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

Connecticut Paid Leave
Connecticut Paid Family and Medical Leave for Leave for Self (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 a serious health condition

You are receiving treatment for or recovering from a serious health condition, including pregnancy, or organ or bone marrow donation.

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

- **Certification for Serious Health Condition** form

You may also be eligible for Short Term Disability (STD) benefits. You may apply for benefits using the **SHORT TERM DISABILITY INCOME (STD) CLAIM FORM** provided.

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:

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CONNECTICUT PAID FAMILY LEAVE (CT PFL)
Certification for Serious Health Condition

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 to be completed by the applicant

First Name:	Middle Name:	Last Name:	Case Number (if known):
Last 4 digits of SSN		Date of Birth:	

Address:
Street 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.

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:

Form Instruction for the Health Care Provider:

Please provide your contact information, complete all relevant parts of this section, and sign the form. Your patient has requested leave under Connecticut Paid Family Leave (CT PFL).

Limit your response to the medical condition(s) for which the employee is seeking CT Paid Family Leave. 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 employee's family members, as defined in 29 C.F.R. § 1635.3(b). ***CT PFL Certification for Serious Health Condition – continued in next page***

CONNECTICUT PAID FAMILY LEAVE (CT PFL)

Certification for Serious Health Condition

Certification for Serious Health Condition – continued from prior page

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

Part A: Patient Medical Information (to Be completed by 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):_____*(mm/dd/yyyy)*.

  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.

    _____
    _____
    _____

CT PFL Certification for Serious Health Condition – continued in next page

CONNECTICUT PAID FAMILY LEAVE (CT PFL)

Certification for Serious Health Condition

CT PFL Certification for Serious Health Condition – continued from prior page

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

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 Conditions

- 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).

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

☐ **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:

_____

_____

_____

CT PFL Certification for Serious Health Condition – continued in next page

CONNECTICUT PAID FAMILY LEAVE (CT PFL)

Certification for Serious Health Condition

CT PFL Certification for Serious Health Condition – continued from prior page

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

Part B: Patient Leave Requirements (to be completed by 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).*
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:**

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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:

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

SHORT TERM DISABILITY INCOME (STD) CLAIM FORM INSTRUCTIONS

Section I **Employer's Statement -** to be completed by the **employer's** authorized representative.

Section II **Employee's Statement -** to be completed by the **employee** who is applying for Short Term Disability Benefits

Section III **AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION -** to be signed by the **employee.**

Section IV **Attending Physician's Statement -** to be completed by the **medical provider** who is treating the employee.

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED.
SEND COMPLETED APPLICATION TO EQUITABLE

Please email, fax or mail the completed application to: Equitable
Attn: EB Claims
8501 IBM Drive, Suite 150-C
Charlotte, NC 28262
Fax Number:(315) 477-2499
Email: ebclaims@equitable.com

Questions? Once the claim has been filed you can call Equitable Claims at (866) 274-9887

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

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

SHORT TERM DISABILITY INCOME (STD) CLAIM FORM

Section I - Employer's Section - To Be Completed by the Employer

Employee Name (first)	(middle name)	(last name)
Social Security/Tax Identification #	Date of Birth	Telephone Number
Employee's Address Street City State Zip		

A. Information About the Employer

Company's Name		
Company's Address Street City State Zip		
Name and Address of Division Where Employee Works (if different from above)		
Division Name	Division Address Street City State Zip	
Group Policy Number	Class	Location

B. Information About the Employee

Date employee was hired	Date employee became insured under the plan	Is employee a union member? ☐ No ☐ Yes If "Yes," name of union _____ Union local number _____

What was the employee's regularly scheduled work week?
_____ Hours per Week Scheduled workdays ☐ Monday – Friday ☐ Other: _____

Is employee covered under a Long-Term Disability plan insured by Equitable? ☐ No ☐ Yes
If "Yes," Effective date of LTD coverage:

Was the employee's Short-Term Disability insurance issued on the basis of a Personal Heath Statement? ☐ Yes ☐ No
If "Yes," attach copy

Was the employee insured under your prior Short-Term Disability policy? ☐ Yes ☐ No
If yes, please provide the inclusive date of coverage From_____ Through _____

Was the employee on Qualified Family Leave when disability began? ☐ Yes ☐ No
Did STD &/or LTD insurance continue while on Family Leave? ☐ Yes ☐ No
Date Qualified Family Leave started: _____

Section-I continued in next page.

Section I - Employer's Section - To Be Completed by the Employer (Continued)

C. Information Needed for Withholding and Reporting Taxes.

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.

D. Information About the Claim

What was the employee's permanent job on their last day at work? (Please attach a copy of the employee's job description.)	
Last day employee actually worked:	On that day, did the employee work a full day? ☐ Yes ☐ No If "No," how many hours were worked? _____
When did the employee stop working?	
Is the employee's condition work related? ☐ Yes ☐ No	
Has a claim been filed with Workers' Compensation? ☐ Yes If "Yes," send initial report of illness or injury or award notice. ☐ No	Date employee is expected to return to work? Full time? ☐ Yes ☐ No

E. Information About Salary

Employee's weekly/hourly rate of pay: $ _____
Will/Is employee receive(ing) Workers' Compensation Payments? ☐ Yes ☐ No
Weekly Amount $_____ Date Payments Start: _____ Date Payments Will End: _____
Is employee receiving Salary Continuation or Sick Leave? ☐ Yes ☐ No
Weekly Amount $_____ Date Payments Start: _____ Date Payments Will End: _____

Section-I continued in next page.

Section I - Employer's Section - To Be Completed by the Employer (Continued)

F. Information About the Physical Aspects of the Employee's Job.

Check the items below that relate to the employee's job and complete the information requested.
Use these definitions for the frequency of occurrence:

Never means the person does not perform this activity.
Occasionally means the person does the activity up to 2 hours 40 minutes at a time.
Frequently means the person does the activity up to 5 hours 20 minutes at a time.
Continuously means the person does the activity more than 5 hours 20 minutes at a time.

	Frequency of Occurrence			
Activity	**Never**	**Occasionally**	**Frequently**	**Continuously**
☐ Standing	☐	☐	☐	☐
☐ Walking	☐	☐	☐	☐
☐ Sitting	☐	☐	☐	☐
☐ Balancing	☐	☐	☐	☐
☐ Stooping	☐	☐	☐	☐
☐ Kneeling	☐	☐	☐	☐
☐ Crouching	☐	☐	☐	☐
☐ Crawling	☐	☐	☐	☐
☐ Climbing	☐	☐	☐	☐
☐ Reaching/Working Overhead	☐	☐	☐	☐
☐ Keyboard Use/Repetitive Hand Motion	☐	☐	☐	☐

Activity	**Description**	**Frequency**	**Weight**
☐ Pushing			lbs.
☐ Pulling			lbs.
☐ Lifting			lbs.
☐ Carrying			lbs.

Can the job be performed sitting and standing? ☐ Yes ☐ No

What are the major tasks requiring the use of one or both hands? Indicate the percentage of the employee's workday that is spent on each of these tasks.

_____ %
_____ %
_____ %

G. Information About the Job as it Relates to the Disability

Can the job be modified to accommodate the disability either temporarily or permanently? ☐ Yes ☐ No
If "Yes," please explain: _____

Is it possible to offer the employee assistance in doing the job (e.g., through technology or personal assistance)?
☐ Yes ☐ No If "Yes," please explain: _____

H. Signature

Name (Please print or type)	
Title	Telephone Number
Signature	

End of Section-I

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

EQUITABLE

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

SHORT TERM DISABILITY INCOME (STD) CLAIM FORM

Section II - Employee's Section - To Be Completed by the Employee

(BE SURE TO ANSWER ALL QUESTIONS - FAILURE TO DO SO MAY DELAY YOUR CLAIM)

A. Information About You

Employee Name (first)	(middle name)	(last name)
Employee's Address Street City State Zip		

Gender ☐ Male ☐ Female ☐ Other	Date of Birth	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Social Security/Tax Identification #

Personal Cell Telephone Number	Alternate Telephone Number	Email Address

I consent to receiving communications from Equitable related to my claim(s) at the email address and/or cell phone number provided above.
☐ **Yes**, I consent to receiving ☐ cell phone ☐ email communications from Equitable. (Your carrier's fees may apply.)
☐ **No**, I do not consent to receiving ☐ cell phone ☐ email communications from Equitable.

B. For an Injury, answer the following questions

Date Injury Occurred	Time Injury Occurred
Where did injury occur?	How did injury occur?

C. For Illness, Injury or Pregnancy, answer the following questions

Reason for claim: ☐ Illness ☐ Injury ☐ Pregnancy - Estimated or actual delivery date?

Name of Medical Provider	Name of Medical Facility

Date you were first treated by this provider	Provider's Telephone Number	Provider's Fax Number

Before you stopped working, did your condition require you to change your job, or the way you did your job?
☐ Yes ☐ No If "Yes," please explain.

Section II - Employee's Section - To Be Completed by the Employee (Continued)

What aspect of your condition made you unable to work?
Are you receiving or eligible for: ☐ Workers' Compensation ☐ State Disability ☐ No Fault Disability ☐ Other _____ If "Yes," what is the policy number, name and address of insurer?_____

Weekly Amount: $	Date Payments Start:	Date Payments End:

Is your condition related to work activities or your workplace? ☐ No ☐ Yes If "Yes," explain:
Have you filed, or do you intend to file a Workers' Compensation claim due to your condition? ☐ Yes ☐ No If "No," explain:

D. Information About the Disability

Last day you worked before the disability:	Did you work a full day? ☐ Yes ☐ No If "No," explain:
Amount earned before the disability (☐Hourly rate ☐Yearly salary): $_____	
Date you were first unable to work:	Since that date, have you done any work? ☐ Yes ☐ No ☐ Part time ☐ Full time If "Yes," please indicate dates worked, name of employer and amount earned:
If you have not returned to work, do you expect to? ☐ Yes ☐ No	Estimated return to work date:

E. Information About Tax Withholding

Federal law requires us to withhold federal income tax from your check if you request us to do so. We are also required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your social security number.

If you want us to withhold tax, please indicate on the line below the dollar amount to be withheld per benefit check.

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

IMPORTANT: If you pay the entire cost of the STD premium, but on Post-tax basis per Section C of the Employer's Statement, you will not be able to request any federal income tax withholding from your check. Puerto Rico residents may not request withholding.

Note to residents of Iowa and the District of Columbia: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than your normal rate) until we receive a signed state Tax Withholding Certificate from you. Please contact your employer or state Tax Department to obtain the proper withholding form.

Note to residents of Nebraska, Rhode Island and South Carolina: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than your normal rate) until we receive a signed federal Form W -4, Employee's Withholding Allowance Certificate, from you. You may go to www.irs.gov to obtain the proper withholding form.

Section II - Employee's Section - To Be Completed by the Employee (Continued)

F. State Fraud Warnings

I affirm that I have read the appropriate State Fraud Warning for my state of residence and that I provided my correct Taxpayer Identification or Social Security Number on Section II. If the Taxpayer Identification or Social Security Number is not supplied, the interest may be subject to federal and state withholding. Under the penalties of perjury, I certify that the information supplied on this form is true and complete, that I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding and that I am a U.S. Person. **The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

New York Fraud Warning: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

NY RESIDENTS SIGN HERE: I have read and understood the New York State Fraud Warning.

Signature:_____ **Date:**_____

Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.

RESIDENTS OF JURISDICTIONS OTHER THAN NEW YORK SIGN BELOW

Alabama, Arkansas, District of Columbia, Louisiana, Maryland, New Mexico, Rhode Island, Texas, West Virginia: Any person who knowingly or willfully presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to civil and criminal penalties, including fines and confinement in prison.

Alaska and New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided under state law.

Arizona: For your protection, Arizona law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: 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.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware, Florida, Idaho, Indiana, and Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Maine, Tennessee, Virginia and Washington: WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or any other person. Penalties may include imprisonment, fines or a denial of insurance benefits.

Kentucky and Pennsylvania: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.
Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
Oregon and All Other States: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement that is material to the interests of an insurer may be guilty of insurance fraud.
Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

The statements contained in this form are true and complete to the best of my knowledge and belief.

I have read and understood the State Fraud Warning applicable to me.

Signature:_____ **Date:**_____
Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.

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

EQUITABLE

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

Section III – Authorization to Obtain and Disclosure Information - Employee to complete

To: Any health care provider, pharmaceutical provider, pharmacy benefits manager, employer, benefit plan, insurer, service provider, financial institution, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. **I AUTHORIZE** you to disclose to Equitable* a complete copy of, and to communicate telephonically or electronically with Equitable's representatives about, any and all of the following personal, private, or privileged information, records, or documents relative to:

Insured's Name (*Please print*)	**Date of Birth**	**Last 4 Digits of Social Security/Tax Identification #**

Any and all medical information or records, including medical histories, physical, mental, or diagnostic examinations, pharmaceutical records, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health; work and performance information and history, including job duties and earnings; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; financial information, including pension benefits and bank records; business transaction billing and payment records; academic transcripts; and any and all information concerning Social Security benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used by Equitable (including subsidiaries and affiliates) for the purpose of evaluating and administering my claim(s) for benefit s and/or leave request and/or request for accommodation. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to Equitable.

I UNDERSTAND that once My Information has been disclosed to Equitable as permitted under this Authorization, it may be re-disclosed by Equitable as permitted by law or my further authorization. I authorize Equitable to use or disclose My Information (i) to my employer for a) functions related to accommodating my restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits or leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, or lawful subpoena (including regarding employment claims); e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim or other audits or reviews; (ii) to the administrator or other service providers, including health and wellness vendors, of my employer's benefit plan(s) and/or programs, including leave management, for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services

Section-III continued on next page.

Section III – Authorization to Obtain and Disclosure Information (Continued)

related to my claim; (vi) for other insurance or reinsurance purposes, including workers' compensation insurance, Social Security Disability insurance, or subrogation or reimbursement purposes; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others; (ix) as may be reasonably necessary to respond to regulatory complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud.

I ALSO UNDERSTAND that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures Equitable may make, unless Equitable has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to Equitable. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing Equitable to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud, respond to regulatory complaints, or protect the personal safety of others. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Insured or Authorized Representative	Date (Valid for 2 years) (*if signed by Authorized Representative*)	Relationship to Insured *(If signing for yourself, use "Self.")*

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

EQUITABLE

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

Section IV Attending Physician's Statement - to be completed by the treating medical provider

HISTORY

Patient's Name (first middle and last name)	Social Security/Tax ID #	Date of Birth
Patient's condition is the result of: ☐ Illness ☐ Injury ☐ Pregnancy ☐ Mental/Nervous Condition		
Is condition due to an illness or injury that is work related? ☐ Yes ☐ No	Height:	Weight:
If pregnancy, what is the expected date of delivery? Month _____ Date _____ Year_____	LMP Date:	

DIAGNOSIS

Diagnosis (including any complications):	ICD10 Code(s):
Subjective Symptoms: Physical Findings: (list all test results, or enclose test)	
Test(s)	
Remarks:	

TREATMENT

Date First Unable to Work:	Date of last office visit:	Date of next office visit:
List all dates of treatment for this condition since patient ceased work:		
Has patient been referred to any other medical provider? ☐ Yes ☐ No If "Yes," Date(s):		
Name of Medical Provider	Specialty	
Treatment for this condition(s) (including surgery/medications):		

Section IV Attending Physician's Statement (Continued)

TREATMENT (continued)

Was the patient hospitalized for this condition? ☐ Yes ☐ No If "Yes," Date(s) admitted: _____
Name of Hospital(s) _____ Date(s) discharged: _____

Was surgery performed? ☐ Yes ☐ No If "Yes," Date: _____ Procedure: _____

RESTRICTIONS and LIMITATIONS

What are the patient's current physical limitations and restrictions?

Address the full range of restrictions/limitations based on your medical findings at the time patient stopped working or reduced work schedule, noting that we will assume there are no restrictions on function unless specified below.
In a general workplace environment the patient is able to:

	Sit	Stand	Walk
Number of hours at a time	☐	☐	☐
Total hours/day	☐	☐	☐
Check here if no restrictions	☐	☐	☐

Please check the frequency with which the patient can perform the following activities:

R = Right L = Left B = Bilateral	**No Restrictions**	**Frequently** (up to 5 hours 20 minutes)	**Occasionally** (up to 2 hours 40 minutes)	**Never**	**Constantly** (up to 8 hours)
Lift / carry 1 to 10 lbs.	☐ R ☐ L ☐ B	☐ R ☐ L ☐ B	☐ R ☐ L ☐ B	☐ R ☐ L ☐ B	
Lift / carry 11 to 20 lbs.	☐ R ☐ L ☐ B	☐ R ☐ L ☐ B	☐ R ☐ L ☐ B	☐ R ☐ L ☐ B	
Lift / carry 21 to 50 lbs.	☐ R ☐ L ☐ B	☐ R ☐ L ☐ B	☐ R ☐ L ☐ B	☐ R ☐ L ☐ B	
Lift / carry 51 to 100 lbs.	☐ R ☐ L ☐ B	☐ R ☐ L ☐ B	☐ R ☐ L ☐ B	☐ R ☐ L ☐ B	
Lift / carry over 100 lbs.	☐ R ☐ L ☐ B	☐ R ☐ L ☐ B	☐ R ☐ L ☐ B	☐ R ☐ L ☐ B	
Climbing	☐	☐	☐	☐	
Balancing	☐	☐	☐	☐	
Stooping	☐	☐	☐	☐	
Kneeling	☐	☐	☐	☐	
Crouching	☐	☐	☐	☐	
Crawling	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	
Handling	☐	☐	☐	☐	
Feeling	☐	☐	☐	☐	
Fingering	☐	☐	☐	☐	
Driving	☐	☐	☐	☐	
Talking	☐	☐	☐	☐	
Hearing	☐	☐	☐	☐	

Section IV Attending Physician's Statement (Continued)

TREATMENT (continued)

R = Right L = Left B = Bilateral		No Restrictions	Frequently (up to 5 hrs 20 mins)	Occasionally (up to 2 hrs 40 mins)	Never	Constantly (up to 8 hrs)
Near Acuity (with best corrected vision)		☐	☐	☐	☐	
Far Acuity (with best corrected vision		☐	☐	☐	☐	
Depth Perception		☐	☐	☐	☐	
Accommodation (visual)		☐	☐	☐	☐	
Color Vision		☐	☐	☐	☐	
Field of Vision		☐	☐	☐	☐	
Reaching only (non load-bearing)	Above shoulder	☐**R** ☐**L** ☐**B**	☐**R** ☐**L**☐**B**	☐**R** ☐**L** ☐**B**	☐**R** ☐**L** ☐**B**	
	Below shoulder level (reach forward for objects on desktop or workstation)	☐**R** ☐**L** ☐**B**	☐**R**☐**L** ☐**B**	☐**R** ☐**L** ☐**B**	☐**R** ☐**L** ☐**B**	
Fingering / handling		☐**R** ☐**L** ☐**B**	☐**R** ☐**L**☐**B**	☐**R** ☐**L** ☐**B**	☐**R** ☐**L** ☐**B**	

Hand dominance: ☐**R** ☐**L** ☐**B**

ACTIVITY	SEVERITY (*)			
	NONE	**Mild**	**Moderate**	**Severe**
Focus	☐	☐	☐	☐
Concentration	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Task Completion (following instructions, multi-tasking, repetitive tasks)	☐	☐	☐	☐
Interpersonal Interactions	☐	☐	☐	☐
Directing/Controlling/Planning	☐	☐	☐	☐
Judgment/Decision Making	☐	☐	☐	☐

(*) Definitions:

NONE: no functional impairment

Mild: minimal impact to regular activities

Moderate: limited in performing multiple activities

Severe: limited in most activities

***Note: Additional information may be required for behavioral health conditions.**

Expected return to work date: _____

Attending Physician's Name (first)	(middle name)	(last name)

Telephone Number:	Fax Number:

License Number:	Degree:	Specialty:

Also sign following fraud warning below.	Signature:	Date Signed:

State Fraud Warnings

By signing below, I affirm that I have read the appropriate State Fraud Warning for my state of residence Under the penalties of perjury, I certify that the information supplied on this form is true and complete

New York Fraud Warning:

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

NY STATE RESIDENTS ONLY READ AND SIGN HERE:

I have read and understood the New York State Fraud Warning.

Signature: _____ Date: _____

Alabama, Arkansas, District of Columbia, Louisiana, Maryland, New Mexico, Rhode Island, Texas, West Virginia: Any person who knowingly or willfully presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to civil and criminal penalties, including fines and confinement in prison.

Alaska and New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided under state law.

Arizona: For your protection, Arizona law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years. The statements contained in this form are true and complete to the best of my knowledge and belief.

RESIDENTS OF ALL OTHER STATES SIGN BELOW

Signature: _____ **Date:** _____