Certification for Care of a Family Member with a Serious Health Condition-continued from prior page

Applicant First Name:	Applicant Middle Name:	Applicant Last Name:	Case Number (if known):

Condition Requiring Multiple Treatments

- A condition requiring restorative surgery after an accident or other injury, or a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

☐ **Conditions requiring Multiple Treatments:** Due to the condition, it is medically necessary for the patient to receive multiple treatments.

Describe the necessary treatment required:

_____

_____

Organ or Bone Marrow Donor

☐ **Organ or Bone Marrow Donor:** The patient is serving as an organ or bone marrow donor

None of the Above

Briefly describe other appropriate medical facts related to the condition(s) that demonstrate that your patient has a serious health condition as defined above:

_____

_____

_____

Patient's Condition Requires	Approximate date the condition started or will start: _____ (mm/dd/yyyy) Provide your best estimate of how long the condition will last: _____ Your patient will need the following assistance: ☐ Psychological care and comfort ☐ Basic medical or personal needs or safety, or for transportation ☐ Someone to accompany them to medical treatments/appointments

Part B: Caregiver Leave Requirements (to be completed by Family Member's Health Care Provider)

Please complete all sections that apply.

Continuous	☐ The applicant *needed / will need* to be absent from work on a continuous basis due to your patient's medical condition, including the need for treatment and recovery. Start Date: _____ *(mm/dd/yyyy)* End Date: _____ *(mm/dd/yyyy)*
Reduced Schedule	☐ The applicant *needed / will need* to work a part-time/reduced schedule due to your patient's medical condition, including the need for treatment and recovery. If checked, please estimate the number of hours per week the applicant will need time off to care for your patient per week: _____Hour(s) per week Start Date: _____ *(mm/dd/yyyy)* End Date: _____ *(mm/dd/yyyy).*

CT PFL Certification for Care of a Family Member with a Serious Health Condition – continued in next page

CONNECTICUT PAID FAMILY LEAVE (CT PFL)

Certification for Care of a Family Member with a Serious Health Condition

CT PFL Certification for Care of a Family Member with a Serious Health Condition-continued from prior page

Applicant First Name:	Applicant Middle Name:	Applicant Last Name:	Case Number (if known):

Part B: Caregiver Leave Requirements (to be completed by Family Member's Health Care Provider) - continued

Intermittent	☐ The applicant *needed / will need* to be out of work on an intermittent basis (periodically), including any episodes of incapacity (i.e. episodic flare-ups), to care for your patient. Start Date: _____ *(mm/dd/yyyy)* End Date: _____ *(mm/dd/yyyy)* If checked, please indicate the intermittent frequency and duration required to best care for your patient over the next 6 months: **Frequency**: _____time(s) every _____ week(s) **OR** _____time(s) every _____month(s) **Duration**: _____hour(s) per episode **OR** _____day(s) per episode If intermittent leave is necessary to accompany your patient to planned medical treatments (scheduled medical visits), such as: psychotherapy, prenatal appointments, please list those dates: _____ _____

Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate, and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

Health Care Provider Signature & Credentials:	**Date:**

Connecticut Paid Family Leave (CT PFL)
Statement of Family Relationship

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Equitable Financial Life Insurance Company

For Assistance Call (866) 274-9887

Send completed form to:

Equitable, EB Claims
8501 IBM Dr, Suite 150-C
Charlotte, NC 28262

Phone: (866)274-9887
Fax: (315)477-2499
Email: ebclaims@equitable.com

Applicant Information

First Name:	Middle Name:	Last Name:	Case Number:
List other last names (if any), under which applicant has worked:		Last 4 Digits of SSN:	Date of Birth:
Street Address:			
City:		State:	Zip:
Cell Phone:	Home Phone:		Work Phone:

Relationship:

I am seeking paid leave benefits in connection with leave to care for a family member with a serious health condition. The family member is my:

☐Spouse
- ☐ Domestic Partner
- ☐ Domestic partner's grandparent
- ☐ Grandparent's domestic partner
- ☐ Grandchild's domestic partner
- ☐ Domestic partner's grandchild

☐ Sibling
☐ Sibling-in-law
☐ Stepsibling
☐ Child

☐ Stepchild
☐ Grandparent
☐ Spouse's grandparent
☐ Grandparent's spouse
☐ Grandchild

☐ Spouse's grandchild
☐ Grandchild's spouse
☐ Parent
☐ Parent-in-law
☐ Stepparent

or

☐ An individual related to me by blood or affinity whose close association with me is the equivalent to one of the listed family relationships.

If the family member is an individual related to you by blood or affinity (including a person who stood in loco parentis to you or for whom you stand in loco parentis) you must complete this section.

I am asserting that an affinity relationship exists between myself and _____

(Applicant to insert name of affinity relationship individual)

Please describe how this relationship demonstrates a family relationship:

_____

_____

_____

CT PFL Statement of Family Relationship – continued in next page

Connecticut Paid Leave (CT PFL)
Statement of Family Relationship - continued

CT PFL Statement of Family Relationship – continued from prior page

Relationship: - continued from prior page

Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate, and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution. I further certify that if benefits are paid in excess of the amount to which I am entitled, I will return to the Authority the amount that was overpaid, and I acknowledge that failure to do so may result in the accrual of interest and other penalties.

Signature:	**Date:**

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Connecticut Paid Leave
Employer Wage Verification

Instructions to the employer: Please complete the following information and return to Equitable within **10 calendar days** of receipt of this form.
You can send it by email **ebclaims@equitable.com** or fax to **(315) 477-2499**.
This form is intended to **verify wages when wage data is unavailable from CT Department of Labor.**

Section 1: Applicant's Information

Applicant Name: *first* *middle* *last*	Case Number (if known):

Date of Birth:	Case Number (if known):	Leave Start Date:

Section 2: Employer Information

Employer Name:		
Address:		
City:	State:	Zip Code:

Contact Name:	FEIN:
Contact Phone Number:	Contact Email:
Date of Hire:	Termination Date:

Section 3: Employee Wages Paid for Employment in CT Only

Please enter gross wages paid by you, for work performed in CT in each of the calendar quarters for the past 2 years.

Quarter	Year	Gross Wages Earned (CT Only)
		$
		$
		$
		$
		$
		$
		$
		$

Please only enter wages that are related to employment in the State of Connecticut. In the next section, you will be able to certify why those wages are not reported to the CT Department of Labor (if applicable).

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CONNECTICUT PAID FAMILY LEAVE (CT PFL) EMPLOYMENT VERIFICATION

Instructions to the employer: Please complete the following information and return to Equitable within 10 calendar days of receipt of this form. You can send it by email ebclaims@equitable.com or fax: (315) 477 2499.

Send completed form to:
Equitable, EB Claims
8501 IBM Dr, Suite 150-C
Charlotte, NC 28262

Phone: (866) 274-9887
Fax: (315) 477-2499
Email: ebclaims@equitable.com

Section 1: Applicant's Leave Information (to be completed by the applicant or employer)

First Name:	Middle Name:	Last Name:	Date of Birth:
Last 4 digits of SSN:	Beginning Date of Leave:	End Date of Leave:	
Leave Type: ☐ Continuous ☐ Intermittent ☐ Reduced Schedule		Case Number (if known):	

Reason for Leave: ☐ Employee's own serious health condition ☐ Caregiver leave ☐ Bonding leave ☐ Military caregiver leave ☐ Qualifying exigence leave ☐ Family violence leave

Section 2: Employer Information (to be completed by the employer)

Employee Name:		
Address:		
City:	State:	Zip Code:
Contact Name:	FEIN:	
Contact Phone Number:	Contact Email:	

If one of the following categories is applicable, check the appropriate box and return the form to Equitable without completing the remaining sections of the form:
☐ Federal Government ☐ Railroad ☐ Private Elementary or Secondary School
☐ Government of another state ☐ Non-contributing employee of a Municipality, Board of Education or Sovereign Nation ☐ Non-contributing employee of CT State Government

Section 3: Applicant's Income and Work Schedule (to be completed by the employer. If the employee is not taking paid leave with this employer, please only complete sections 1-3, section 7 and submit back to Equitable.)

Employee's Rate of Pay (e.g., 13/hour or $800/week):	Employee's Hire Date:	Date of employee's separation from employment (if applicable):

Please select the workdays that the employee typically works
☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

A "workweek" is the employee's usual or normal schedule (hours per week). If the employee has a standard workweek (e.g., 40 hours/week, or 24 hours/week) please provide that schedule:

CT PFL Employment Verification Continued on next page.

CONNECTICUT PAID FAMILY LEAVE (CT PFL)
EMPLOYMENT VERIFICATION

CT PFL Employment Verification continued from prior page

Section 3: Applicant's Income and Work Schedule (to be completed by the employer. If the employee is not taking paid leave with this employer, please only complete sections 1-3, section 7 and submit back to Equitable.) - continued

If the employee's workweek varies from week to week, please state the hours worked in each of the 12 weeks prior to the receipt of this form or prior to the start of leave, whichever occurs first (including any overtime worked), plus any hours for which the employee took any paid time off:

Week 1:	Week 2:	Week 3:	Week 4:
Week 5:	Week 6:	Week 7:	Week 8:
Week 9:	Week 10:	Week 11:	Week 12:

Section 4: Scheduled Closures (to be completed by the Employer)

For the requested leave period, please provide the specific dates of any Company holidays or other scheduled closures or shutdowns during which the employee would not ordinarily be expected to work if not on leave:

Applicant's First Name:	Applicant's Middle Name:	Applicant's Last Name:	Case Number (if known):

Section 5: Other Potential Sources of Income (to be completed by the Employer)

Has the employee applied for Worker's Compensation benefits? ☐ Yes ☐ No
If Yes, have the Worker's Compensation benefits been approved? ☐ Yes ☐ No
If Yes, please indicate the dates for which the employee is approved to receive Worker's Compensation Benefits:
To:_____ From: _____*(mm/dd/yyyy)*.

"Income-replacement benefits" refers to employer-provided sources of income to the employee, including sick leave, vacation leave, paid time off, disability benefits, etc. **Please indicate which of the following applies to the employee (please check all that apply and at least one option must be selected):**

☐ Employee will not receive any employer-provided income-replacement benefits while on leave.

☐ Employee will receive employer-provided income-replacement benefits equal to the employee's regular wages for the entire duration of the employee's leave.

☐ Employee will receive employer-provided income-replacement benefits that are equal to the employee's regular wages for a portion of the employee's leave.
Please indicate the last date the employee will stop receiving such income-replacement benefits:
_____

CONNECTICUT PAID FAMILY LEAVE (CT PFL)

EMPLOYMENT VERIFICATION

CT PFL Employment Verification continued from prior page

Section 5: Other Potential Sources of Income (to be completed by the Employer) - continued

☐ Employee will receive employer-provided income-replacement benefits that are less than the employee's regular wages for some or all of the employee's leave.
Please indicate if the employer-provided income-replacement benefits are:
☐ **primary** - the benefit payment duration and amount will be the same whether or not CT PFL benefits are payable
☐ **secondary** – the benefit payment will be delayed or reduced if CT PFL benefits are payable

If the employer-provided income-replacement benefits are primary, what percentage of the employee's wages will be paid and for how long? Percentage: _____Duration: _____
If the employer-provided income-replacement benefits are primary and the percentage will change over time, please indicate separate percentages on each line below as applicable:

Percentage:_____ Duration:
Percentage: _____ Duration:

If the income-replacement benefits are secondary, CT Paid Family Leave delegates to the employer the responsibility for complying with the statutory requirement that the sum of the CT Paid Family Leave benefits plus employer-provided benefits does not exceed 100% of the employee's regular wages.

Section 6: Leaves Requiring Additional Employer Approval (to be completed by the Employer)

Complete only if Intermittent or Reduced Schedule Bonding Leave is requested by the employee:
Have you approved your employee to take intermittent leave or reduced schedule leave for the purpose of bonding with a newborn or newly adopted child or newly placed foster child? ☐ Yes ☐ No

If **Yes**, please describe the timing, frequency and duration of intermittent leave or change in schedule (e.g., leave taken 2 days/month, schedule reduced by 15%):

Complete only if Qualifying Exigency Leave for an "other approved reason" is requested by the employee:
Have you approved your employee to take qualifying exigency leave for a reason other than leave to address short-notice deployment, military events and related activities, emergency childcare or parental care, financial and legal arrangements, counselling, covered servicemember's rest and recuperation, post-deployment activities? ☐ Yes ☐ No

If **Yes**, please describe the timing, frequency and duration of such qualifying exigency leave, (e.g., leave taken 2 days/month, schedule reduced by 15%):

Section 7: Employer Declaration and Signature

Employee Signature	**Date:**
Printed Name:	**Title:**

Electronic Funds Transfer (EFT) Request Form

Clear Form

Instructions

1. Read the Terms and Conditions listed below.

2. Enter your name, address, home telephone number and Employee ID.

3. Complete the bank and 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.

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: ☐ **Saving:** ☐

Account Number: _____ Account Number: _____

Bank Routing Number: _____

Attach a voided blank personal check.

Indicate any other names on the account selected:

_____

AUTHORIZATION

I / We authorize _____ hereinafter called "The Insurance Company" and/or its Third Party Administrator, hereinafter called "TPA", 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:**

_____ _____

TERMS AND CONDITIONS

The Insurance Company and/or its TPA will not be responsible for any banking fees charged for direct deposit or electronic funds transfer.

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 hathe 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 here in.

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 the death 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 an/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: Date

_____ _____

Date: