Group Policy Number

Employer Name

Regular Mail:
Equitable Employee Benefits
Group - P.O. Box 2107,
Grapevine, TX 76099-2107

EQUITABLE

Equitable Financial Life Insurance Company
Equitable Financial Life Insurance Company of America
For Assistance Call (866) 274-9887; Fax (469) 417-1956
Email: EQHLifeClaims@webtpa.com

Employee Benefits
Life Claim – Accelerated Benefit Option

Please send the completed form and all attachments to: Equitable Employee Benefits

How to present a claim

1. **Disclosure Statement and Tax Certification** — Employees should first carefully read the Disclosure Statement below and sign and date the Acknowledgement. They should then read the Important Tax Information and Tax Certification (page 7) and complete, sign, and date the Tax Certification.

2. **Accelerated Benefit Option Claim Form** — Both the "Employee Statement" (page 2) and the "Group Contract Holder Statement" (page 4) attached to these instructions must be completed. Section 1 of the "Group Contract Holder Statement" must be completed if the claim is for an employee/member or for a dependent of an employee. The "Employee Statement" should be completed and returned to the benefits administrator (Group Contract Holder).

3. **Attending Physician Certification** — Medical evidence of terminal illness should be submitted on the Attending Physician's Certification form. Please be aware any expenses charged by the physician are the responsibility of the beneficiary

This form should be completed by the physician and certify the nature of the employee's or dependent's illness. It should be mailed to Equitable Employee Benefits Group 8500 Freeport Pkwy 4th Floor, Irving, TX 75063

If you have any questions, please call our Group Life Claim Division at 866-274-9887 and a customer service representative will assist you.

To Be Completed by Employee

Disclosure Statement

The money received from the Accelerated Benefit Option can be used for any purpose. If you exercise this option and accept payment, you should be aware that such payment may adversely affect your eligibility for Medicaid or other government benefits or entitlements. In addition, the Accelerated Benefit Option payment, or a portion thereof, may be considered taxable income. Equitable recommends that assistance be sought from a personal tax advisor and/or an attorney regarding how election of this option may affect your personal situation. Equitable offers this option based on our interpretation of current law, which may change in the future.

By electing this option, the total amount of employee term life insurance otherwise payable at death, including any amount under an extended benefit, will be reduced by the amount paid under the Accelerated Benefit Option. Also, any amount that could otherwise have been converted to an individual insurance contract will be reduced by the amount paid under this option.

Receipt of accelerated benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children, and Supplemental Security Income. Prior to applying for accelerated benefits, certificateholders should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependents. Receipt of accelerated benefits may be taxable. Prior to applying for such benefits, certificateholders should seek assistance from a qualified tax advisor. No health care facility as defined in Section 20 of the Public Health law can require any person to accelerate payment of a benefit as a condition of admission to such health care facility or for providing any care in such facility. Insurers are prohibited from paying accelerated death benefits to the certificateholders for a period of 14 days from the date on which the certificateholder is provided a numerical computation of the accelerated benefit and an illustration of the effect of an accelerated benefit claim on contract values.

Acknowledgement: I have read the disclosure information above.

X _____ _____
Employee's Signature **Date** (MM DD YYYY)

X _____ _____
Beneficiary's Signature (Required only if designation is irrevocable) **Date** (MM DD YYYY)

E15729
01/2025

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To Be Completed By Employee

Employee Statement Please complete in full.

Name | Social Security Number | Date of Birth (MM DD YYYY)

Email Address:

Home Address:

Mailing Address (if different):

Claimant's Information *(Should only be completed if different from employee)*

First Name | MI | Last Name

Social Security Number | Date of Birth (MM DD YYYY) | Date of Disability (MM DD YYYY)

Gender

☐ Male ☐ Female

Relationship to Employee

☐ Employee ☐ Spouse* ☐ Child ☐ Other

State of Residence

Relationship to Employee | Telephone Number

Residence: Street | Apt.

City | State | ZIP Code

** Note: Spouse includes the Proposed Insured's legally married spouse, or civil union partner or domestic partner if legally recognized in the governing jurisdiction*

Last day worked prior to current disability (MM DD YYYY) | Date first treated by physician (MM DD YYYY) | Amount being claimed

$

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Accelerated Benefit Option Claim Form

(Use for employee/member and dependent claims.)

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To Be Completed by Employee
Employee Statement (continued)

*If claim is for a dependent, please provide the following information:

Name	Social Security Number	Date of Birth (MM DD YYYY)

List physicians consulted because of this disability — Period Treated

Name	From (MM DD YYYY)	To (MM DD YYYY)
Dr.		

Address

Name | From (MM DD YYYY) | To (MM DD YYYY)
Dr.

Address

List any hospital confinements for this disability — Period Confined

Name of hospital	From (MM DD YYYY)	To (MM DD YYYY)

If you have any other Equitable policies, please show policy number(s) (complete as it pertains to employee or dependent):

Has this insurance been assigned? ☐ Yes ☐ No

Has any government agency required that you involuntarily exercise this option as a condition for obtaining or retaining a government benefit or entitlement? ☐ Yes ☐ No

Benefit will be made in a lump sum if approved.

E15729
01/2025

State Fraud Warnings

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 READ AND SIGN ONLY: I have read and understood the New York State Fraud Warning.

Signature:_____ _____
Employee's Signature **Current Date (mm/dd/yyyy)**

Alabama, Arkansas, District of Columbia, Louisiana, Maryland, New Mexico, Rhode Island, Texas, West Virginia: 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 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 statement 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 statement 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 may be subject 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 includes any false or misleading information on an application for an insurance policy 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 two (2) years.

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Group Insurance Contract Holder Statement To be completed by Employer/Plan Administrator. Please complete all five sections.

1 Employer/Plan Administrator *(To be completed by Employer)*

Street

Suite

City

State

Zip Code

Telephone

2 Employee Information

Date of Employment (mm dd yyyy)

☐ Hourly ☐ Full time

☐ Salary ☐ Part time

Date Last Worked (mm dd yyyy)

Occupation

Where Employed

If not actively at work immediately prior to disability, what was the reason? (Attach explanation, if applicable.)

☐ Disability ☐ Leave of Absence ☐ Vacation ☐ Discharge

☐ Resigned ☐ Retired ☐ Temporary Layoff ☐ Other

Street

Suite

City

State

Zip Code

4 Insurance Coverages

Complete only for the coverage that applies to this claim

	Benefit Amount	Effective Date (DDMMYYYY)	Percentage to be Distributed (percentage not to exceed 75%)
☐ Basic Life			
☐ Supplemental Life			
☐ Voluntary Life			
☐ Dependent Life			

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Employee/Member Salary Amount on Last Day Worked

$

per

☐ Hour ☐ Week ☐ Month ☐ Year

Was insurance ever assigned?

☐ Yes ☐ No

Optional Term Life, if applicable, must be supported by proof of enrollment.

Maximum Amount Available Under the Accelerated Benefit Option

$

Has insurance percentage increased in last two years? ☐ Yes ☐ No

If yes, provide date (MM DD YYYY)

Was evidence of insurability required to secure current coverage ☐ Yes ☐ No

Is there contributory insurance? ☐ Yes ☐ No

Date Last Premium Paid (MM DD YYYY)

5 Payment Information

Mail Payment to:

☐ Employer at address listed above

☐ Claimant at address listed below

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Grapevine, TX 76099-2107

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Accelerated Benefit Option Claim Form Attending Physician's Certification (Please print.)

This section to be completed by the Employee

The patient is responsible for the completion of this form without expense to Equitable

Name of Patient | Social Security Number | Date of Birth (MM DD YYYY)

Patient's Address

I hereby authorize release of information requested on this form by the named physician or health care provider for the purpose of processing healthcare claim(s) for services I have received.

X _____ _____
Patient's Signature | Date (MM DD YYYY)

This section to be completed by the Physician

Date of first visit (MM DD YYYY) | Date of last visit (MM DD YYYY) | Date total disability began (MM DD YYYY)

Diagnosis | ICD Diagnosis | Present Condition

Is the patient's condition expected to result in death within 12 months? ☐ Yes ☐ No

Is the patient unable to perform two or more activities of daily living without assistance? ☐ Yes ☐ No
If Yes, please note:

Does the patient have a cognitive impairment requiring another person's active help or verbal guidance? ☐ Yes ☐ No

Objective Findings/medical records/include any results of current x-rays, EKG, or any other special test (please attach)

List any hospital confinements for this disability
Name of hospital | Period Confined From (MM DD YYYY) | To (MM DD YYYY)

Name of Attending Physician (Please print.) | Degree/Specialty | Telephone Number

Physician's Address | Fax Number

X _____ _____
Signature | **Date** (MM DD YYYY)

E15729 01/2025

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IMPORTANT TAX INFORMATION (To be completed by Employee)

1 Insured/Claimant's Information

First Name | MI | Last Name

Social Security Number

2 Employee's Information

First Name | MI | Last Name

Street | Suite

City | State | Zip Code

Telephone

3 Taxpayer Identification Number

Equitable requires your Taxpayer Identification Number. The Taxpayer Identification Number is either the Social Security Number or the Employer Identification Number. If you:

- are an individual, your Taxpayer Identification Number is the Social Security Number.
- represent a trust or estate, the Taxpayer Identification Number is its Employer Identification Number.
- represent a minor, please provide the minor's Social Security Number.
- are applying for a Taxpayer Identification Number, please write "applied for" in the space provided.

TAXPAYER IDENTIFICATION NUMBER/FORM W9 CERTIFICATION: Under penalties of perjury, I certify that (cross out any item that is not true):

1. The number shown on the application is my correct Social Security/Tax ID number,
2. I am not subject to backup withholding due to failure to report interest or dividend income,
3. I am a U.S. citizen or other U.S. person (including a U.S. resident alien), and
4. I am not subject to FATCA reporting

If you crossed out item 3 above, please indicate country of citizenship

and attach applicable IRS Form W-8(BEN, BEN-E, EXP, ECI, IMY).

Social Security Number or Taxpayer Identification Number of beneficiary

X _____ _____

Signature **Date** (MM DD YYYY)

E15729 01/2025