



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 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

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

Send completed form to:

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**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? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes," name of union _____ Union local number _____
What was the employee's regularly scheduled work week? _____ Hours per Week Scheduled workdays <input type="checkbox"/> Monday – Friday <input type="checkbox"/> Other: _____		
Is employee covered under a Long-Term Disability plan insured by Equitable? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes," Effective date of LTD coverage: _____		
Was the employee's Short-Term Disability insurance issued on the basis of a Personal Health Statement? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," attach copy		
Was the employee insured under your prior Short-Term Disability policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the inclusive date of coverage From _____ Through _____		
Was the employee on Qualified Family Leave when disability began? <input type="checkbox"/> Yes <input type="checkbox"/> No Did STD &/or LTD insurance continue while on Family Leave? <input type="checkbox"/> Yes <input type="checkbox"/> No Date Qualified Family Leave started: _____		

Section-I continued in next page.

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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? _____ %
 What percentage, if any, do you contribute towards the cost of the STD premium? _____ %
 Is the Employer-paid premium added to the Employee's taxable wages? "Gross-Up" Yes No
 Does the employee contribute towards the cost of the STD premium? Yes No If yes, at what percent? _____ %
 If yes, is it on a Pre-Tax basis or Post-Tax basis

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

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes If "Yes," send initial report of illness or injury or award notice. <input type="checkbox"/> No	Date employee is expected to return to work? Full time? <input type="checkbox"/> Yes <input type="checkbox"/> No
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E. Information About Salary

If Salaried (Exempt), Employee's weekly rate of pay: \$ _____
 If Hourly (Non-Exempt), Employee's Hourly Rate of Pay: \$ _____
 Eligible for Commissions Bonus(es) Other _____ (please specify)

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.

Activity	Frequency of Occurrence			
	Never	Occasionally	Frequently	Continuously
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Reaching/Working Overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Keyboard Use/Repetitive Hand Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activity	Description	Frequency	Weight
<input type="checkbox"/> Pushing	_____		lbs.
<input type="checkbox"/> Pulling	_____		lbs.
<input type="checkbox"/> Lifting	_____		lbs.
<input type="checkbox"/> 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

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**SHORT TERM DISABILITY INCOME (STD)
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**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 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Date of Birth	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> 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. <input type="checkbox"/> Yes , I consent to receiving <input type="checkbox"/> cell phone <input type="checkbox"/> email communications from Equitable. (Your carrier's fees may apply.) <input type="checkbox"/> No , I do not consent to receiving <input type="checkbox"/> cell phone <input type="checkbox"/> 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: <input type="checkbox"/> Illness <input type="checkbox"/> Injury <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please explain.		

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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: <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> State Disability <input type="checkbox"/> No Fault Disability <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes," explain:		
Have you filed, or do you intend to file a Workers' Compensation claim due to your condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," explain:		

D. Information About the Disability

Last day you worked before the disability:	Did you work a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," explain:
Amount earned before the disability (<input type="checkbox"/> Hourly rate <input type="checkbox"/> Yearly salary): \$ _____	
Date you were first unable to work:	Since that date, have you done any work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Part time <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 Nebraska: Should you choose federal income tax withholding, your state requires us to withhold state income tax unless you opt out of withholding or elect a different rate. 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 District of Columbia: If you choose District of Columbia income tax withholding, we are required to withhold at the highest DC income tax rate.

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:** _____

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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 <i>(Please print)</i>	Date of Birth	Last 4 Digits of Social Security/Tax Identification #
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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.

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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.

<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Signature of Insured or Authorized Representative	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Date (Valid for 2 years) <i>(if signed by Authorized Representative)</i>	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Relationship to Insured <i>(If signing for yourself, use "Self.")</i>
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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: <input type="checkbox"/> Illness <input type="checkbox"/> Injury <input type="checkbox"/> Pregnancy <input type="checkbox"/> Mental/Nervous Condition		
Is condition due to an illness or injury that is work related? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Check here if no restrictions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
Lift / carry 11 to 20 lbs.	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
Lift / carry 21 to 50 lbs.	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
Lift / carry 51 to 100 lbs.	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
Lift / carry over 100 lbs.	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Handling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fingering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Talking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Far Acuity (with best corrected vision)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depth Perception		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Accommodation (visual)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Color Vision		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Field of Vision		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reaching only (non load-bearing)	Above shoulder	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
	Below shoulder level (reach forward for objects on desktop or workstation)	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
Fingering / handling		<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	

Hand dominance: R L B

ACTIVITY	SEVERITY (*)			
	NONE	Mild	Moderate	Severe
Focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task Completion (following instructions, multi-tasking, repetitive tasks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpersonal Interactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Directing/Controlling/Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Judgment/Decision Making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(*) 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)
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Telephone Number: _____ Fax Number: _____

License Number: _____ Degree: _____ Specialty: _____

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

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

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 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.

RESIDENTS OF ALL OTHER STATES SIGN BELOW

Signature: _____ **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 have the right of offset for such a refund.

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

CANCELLATION

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

Signature:

Date:

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

Signature of Other Person(s) on Account:

Date: