Group Employee Benefits

Application For Wellness Benefit included in Accident, Hospital Indemnity, and/or Critical Illness/Specified Disease policies

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

Regular Mail:
Group Claims Department
P.O.Box 9757
Portland, ME 04104

Section I **Employee's Statement -** to be completed by the **employee** who is applying for Wellness Benefits included in Accident, Hospital Indemnity, and/or Critical Illness/Specified Disease policies

Please email, fax or mail the completed application to:

Group Claims Department
P.O. Box 9757
Portland, ME 04104
Email: EquitableClaims@yourbenefitexpert.com
Fax Number: (866) 376-9480

Questions?

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

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED. FORWARD THE COMPLETED APPLICATION TO YOUR EQUITABLE BENEFIT MANAGEMENT SERVICE CENTER.

*"Equitable" is the brand name of Equitable Holdings, Inc. and its family of companies, including Equitable Financial Life Insurance Company (Equitable Financial) and Equitable Financial Life Insurance Company of America (Equitable America). Insurance products are issued either by Equitable Financial or Equitable America, which each has sole responsibility for their respective insurance and claims-paying obligations.

Equitable Financial Life Insurance Company / Equitable Financial Life Insurance Company of America*

APPLICATION FOR WELLNESS BENEFITS

Section I - Employee's Statement

To Be Completed by the Employee (BE SURE TO ANSWER ALL QUESTIONS - FAILURE TO DO SO MAY DELAY YOUR CLAIM)			
Policyholder/employer name	**Policyholder number**	**Phone number**	
Street Address	**City**	**State**	**Zip code**

Claiming benefits for: ☐ **Insured** ☐ **Spouse** ☐ **Dependent**

Under which policies: ☐ **Accident** ☐ **Critical Illness/Specified Disease** ☐ **Hospital Indemnity**

A. Information About You, Your Spouse, or Your Dependent			
Last name: First: Middle Initial:	Gender: ☐Male ☐Female	Date of Birth:	Social Security Number:
Address: (Street, City, State & Zip)	Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced		
Personal Telephone Number: ( )	Email address:		

Claimant name	SSN	Date of Birth (mm/dd/yyyy)
Claimant phone number	Claimant email address	

Physician	Date of Service (mm/dd/yyyy)	Phone number	
Street address	City	State	Zip code

- ☐ Breast cancer screening (clinical breast exam, mammography, MRI, thermography, ultrasound), cervical cancer screening
- ☐ CA 15-3 (blood test for breast cancer)
- ☐ CA 125 (blood test for ovarian cancer)
- ☐ All generally accepted cancer screening tests
- ☐ Cardiac exercise stress test
- ☐ Carotid doppler
- ☐ CEA (blood test for colon cancer)
- ☐ Chest x-ray
- ☐ Colorectal cancer screening (fecal occult blood test, colonoscopy, sigmoidoscopy)
- ☐ Diabetes tests (fasting blood glucose test, hemoglobin A1c)
- ☐ Echocardiogram
- ☐ Electrocardiogram (ECG) – resting or stress
- ☐ Hemoccult stool analysis
- ☐ Immunizations
- ☐ Interscholastic sports physical exam
- ☐ Lipid panel (cholesterol, triglycerides, HDL, LDL)
- ☐ Pap smear
- ☐ Prostate cancer screening (digital rectal exam, PSA blood test)
- ☐ Serum protein electrophoresis
- ☐ Skin cancer screening

For direct deposit of your benefits, carefully complete this section.

Name of bank or financial institution	City and state of bank or financial institution
Insured account number at bank or financial institution	Bank or financial institution routing number

B. State Fraud Warnings

By signing below, 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 page 2. **(New York State Residents need to also sign the New York State Fraud Warning on page 4.)** 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 STATE RESIDENTS READ AND SIGN ONLY: I have read and understood the New York State Fraud Warning.

Signature:

___________________________________ _______________________

Signature **Current Date (mm/dd/yyyy)**

Alabama, Arkansas, 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 a false or fraudulent claim for 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.

District of Columbia, 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 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.

Signature ____ Date______________________