

Group Term Life Evidence of Insurability Form



EQUITABLE

Regular Mail: Equitable Employee Benefits Group
8501 IBM Drive, Suite 150-B
Charlotte, NC 28262

Equitable Financial Life Insurance Company of America*
For Assistance Call (866) 274-9887
Email: EOIProcessing@Equitable.com

Please complete the Equitable Financial Life Insurance Company of America Statement of Insurability form in its entirety for each applicant requesting coverage. If your employer has not completed the Employer Section of this document, please complete the section on their behalf and contact them with any questions regarding the required information. Once complete, mail the form to the address listed above. Please note that missing information will cause a delay in processing your application.

During the evaluation process Equitable may request the completion of a supplemental form.

Reason for Applying:

Applying for coverage over guaranteed issue limit New Hire Late Enrollee Increasing Coverage

Other: _____

Date of Hire: _____

Employer Name					Group Plan #			
Insured Last Name (Employee)	First Name	Int	Sex (Circle one) M F	Birthdate	HT	WT	SS#	
Home Address						Telephone #		
Cell Phone		Email Address			Annual Earnings			
Insured Last Name (Spouse)	First Name	Int	Sex (Circle one) M F	Birthdate	HT	WT	SS#	

Employee Amount of Basic Life Insurance Currently Inforce	Spouse Amount of Basic Life Insurance Currently Inforce
Employee Basic Life Insurance Amount Elected	Spouse Basic Life Insurance Amount Elected
Employee Amount of Supplemental/Voluntary Life Insurance Currently Inforce	Spouse Amount of Supplemental/Voluntary Life Insurance Currently Inforce
Employee Supplemental/Voluntary Life Insurance Amount Elected	Spouse Supplemental/Voluntary Life Insurance Amount Elected

IF APPLYING FOR LIFE INSURANCE, questions 1-4 must be answered by each person applying for coverage.	
1. Have you ever tested positive for or been diagnosed by a member of the medical profession as having Acquired Immunodeficiency Syndrome (AIDS) or any immune deficiency disorder other than HIV?	Employee <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past 7 years, you (proposed insured) been treated for or diagnosed as having any of the following: a) any disorder or condition of the heart, liver, kidney(s); lung or respiratory system; b) any disorder or condition of your digestive system including your esophagus, stomach, or intestines; c) any mental, nervous, emotional or neurological disorder or condition including depression, psychosis or bipolar disorder requiring treatment (including confinement); d) auto immune disorder; e) diabetes; f) cancer; or g) a stroke?	Employee <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past 2 years, have you (proposed insured) received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue the use of alcohol or prescribed or non-prescribed drugs?	Employee <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past 5 years, have you (proposed insured); (a) been diagnosed or treated by a member of the medical profession for any illness or injury, disease or disorder NOT listed in the questions above (including routine physicals only when there is an existing or newly diagnosed medical condition); or (b) visited a hospital or other health care facility for observation, diagnosis, treatment or an operation; undergone any diagnostic testing including but not limited to X-ray, blood work, ultrasound, an MRI, a CT scan, or P ET scan with abnormal findings, or been prescribed medication(s) – (other than for cold, flu or allergies)?	Employee <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No

Equitable is the brand name of Equitable Holdings, Inc. and its family of companies, including Equitable Financial Life Insurance Company (Equitable Financial) (NY, NY), Equitable Financial Life Insurance Company of America (AZ stock corp., admin. office: Jersey City, NJ), and Equitable Distributors, LLC.

Group Plan #

Employer Name



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For each "yes" answer to question 4 give details below. (Continue on reverse side if additional space is needed.)					
Question #	Proposed Insured	Test, Injury, Illness, Disease, Operation or Complication	Date Of		Full Details (including Doctor's Names and Addresses)
			Onset	Recovery	

In order to complete the evaluation of this application, Equitable may contact you, through the mail or over the telephone to:

1. clarify any information contained on this form;
2. obtain any information missing from this form;
3. ask additional questions of you by providing a supplemental form

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FRAUD WARNINGS

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas, Louisiana, New Mexico, Rhode Island, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: The falsity of any statement in this application shall not bar Our right to recovery under the contract unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by Us.

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.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

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. Penalties may include imprisonment, fines or a denial of insurance benefits.

Florida: Any person who knowingly and with an intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance Company or other person files an application for insurance 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.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for 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 fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York: 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.

Ohio: Any person who, with intent to defraud or knowing that he/she 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.

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.

Oregon: Any person who, with intent to defraud or knowing that he/she 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.

Pennsylvania: Any person who knowingly and with the intent to defraud any insurance Company or other person files an application for insurance or a 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.

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 are 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.

All Other States: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

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Employer Name



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Agreements, Authorizations & Signature

I have read this Statement of Insurability and all statements and answers as they pertain to the applicant. These statements are true and complete to the best of my knowledge and belief, and I understand all statements and answers I have given will be used by Equitable Financial Life Insurance Company of America to determine insurability. I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Equitable of any change in my medical condition while my enrollment is pending. I agree that if my enrollment is approved by Equitable Financial Life Insurance Company of America, the effective date of any coverage will be determined in accordance with the terms of the group policy, including any actively at work requirement. I acknowledge this Statement of Insurability form (when approved), the group policy, certificate of insurance, and any endorsement, amendment or rider hereto, are part of the insurance coverage(s) applied for. I understand that no insurance agent or broker, or persons other than officers of Equitable Financial Life Insurance Company of America or, can modify, waive or change this form, nor bind coverage or guarantee approval of this form.

I authorize Equitable Financial Life Insurance Company of America, or its reinsurers, to make a brief report of my personal health information to MIB. I have read the separate notice enclosed with this form pertaining to the Medical Information Bureau as required by the Fair Credit Reporting Act.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

I have read this Statement of Insurability and all statements and answers as they pertain to the applicant. These statements are true and complete to the best of my knowledge and belief.

Signed at _____
City, State

Proposed Insured (Employee)

Date

Proposed Insured (Spouse, if applicable)

Date

Employee Signature (Required for all Proposed Insureds)

Date

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This authorization is valid for Equitable Financial Life Insurance Company of America

Proposed Insured's Name _____ Date of Birth _____

AUTHORIZATION TO RELEASE INFORMATION PROTECTED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA")

TO OBTAIN HEALTH INFORMATION In this authorization, "I" "we" "our" "me" and "us" means the Proposed Insured or Authorized Representative. I (We) authorize any physician, hospital, clinic, medical practitioner, medical testing laboratory, pharmacy, pharmacy benefit manager, medically related facility or other health care provider, health plan or insurance company (including those listed above, with respect to their coverages) and the Medical Information Bureau to disclose to the Company listed above and their authorized representatives (collectively hereinafter "the Company named above") any and all information, including medical reports, pharmaceutical records or prescription history, whether fact or opinion, they may have about any diagnosis, treatment, medication or drug history, and prognosis regarding my past, present or future physical or mental condition.

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

PURPOSE OF AUTHORIZATIONS I understand the following parties may need to collect information on me in regard to the proposed coverage: The Company named above and their reinsurers; any insurance support organization; any consumer reporting agency; and all persons authorized to represent these organizations for this purpose. I (We) understand that the information obtained will be used by the Company named above to determine my (our) eligibility for life insurance coverage and any associated risk rating classification, and to obtain reinsurance. If a policy is issued to me (us), this information may also be used in the future to administer my (our) policy and process claims made under the policy. In addition, information may be disclosed to the Medical Information Bureau (MIB) who, upon request, may disclose such information about me (us) in its file to another member company with whom I (we) apply for life or health insurance or to whom a claim for benefits may be submitted; when requested by a government agency; in connection with a legal or arbitration proceeding; or for other purposes as required or permitted by applicable law.

COVERAGE CONDITIONS I (We) understand that the Company named above are conditioning the issuance of coverage on the provision of this authorization, and that, while I (we) may refuse to sign this authorization, my (our) refusal to do so could result in coverage not being issued.

ADDITIONAL AUTHORIZATIONS You have advised me (us) that the Company named above may request additional authorizations in order to obtain the information the Company named above need to complete its/their review of my (our) application and, if the policy is issued, in connection with any claim asserted under the policy.

I (we) understand that I (we) am not obligated to provide these additional authorizations but that, if I (we) choose not to provide them, this application and any claim made under the policy, if issued, may be rejected.

DURATION Unless revoked, I (we) agree that this authorization will expire on the earlier of the dates that the Company named Equitable Financial Life Insurance Company of America above decline my application for coverage or, if a policy is issued, 24 months from the date of my application. I (We) understand that I (we) may revoke my (our) authorization at any time. No termination or revocation shall affect (1) any action the Company named above has/have taken in reliance on this authorization or (2) any right granted the Company named above by law to contest a claim under the policy or the policy items. If I (we) choose to revoke any authorization, the application and any claim made under the policy, if issued, may be rejected. My revocation must be submitted in writing to: Chief Underwriter, Equitable Financial Life Insurance Company of America, 1290 Avenue of the Americas, New York, New York 10104.

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

Signature of Proposed Insured (Employee) or Authorized Representative **Date**

Signature of Proposed Insured (Spouse, if applicable) or Authorized Representative **Date**

Print name of Proposed Insured (Employee) or Authorized Representative **Date**

Print name of Proposed Insured (Spouse, if applicable) or Authorized Representative **Date**

Description of Personal Representative's Authority or Relationship to Proposed Insured **Date**

Dated at _____ on _____
City, State (MM/DD/YYYY)

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