Equitable Financial Life Insurance Company of America

Group Term Life Evidence of Insurability Form

EQUITABLE*

INSTRUCTIONS TO THE PROPOSED INSURED (The Proposed Insured is the person for whom insurance is being requested. The Proposed Insured may be the Employee or the Employee's Spouse/Domestic Partner/ Civil Union Partnership).

1. Complete the fields for the Employee Information Section (Section A) and the Spouse Information (Section C), if applicable. For the purposes of this form, the term "Spouse" throughout the form means your legal spouse, domestic partner, or civil union as defined in your state of residence.
2. If the Insurance Details (Section B) is not completed, obtain the information before finalizing the form. Contact your Employer/Benefits Administrator if the Life Insurance amounts were not provided.
3. Complete Employee and Spouse (if applicable) Health Questions (Section D and Section E.).
4. Sign and date the Agreements, Authorizations and Signature Sections (Page 6 and 7). Each Proposed Insured must complete a separate HIPAA form.
5. After completion, make a copy of the completed form for your records and FAX, MAIL or EMAIL the original forms to the address at the right. Emailed forms must be printed and signed before they are scanned and submitted.

Equitable Financial Life Insurance Company of America
P.O. Box 1507
Secaucus, NJ 07096
Fax: 1-816-502-9118

Submit Completed Forms: EOIprocessing@Equitable.com

If you have any questions regarding this form, contact our Customer Service Team 1-866-274-9887

Use this form to apply for insurance coverage. You may also complete this Evidence of Insurability Form online through Equitable's enrollment portal.

Employer Name _____ **Group/Policy Number** _____

A. EMPLOYEE INFORMATION

Employee Name *(First, MI, Last)* _____ Gender: ☐Male ☐Female

SSN _____ Email Address _____ Birth Date _____ Height ____ (ft/inches) Weight ____ (lbs.)

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

Hire Date _____ Salary _____ Occupation _____

Primary Health Practitioner _____ Practitioner Phone (_____) _____

Practitioner Address _____ City _____ State _____ Zip _____

B. INSURANCE DETAILS *(Complete this table based only on the coverage you have through this plan.)*
Are you completing this form due to a Family Status Change (Marriage, Divorce, Birth, Adoption, etc.)? ☐Yes ☐No

Coverage Type	(A) Current Amount	(B) Total Amount Requested
☐ Employee - Basic Life	$	$
☐ Spouse - Basic Life	$	$
☐ Employee - Supplemental Life	$	$
☐ Spouse - Supplemental Life	$	$
☐ Employee - Voluntary Life	$	$
☐ Spouse - Voluntary Life	$	$

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Employee Name _____ SSN *(last 4 digits only)* _____

C. SPOUSE INFORMATION

Spouse Name *(First, MI, Last)* _____ Gender: ☐Male ☐Female

SSN _____ Email Address _____ Birth Date _____ Height ____ (ft/inches) Weight ____ (lbs.)

Home Phone(_____) _____ Cell Phone(_____)_____

Hire Date _____ Salary _____ Occupation _____

Primary Health Practitioner _____ Practitioner Phone(_____) _____

Practitioner Address _____ City _____ State _____ Zip_____

D. EMPLOYEE AND SPOUSE HEALTH QUESTIONS *(Must be answered for coverage that is not Guaranteed Issue)*

IF APPLYING FOR LIFE INSURANCE, All questions must be answered by each person applying for coverage. If any questions are answered "yes" please check and circle box for any ailments that apply

Employee (EE)		Spouse (SP)		
Yes	No	Yes	No	
☐	☐	☐	☐	**1**. In the last 12 months, has any Proposed Insured used any tobacco products, including cigarettes, cigars, pipes, and smokeless tobacco, e-cigarettes/vaping, or used nicotine gum or a nicotine patch?
				2. Has any Proposed Insured ever been diagnosed by a licensed medical professional with, received medical advice for, or sought treatment for any of these ailments:
☐	☐	☐	☐	a. Cirrhosis of the liver or chronic hepatitis (excluding hepatitis A and fully recovered, treated hepatitis C), kidney disease or failure, type I or insulin dependent diabetes, chronic disease of the pancreas, or Crohn's disease?
☐	☐	☐	☐	b. Stroke, transient ischemic attack (TIA), peripheral vascular disease, vasculitis, aneurysm, blocked arteries, cardiomyopathy, congestive heart failure, heart valvular disease other than mitral valve prolapse or mitral valve regurgitation, heart valve repair or replacement, pacemaker implantation, heart attack, coronary heart disease, heart related surgery, or angina?
☐	☐	☐	☐	c. Sickle cell anemia, hemophilia, aplastic anemia, thrombocytosis, systemic lupus, polymyositis, myasthenia gravis, or mixed connective tissue disease?
☐	☐	☐	☐	d. Parkinson's disease, amyotrophic lateral sclerosis (Lou Gehrig's disease), muscular dystrophy, multiple sclerosis, cerebral palsy, disorder of the brain or spinal cord, paralysis, schizophrenia, bipolar/manic depression, suicide attempt, dementia or any other cognitive disease?
☐	☐	☐	☐	e. Chronic obstructive pulmonary disease (COPD), emphysema, cystic fibrosis, status asthmaticus, or any disease that requires oxygen?
☐	☐	☐	☐	f. Transplant of an organ, stem cells, or bone marrow or advised of the need of transplant of an organ, stem cells, or bone marrow?
☐	☐	☐	☐	g. Cancer or malignancy, leukemia, melanoma, benign brain tumor, Hodgkin's disease, or non-Hodgkin's lymphoma (not including basal cell or squamous carcinoma of the skin that has been removed)?

Employee Name _____ SSN *(last 4 digits only)* _____

EMPLOYEE AND SPOUSE HEALTH QUESTIONS *(continued)*

IF APPLYING FOR LIFE INSURANCE, All questions must be answered by each person applying for coverage. If any questions are answered "yes" please provide additional information in the details section below.

Employee (EE) Yes	Employee (EE) No	Spouse (SP) Yes	Spouse (SP) No	
☐	☐	☐	☐	**3**. Has any Proposed Insured ever been diagnosed by a licensed medical professional with Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)?
☐	☐	☐	☐	**4**. In the past 10 years, has any Proposed Insured pled guilty or no contest to or been convicted of a felony, or have felony charges outstanding against you?
☐	☐	☐	☐	**5**. In the past 5 years, has any Proposed Insured had their driver's license suspended or revoked or pled guilty to or been convicted of driving while impaired, intoxicated or under the influence of any drug?
☐	☐	☐	☐	**6**. In the past 5 years, has any Proposed Insured used, except as legally prescribed by a physician: opiates, morphine, tranquilizers, sedatives, amphetamines, barbiturates, methadone, benzodiazepine, hallucinogens, methamphetamines, heroin, cocaine, crack, ecstasy, PCP, or LSD?
☐	☐	☐	☐	**7**. In the past 5 years, has any Proposed Insured been advised by a medical professional to limit or discontinue the use of alcohol or drugs (prescribed or non-prescribed), or received treatment or counseling, or been a member in any self-help group because of use of alcohol or drugs?

Employee Name _____ SSN *(last 4 digits only)* _____

Employee (EE) Yes	Employee (EE) No	Spouse (SP) Yes	Spouse (SP) No	
				Additional Questions. All questions must be answered by each person applying for coverage. If any questions are answered "yes" please check and circle box for any aliments that apply.
				8. In the past 5 years, has any Proposed Insured been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any of the following diseases or disorders:
☐	☐	☐	☐	a. High blood pressure, irregular heart-beat, heart murmur, or any other heart or circulatory system disorder?
☐	☐	☐	☐	b. Neoplasm, nodule or polyp, precancerous condition, or dysplastic nevi?
☐	☐	☐	☐	c. Thyroid, pituitary or other endocrine disorder?
☐	☐	☐	☐	d. Hepatitis C, ulcer, ulcerative colitis, or other gastrointestinal disorder?
☐	☐	☐	☐	e. Type II diabetes?
☐	☐	☐	☐	f. Asthma, bronchitis, sleep apnea, or any other lung or respiratory disease?
☐	☐	☐	☐	g. Rheumatoid arthritis, fibromyalgia, chronic fatigue syndrome, connective tissue disease, or any other autoimmune disorder?
☐	☐	☐	☐	h. Headaches, epilepsy, seizures, fainting, dizziness, or optic neuritis?
☐	☐	☐	☐	i. Anxiety, depression, post-traumatic stress disorder, or any mood, emotional, mental, or nervous disorder?
☐	☐	☐	☐	j. Any disease of the blood cells or serum including, but not limited to, anemia, polycythemia, or bleeding or clotting disorders?

Employee Name _____ SSN *(last 4 digits only)* _____

For every "Yes" answer to question 8 in the previous section, give details below. (Continue on reverse side if additional space is needed.)

Question #	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Full Recovery	Health Practitioner Names and Full Address (Street, City, State, ZIP), Phone
	☐EE ☐spouse				☐Yes ☐No	
	☐EE ☐spouse				☐Yes ☐No	
	☐EE ☐spouse				☐Yes ☐No	
	☐EE ☐spouse				☐Yes ☐No	
	☐EE ☐spouse				☐Yes ☐No	

E. EMPLOYEE AND SPOUSE ADDITIONAL QUESTIONS

IF APPLYING FOR LIFE INSURANCE, All questions must be answered by each person applying for coverage. Please answer each question below and provide details in the Additional Details section immediately below.

Employee (EE) Yes	Employee (EE) No	Spouse (SP) Yes	Spouse (SP) No	
☐	☐	☐	☐	**1**. Does any Proposed Insured currently consume alcohol? If "yes", please provide type, frequency, and amount consumed, in Section E.
☐	☐	☐	☐	**2**. Does any Proposed Insured currently use prescribed or non-prescribed drugs? If "yes", please provide full details to drug(s) in use, dosage, and frequency of use in Section E.
☐	☐	☐	☐	**3**. Has any Proposed Insured had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified or issued other than as applied for? If yes, provide details in Section E.

E. ADDITIONAL DETAILS

(1) _____

_____

(2) _____

_____

(3) _____

_____

Fraud Warning

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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Employee Name _____ SSN *(last 4 digits only)* _____

Agreements, Authorizations & Signature

I have read this Evidence 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 of America 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 of America 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 of America, 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 Evidence 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 of America, can modify, waive or change this form, nor bind coverage or guarantee approval of this form. I authorize Equitable Financial Life Insurance Company of America, 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.

Any person who knowingly presents a false statement in an evidence of insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.

I have read this Evidence 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.

Signed at _____
City, State

_____ _____
Employee Signature **Date**

_____ _____
Spouse Signature (if applicable) **Date**

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Employee Name _____ SSN *(last 4 digits only)* _____

This authorization is valid for Equitable Financial Life Insurance Company of America

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

_____
Print Name of Proposed Insured or Authorized Representative

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

Dated at _____ **on** _____
City, State **(MM/DD/YYYY)**

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Employee Name _____ SSN *(last 4 digits only)* _____

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

_____
Print Name of Proposed Insured or Authorized Representative

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

Dated at _____ **on** _____
City, State **(MM/DD/YYYY)**

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