Equitable Employee Benefits

Evidence of Insurability (EOI)

EQUITABLE

REGULAR MAILING ADDRESS:

EQUITABLE
8501 IBM DRIVE, SUITE 150-B
CHARLOTTE, NC 28262

Completed form must be signed, dated and returned to Equitable within 31 days of becoming eligible for the coverage. Submit completed Forms to: EOIprocessing@equitable.com

Employer Section

Please complete the information in the Employer Section before providing the Evidence of Insurability application to the employee. The employee or dependent requesting coverage subject to Evidence of Insurability must complete the Applicant Section in entirety and return the application to Equitable Employee Benefits for processing.

Employer Name _____ Group Number _____

Employee First Name _____ M.I. _____ Last Name _____

Employee Annual Earnings (please refer to the definition of earnings in your plan documents) _____

Employee Short-Term Disability Inforce Coverage Amount _____

Employee Long-Term Disability Inforce Coverage Amount _____

Employee Section

Please complete the Equitable Evidence 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 Equitable at the address listed above. Please note that missing information will cause a delay in processing your application.

Employee Address _____ City _____ State _____ Zip _____

Primary Phone Number _____ Email _____

Short-Term Disability Coverage Requested _____ Long-Term Disability Coverage Requested _____ Date of Hire _____

Group Disability Income Statement of Insurability

Equitable Financial Life Insurance Company
Regular Mail: 8501 IBM DRIVE, SUITE 150-B CHARLOTTE, NC 28262
Phone: (866) 274-9887
https://Equitable.com
Submit Completed Forms: EOIprocessing@equitable.com

Reason for Applying:
☐ Applying for coverage over guaranteed issue limit ☐ New Hire ☐ Late Enrollee
☐ Increasing Coverage ☐ Adding Dependent(s) ☐ Other: _____

Applicant Information

Applicant's Name: Last, First, MI		Date of Birth: (Month/Date/Year)	
Sex: ☐ Male ☐ Female	Age:	Height: (ft. in.)	Weight: (lb.)
Driver's License Number and State:		Social Security No. - -	Already Enrolled: ☐ Yes ☐ No
Are you a U.S. Citizen or Permanent Resident? ☐ U.S. Citizen ☐ Permanent Resident ☐ Neither		If Permanent Resident, give Alien Registration number:	
Physician's Address: (Street, City, State, Zip)		Physician's Phone No. ( ) -	
Employee Member Name: (if different than Applicant)		Employee's Job Title:	
Employer Name:		Group Number:	

Medical Information	
You must answer each of the following questions to the best of your knowledge and belief.	
Within the past 5 years, have you been diagnosed with or treated by a licensed medical physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the Human Immunodeficiency Virus (HIV) infection or other sickness or condition derived from such infection?	☐ Yes ☐ No
Are you currently pregnant?	☐ Yes ☐ No
Within the past 5 years, with the exception of a past pregnancy, have you lost time from work for more than 10 consecutive work days due to a disability, injury, or sickness?	☐ Yes ☐ No
Within the past 5 years, have you used any controlled substances, with the exception of those taken as prescribed by your physician, been diagnosed or treated for drug or alcohol abuse (excluding support groups), or been convicted of operating a motor vehicle while under the influence of drugs or alcohol?	☐ Yes ☐ No
Within the past 5 years, have you been diagnosed with or treated by a licensed member of the medical profession for:	

Heart Disease (Do not check "Yes" if you only have High Blood Pressure or a Heart Murmur)	☐ Yes ☐ No	Disease, injury or surgery of Joint, Ligaments, Knee, Back, or Neck (including Arthritis)	☐ Yes ☐ No
Heart-Related Surgery or Heart Attack	☐ Yes ☐ No	Muscular Dystrophy	☐ Yes ☐ No
High Blood Pressure If you checked "Yes" to High Blood Pressure, have you had a change in medication within the last 6 months?	☐ Yes ☐ No	Hepatitis (Do not check "Yes" for Hepatitis A) or Cirrhosis	☐ Yes ☐ No
Blocked Arteries (Arteriosclerosis, Atherosclerosis, Aneurysm, or Deep Vein Blood Clot)	☐ Yes ☐ No	Amyotrophic Lateral Sclerosis (ALS) or Multiple Sclerosis (MS)	☐ Yes ☐ No
Stroke or transient ischemic attack (TIA)	☐ Yes ☐ No	Alzheimer's or Parkinson's Disease	☐ Yes ☐ No
Chronic Obstructive Pulmonary Disease (COPD) or Emphysema	☐ Yes ☐ No	Paralysis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Major Organ Transplant	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Chronic Fatigue Syndrome or Fibromyalgia	☐ Yes ☐ No

Sleep Apnea	☐ Yes ☐ No	Narcolepsy	☐ Yes ☐ No
Cancer (Do not check "Yes" for Basal Cell Carcinoma only) If "Yes", Date of Diagnosis: _____	☐ Yes ☐ No	Ulcerative Colitis or Crohn's Disease	☐ Yes ☐ No
Psychotic, Psychiatric, Personality, or Bi-Polar Disorder	☐ Yes ☐ No	Kidney Failure or Dialysis	☐ Yes ☐ No

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 or its administrator 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 Financial Life Insurance Company or its administrator 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 or its administrator, 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, can modify, waive or change this form, nor bind coverage or guarantee approval of this form.

I have read the applicable Fraud Warning beginning on page 5 of this form.

II authorize Equitable Financial Life Insurance Company, 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.

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.

Signed at _____
City, State

_____ _____
Applicant Signature **Date**

This authorization is valid for the Equitable Financial Life Insurance Company

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/ Patient 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 Companies listed above and their authorized representatives (collectively hereinafter "the Companies 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 Companies 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 Companies 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 Companies named above to determine my (our) eligibility for disability income 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 Companies 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 Companies named above may request additional authorizations in order to obtain the information the Companies 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 Companies named 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 Companies named above has/have taken in reliance on this authorization or (2) any right granted the Companies 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 Life Insurance Company or MONY Life Insurance Company of America, Equitable Financial Life Insurance Company, 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/Patient or Authorized Representative

_____

Print Name of Proposed Insured/Patient or Authorized Representative

_____

Description of Personal Representative's Authority or Relationship to Proposed Insured/Patient

Dated at _____ on _____.
City, State **(mm/dd/yyyy)**