EQUITABLE

ACCIDENT, HOSPITAL INDEMNITY, AND CRITICAL ILLNESS CLAIM FOR WAIVER OF PREMIUM

Equitable Financial Life Insurance Company
Equitable Financial Life Insurance Company of America
For Assistance: Call (866) 274-9887
Monday–Friday, 8:00 a.m. – 8:00 p.m. EST

Regular Mail:
Group Claims Department
8501 IBM Drive, Suite 150B
Charlotte, NC 28262

Email:
waiverclaims@equitable.com

INSTRUCTIONS FOR WAIVER OF PREMIUM

This claim kit is being provided so that consideration can be given to the establishment of a claim for Waiver of Premium benefits. Please note the following instructions.

Section I. - Insured's Statement of Claim for Waiver of Premium Benefits, Occupational Description, Disclosure Authorization and State Fraud Warnings

These four documents must be fully completed and signed by the Insured. If the Insured is not able to do so, the Spouse, Parent, Beneficiary, or the Insured's legal representative may complete it.

Section II. - Attending Physician's Statement of Disability

Both pages are to be fully completed by the physician who has treated the Insured during disability. Medical certification of disability must be submitted for the entire period for which claim is being presented. If certification is to be submitted by more than one physician, additional form(s) should be requested.

Section III. - Policyholder Statement

An employer/firm representative for which the Insured was working when disability began should complete this. A copy of the enrollment form should be included (if applicable) should be submitted with this form.

Be sure that all forms are completed and signed.

Completed forms are to be returned to:

Group Claims Department
8501 IBM Drive, Suite 150B
Charlotte, NC 28262
Email: waiverclaims@equitable.com

Note: Any other information that you can submit, such as Social Security Disability Award Letter, Worker's Compensation Allowance, a Veteran's Administration Determination of Disability, and Employer's Retirement notification, hospital or physician's reports or other correspondence that may make reference to the onset and continuance of disability, may help expedite the processing of this claim.

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. Equitable Advisors is the brand name of Equitable Advisors, LLC (member FINRA, SIPC) (Equitable Financial Advisors in MI & TN). The obligations of Equitable Financial Life Insurance Company and Equitable Financial Life Insurance Company of America are backed solely by their claims-paying abilities.

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SECTION I. INSURED'S STATEMENT OF CLAIM FOR WAIVER OF PREMIUM

INSURED'S INFORMATION: ***Please print clearly or type.***

Employer Name _____ Policy Number _____

1. Your Name Last First Middle Initial	2. Date of birth	3. Last 4 digits of Social Security Number / /
1a. Your address Street (If P.O. Box, show street address also) City State Zip Code	1b. Gender ☐ Male ☐ Female	1c. Your phone number and area code ( ) Email address

4a. Employer's Name	4b. Employer's Address Street City State Zip Code Telephone Number
5. Your occupation when disability began	
5a. List all prior occupations.	7.Your last day worked prior to disability Mo._____ Day _____ Year _____

If ACCIDENT

8. Describe how, where and on what date it occurred and what injury resulted.

Have you ever had a similar injury? ☐ Yes ☐ No

If "Yes," give dates:

Name and address of Physician or Hospital

If ILLNESS

Give nature and details of illness, including date of onset.

Have you ever had a similar illness? ☐ Yes ☐ NO

If "Yes" Give Dates

Name and Address of Physician or Hospital

9. I was unable to work from _____ to _____ I worked part-time from _____ to _____ .

10. Check one: ☐ I am presently disabled. ☐ I am not presently disabled. Disability ceased on _____.
mo. day yr.

11. I expect to return to work on or about _____.
mo. day yr.

12. Indicate your highest level of education completed:

☐ College — Years completed _____ ☐ High School — Years completed _____ ☐ Primary School — Years completed _____

Please specify degree(s), diploma(s), or certificate(s) and area(s) of concentration.

Do you have any other formal or vocational training?

13. If treated by anyone other than the physician completing the Attending Physician's Statement of Disability in the last five years, give names, addresses and dates of treatment. (If "none," so state.)

Name _____ Name _____

Street Address _____ Street Address _____

City, State, Zip _____ City, State, Zip _____

Dates _____ Dates _____

14. Please check any and all benefits that you are eligible to receive:

			Date Applied	Effective Date
A. Social Security	No	Yes	____/____/____	____/____/____
B. Worker's Compensation	No	Yes	____/____/____	____/____/____
C. State Disability Insurance	No	Yes	____/____/____	____/____/____
D. Social Security Disability Benefits	No	Yes	____/____/____	____/____/____
E. Social Security Retirement Benefits	No	Yes	____/____/____	____/____/____
F. Retirement or Pension	No	Yes	____/____/____	____/____/____
G. Short- or Long-Term Disability	No	Yes	____/____/____	____/____/____
H. Unemployment	No	Yes	____/____/____	____/____/____
I. Individual or Group	No	Yes		
Disability Income	No	Yes	____/____/____	____/____/____
H. Other _____			____/____/____	____/____/____

Describe all disability coverage in force or applied for:

Company or Source (Indicate policy or claim number)	Type (Worker's Compensation, State Disability, Group Disability, etc.)

If you have not applied for benefits, please explain why: _____

I HEREBY DECLARE THAT ALL STATEMENTS GIVEN HEREIN ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Dated _____ Signed _____

Email Address _____

Relationship, if other than Insured _____

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OCCUPATIONAL DESCRIPTION

Occupational Title(s)	Number of hours worked in a normal week _____
Nature of employer's business	Years with employer _____ Years in occupation _____

List the duties of your occupation(s) in order of their importance, with a detailed description of each.

- Duty _____ Hours spent each week _____

  Description _____

  _____

- Duty _____ Hours spent each week _____

  Description _____

  _____

- Additional Work History _____

  _____

  _____

- Military Service _____

  _____

  _____

  - Additional Comments on Physical Requirements _____

    _____

    _____

Signed _____

Date _____

Email Address _____

Relationship, if other than Insured _____

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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 the following personal, private, or privileged information, records, or documents relative to:

Insured's Name *(Please print)*	Date of Birth	Last 4 Digits of Social Security Number

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 redisclosed 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 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.

Signature of Insured or Authorized Representative	Date (Valid for 2 years)	Relationship to Insured (if signed by Authorized Representative)

*All group insurance products are issued either by Equitable Financial or Equitable America, which have sole responsibility for their respective insurance and are backed solely by their claims-paying obligations. Some products are not available in all states.

Equitable Financial Life Insurance Company
Equitable Financial Life Insurance Company of America*
Toll-Free Number:(866) 274-9887 Email: waiverclaims@equitable.com
Group Claims Department
8501 IBM Drive, Suite 150B Charlotte, NC 28262

State-specific fraud warnings for insurance claim forms

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, final 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 Residents of 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.

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.

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.

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

X _____
POLICY OWNER'S SIGNATURE DATE

Insured's Signature (X) _____ **Address** _____

City _____ **State** _____ **Zip** _____

Telephone ( ) _____

E15717

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SECTION II. ATTENDING PHYISICAN'S STATEMENT OF DISABILITY

Please give this form to your physician to complete and return to us.
The patient is responsible for the completion of this form by his or her physician without expense to Equitable.

Patient Name:	Date of Birth:	Insured ID Number:
Patient Address: (Street, City, State & Zip Code)		

Use current information from your patient's most recent office visit or examination to complete this form.

Patient's condition is the result of: ☐ Sickness ☐ Injury ☐ Pregnancy

If pregnancy, what is the expected date of delivery? Month Day Year

Is condition due to illness or an injury that is work related? ☐ Yes ☐ No

DIAGNOSIS

Primary diagnosis: ICD-9 Code: ☐
ICD- 10Code: ☐

Secondary diagnoses: ICD-9 Code: ☐
ICD-10 Code(s): ☐

Subjective symptoms:

Blood pressure: Date BP taken: Height: Weight:

Pertinent Test Results (list all results, or enclose test):

Test: Date: Results:

Test: Date: Results:

Physical Examination Findings:

Current Medications, Dosage and Frequency:

TREATMENTS

Date your patient reported stopping work: Date of Disability: Expected Return to Work Date:

Date you first treated this patient: Date you first treated this patient for this condition:

Date of reported onset of this condition: Date of most recent treatment:

How often has patient been seen/treated for this condition? Date of next office visit:

Has patient been referred to any other physician? ☐ Yes, ☐ No If "Yes," Date(s) of Referral:

Other Physician Name: Phone Number: ( ) Specialty:

Other Physician Name: Phone Number: ( ) Specialty:

Has surgery been performed? ☐ Yes ☐ No Is surgery planned? ☐ Yes ☐ No

If "Yes," Date: Procedure: CPT Code:

Was patient hospitalized for this condition? ☐ Yes ☐ No

If "Yes," Name of Hospital: Telephone Number of Hospital: ( )

Date(s) admitted: Date(s) Discharged:

ABILITIES

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			
Total hours/day			
Check here if no restrictions	☐	☐	☐

Please check the frequency with which the patient can perform the following activities:

R = Right L = Left B = Bilateral		No Restrictions	Frequently (34-67%)	Occasionally (1-33%)	Never
Lift / carry 1 to 10 lbs		R L B	R L B	R L B	R L B
Lift / carry 11 to 20 lbs		R L B	R L B	R L B	R L B
Lift / carry 21 to 30 lbs		R L B	R L B	R L B	R L B
Lift / carry 31 to 40 lbs		R L B	R L B	R L B	R L B
Lift / carry 41 to 50 lbs		R L B	R L B	R L B	R L B
Lift / carry 51 to 100 lbs		R L B	R L B	R L B	R L B
Lift / carry over 100 lbs		R L B	R L B	R L B	R L B
Bending at waist		☐	☐	☐	☐
Kneeling / crouching		☐	☐	☐	☐
Driving		☐	☐	☐	☐
Reaching only (non load-bearing)	Above shoulder	R L B	R L B	R L B	R L B
	Below shoulder level (reach forward for objects on desktop or workstation)	R L B	R L B	R L B	R L B
Fingering / handling		R L B	R L B	R L B	R L B

Hand dominance: R L

Progress (Please check one): ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

Expected duration of any restriction(s) or limitation(s) listed above:

Does the patient have a psychiatric / cognitive impairment? ☐ Yes ☐ No If "Yes," please describe the extent of the impairment and its etiology:

Do you believe the patient is competent to endorse checks and direct the use of the proceeds? ☐ Yes ☐ No

Attending Physician's Name: (please print or type)		Telephone Number: ( )
License Number:	EIN Number:	Fax Number: ( )
Degree	Specialty:	
Street Address: Street, City, State & Zip Code)		

Acknowledgement – I hereby certify that the answers I have made to the foregoing questions are both complete and true to best of my knowledge and belief.

Signature_____ Date signed _____

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SECTION III. POLICYHOLDER'S STATEMENT (to be completed by employer)

This form is for the purpose of considering a claim for Waiver of Premium of the Insured named below.
When completed, this form should be returned to the address below.
(Enclose copy of the enrollment form (if applicable) with the submission of this completed form)

Name of Insured_____

Date of Birth____/____/____

Name of Employer _____

Address of Employer:_____ Street_____

City _____State _____Zip _____

Telephone ( ) -)

Date of Hire: _____/ _____ /_____

Employee Worked: ☐ Full-Time ☐ Part-Time

Average Number of Hours Worked Per Week: _____

Actual Date Employee Last Worked: _____/ _____ /_____

Reason Employee Ceased Working: _____

Date Employment Was Terminated
(if different from date last worked) _____

Reason Terminated:

Expected Date of Return to Work: _____/ _____ /_____

What was the employee's permanent job on his or her last day of work? _____

How long has the employee been in this job? _____

Amount of Insurance

	Basic	Effective Date of Coverage (mm/dd/yyyy)	Voluntary/Supplemental	Effective date of coverage (mm/dd/yyyy)
Life Insurance	$ _____	_____/_____/_____	$ _____	_____/_____/_____
Accidental Death & Dismemberment	$ _____	_____/_____/_____	$ _____	_____/_____/_____
Dependent Life	$ _____	_____/_____/_____	$ _____	_____/_____/_____
Dep. Accidental Death & Dismemberment	$ _____	_____/_____/_____	$ _____	_____/_____/_____

Employee's Job Title: _____

Nature of Duties **(provide copy of job description):** _____

_____

Can the Employee's/Insured's job be modified to accommodate his/her disability? ☐ Yes ☐ No

_____

Have any Worker's Compensation, Short-Term or Long-Term Disability benefits been paid? ☐ Yes ☐ No

If "Yes," please provide the name and address of the carrier, along with dates covered. _____

_____ From _____ to _____
Mo. Day Yr. Mo. Day Yr.

Acknowledgement
I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.

_____
NAME (POLICYHOLDER REPRESENTATIVE)

_____
SIGNATURE (EMPLOYER REPRESENTATIVE) **DATE**

Email address _____

Phone Number ( ) - _____

Please be sure to enclose copy of enrollment when mailing in this form to:

Regular mail:

Group Claims Department
8501 IBM Drive, Suite 150B
Charlotte, NC 28262

Email:

waiverclaims@equitable.com

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