EQUITABLE

Group Employee Benefits

Application For Accident Insurance Benefits

Equitable Financial Life Insurance Company
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 Accident Insurance Benefits

Section II **Authorization to Obtain Information -** to be signed by the **employee.**

Section III **Attending Physician's Statement -** to be completed by the physician who is treating the **claimant.**

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 ACCIDENT INSURANCE 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** 020715	**Phone number**	
Street Address	**City**	**State**	**Zip code**

Receive your claim payment more quickly! For direct deposit of your benefits, carefully complete this section.

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

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

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		
Mobile Telephone Number: ( )	Email address:		
Preferred method for claim updates: ☐ Phone ☐ Email ☐ Text			
Did injury result from employment? ☐ Yes ☐ No ☐ Currently disputed			

Spouse name (as it appears on your spouse's Social Security card)		☐ Male ☐ Female
Social Security Number	Date of Birth (mm/dd/yyyy)	Did injury result from employment? ☐ Yes ☐ No ☐ Currently disputed

Dependent name (as it appears on your child's Social Security card)		☐ Male ☐ Female
Social Security Number	Date of Birth (mm/dd/yyyy)	Did injury result from employment? ☐ Yes ☐ No ☐ Currently disputed

B. Claim Information

Date of accident	Time of accident
Describe the accident	
Name of Physician:	Telephone Number: ( )
Address of Physician: (Street, City, State & Zip)	
Hospital name	Telephone Number: ( )
Address of Hospital: (Street, City, State & Zip)	

B. Claim Information – continued

The following benefits, subject to the election of your employer, may be covered under your Certificate. The benefit available and amount payable for each covered benefit will be shown in the Certificate. See the Certificate for the definition of benefits.

In order for benefits to be processed, please provide documentation of services provided or performed related to the accident. The itemized documentation must include the name of the provider, date of service, type of service and charge.

The following checklist can assist in your submission. (Check all that apply.)

☐ Accident Emergency Treatment (non-Emergency Room, non-Urgent Care facility)	☐ Laceration
☐ Accidental Death (including Common Carrier)	☐ Loss of hearing, sight, or speech
☐ Accidental Dismemberment	☐ Medical device
☐ Accident follow-up care	☐ Mental Health Therapy
☐ Acupuncture	☐ Organized Sports Injury
☐ Ambulance (ground, air)	☐ Paralysis
☐ Anesthesia	☐ Physical or Occupational therapy
☐ Blood / Plasma / Platelet transfusion	☐ Physician follow-up treatment
☐ Brain injury	☐ Prescription drug
☐ Burn	☐ Prosthesis
☐ Catastrophic accident	☐ Rehabilitation Unit
☐ Chiropractic	☐ Skin Graft
☐ Coma	☐ Surgery benefit
☐ Concussion	☐ Debridement
☐ Diagnostic exam	☐ Exploratory surgery
☐ Dislocation	☐ Hernia repair
☐ Emergency dental	☐ Laparoscopic surgery
☐ Emergency room treatment	☐ Miscellaneous surgery
☐ Epidural pain management	☐ Open surgery
☐ Eye injury	☐ Ruptured / herniated disc
☐ Family & Pet Care	☐ Tendon / ligament / rotator cuff
☐ Fracture	☐ Torn knee cartilage
☐ Gunshot wound	☐ Transportation and Family Lodging
☐ Hospital admission and confinement	☐ Urgent Care facility
☐ Hospital Intensive Care Unit admission and confinement	☐ X-ray

Please include the following documents for all that apply:

- Hospitalization: copy of hospital bill indicating diagnosis, services or treatment, and days hospitalized
- Surgery: a copy of the operative report
- Motor Vehicle Accident or any incident investigated by a law enforcement agency: a copy of the police report
- Death: a certified copy of the death certificate for the deceased
- Other: copy of medical bills, physician records, ambulance charges, lodging and transportation expenses, and other appropriate documentation to support claim for benefits

Wellness Benefit: See policy for covered tests or procedures. If submitting a claim for this benefit, please use the Wellness Claim Statement (Form E15711).

C. 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. T**he 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**_____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Section II

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 of 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 re- disclosed 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)*

* "Equitable" is Equitable Financial Life Insurance Company and its affiliates, including Equitable Financial Life Insurance Company of America, as well as any party acting on its behalf.

Section III Attending Physician's Statement

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

Patient name	Patient SSN	Patient Date of Birth (mm/dd/yyyy)	
Was the injury the result of any of the following? (Check all that apply) ☐ Use of drugs ☐ Committing a felony ☐ Intoxication ☐ Self-inflicted ☐ Attempted suicide ☐ Work related ☐ Complication of treatment			
Date of accident (mm/dd/yyyy)	Diagnosis	Date diagnosis made (mm/dd/yyyy)	ICD Codes:
Has this patient been treated for this condition or a similar condition prior to this occurrence? ☐ Yes ☐ No If "Yes," please provide diagnosis, the dates of treatment and names of other medical providers.			

Provide the following information of any referring physicians.			
Name of physician	Specialty	Phone number	
Street address	City	State	Zip code
Name of physician	Specialty	Phone number	
Street address	City	State	Zip code
For services related to a hospitalization, please provide the following.			
Name of hospital			
Street address	City	State	Zip code
Admission date (mm/dd/yyyy)		Discharge date (mm/dd/yyyy)	

Attending Physician's Name:	Telephone Number: ( )	Fax Number: ( )
Address: (Street, City, State & Zip Code)		
Social Security Number or E.I.N. Number:	Degree:	Specialty:
Signature:		Date Signed: