



EQUITABLE

Group Employee Benefits

Application For Critical Illness/Specified
Disease 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 Critical Illness/Specified Disease 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 CRITICAL ILLNESS/SPECIFIED DISEASE 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

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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security Number
Address: (Street, City, State & Zip)			Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
Mobile Telephone Number: ()			Email address:		
Preferred method for claim updates:			<input type="checkbox"/> Phone	<input type="checkbox"/> Email	<input type="checkbox"/> Text

Spouse name (as it appears on your spouse's Social Security card)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number	Date of Birth (mm/dd/yyyy)

Dependent name (as it appears on your child's Social Security card)	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security Number	Date of Birth (mm/dd/yyyy)	Married <input type="checkbox"/> Yes <input type="checkbox"/> No

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 _____

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) <input type="checkbox"/> Use of drugs <input type="checkbox"/> Committing a felony <input type="checkbox"/> Intoxication <input type="checkbox"/> Self-inflicted <input type="checkbox"/> Attempted suicide			
Date of first symptoms (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?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," please provide diagnosis, the dates of treatment and names of other medical providers.			

Primary physician		Specialty	Phone number	
Street address		City	State	Zip code
Provide the following information of any treating 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)	

<input type="checkbox"/> Advanced ALS/Lou Gehrig's disease	Documentation of diagnosis by a physician and requires either a feeding tube or non-invasive ventilation
<input type="checkbox"/> Advanced Alzheimer's disease	Documentation of diagnosis on the FAST Staging Scale (Stage 6 or higher) related to Alzheimer's related dementia by a qualified medical provider and a current assessment documenting neurological impairments
<input type="checkbox"/> Advanced multiple sclerosis	Documentation of a diagnosis by a physician of impairment of motor function and other neurological abnormalities lasting for a continuous period and lesions or demyelination in one or more areas of the central nervous system. Advanced Multiple Sclerosis means an Age-Related Multiple Sclerosis Severity Score (ARMSSS) of 6 or above.
<input type="checkbox"/> Advanced Parkinson's disease	Documentation of primary idiopathic Parkinson's disease at stage 4 or higher on the Hoehn/Yahr scale by a qualified neurologist and a neurologist evaluation addressing current physical examination/condition
<input type="checkbox"/> Angioplasty	Surgical report and hospital discharge summary
<input type="checkbox"/> Benign brain tumor	Hospital discharge summary, pathology report, and current assessment to address any persistent neurological deficits. Neurological treatment records to include diagnostic test results and neurological exam findings.
<input type="checkbox"/> Blindness	Ophthalmologist's report with visual acuity and visual fields at onset and six months past onset
<input type="checkbox"/> Bone marrow transplant	Documentation of diagnosis by a physician of a condition such as leukemia, lymphoma, aplastic anemia, or other disease of the bone marrow and which requires the replacement of the Insured's bone marrow by autologous, allogeneic, and/or umbilical cord blood transplant.
<input type="checkbox"/> Breast cancer	Pathology report
<input type="checkbox"/> Coma	Hospital records and test results at onset and one week post event
<input type="checkbox"/> Complete loss of hearing	Audiogram testing results with documented decibel hearing loss
<input type="checkbox"/> Coronary bypass surgery	Surgical report and hospital discharge summary
<input type="checkbox"/> End-stage kidney disease	Physician or dialysis center report of regular hemodialysis and/or peritoneal dialysis for longer than 90 days and chronic and irreversible kidney failure
<input type="checkbox"/> End-stage heart failure	Proof of listing with United Network of Organ Sharing (UNOS)
<input type="checkbox"/> Heart attack	Cardiac enzyme and biomarkers, Electrocardiogram (EKG), Thallium scans, MUGA scans, stress echocardiogram, hospital discharge summary, and cardiac catheterizations
<input type="checkbox"/> Hospitalized infectious disease	Documentation of diagnosis of an infectious disease and duration of hospital confinement.
<input type="checkbox"/> Invasive cancer	Pathology report, operative report (if available), and laboratory records
<input type="checkbox"/> Loss of speech	Speech evaluations at onset date and six months post onset date
<input type="checkbox"/> Major organ failure	Proof of listing with United Network of Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP)
<input type="checkbox"/> Non-invasive cancer	Pathology report

<input type="checkbox"/> Occupational infectious disease	<ul style="list-style-type: none"> • Documentation showing that within five days of the accidental exposure, the exposure was reported and recorded by the appropriate person according to legislation, regulators, or standard guidelines that apply to the occupation; • A negative antibody for HIV (or Hepatitis B, C, and/or D) test, performed by a state certified and licensed laboratory within 5 days of exposure; and • A positive antibody for HIV (or Hepatitis B, C, and/or D) test, taken in the 90 to 180 days following the exposure
<input type="checkbox"/> Paralysis	Initial hospital discharge summary and assessment at 6 months post onset
<input type="checkbox"/> Severe autoimmune disease	Documentation supporting one or more of the following:: <ul style="list-style-type: none"> • irreversible organ damage as a direct result of the Autoimmune Disease; • altered function of the brain, spinal cord, muscles or nerves (permanent neurological deficit) that results in cognitive deficit or difficulty with ambulation or arm movements; • permanent skin thickening that prevents normal swallowing or prevents unrestricted use of extremities; • a Hospital Confinement of at least 1 day directly related to the Autoimmune Disease; or • inability to perform 3 or more Activities of Daily Living without the assistance of another person.
<input type="checkbox"/> Severe burns	Hospital admission/discharge summaries and medical documentation that specifies degree and size of burn
<input type="checkbox"/> Severe mental/nervous disorder	Documentation of the diagnosis (from the list below) as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and which results in an Insured's participation in an intensive outpatient program or partial hospitalization program. Covered disorders: Bipolar I or 2 disorder; Major depressive disorder (MDD); Obsessive-compulsive disorder (OCD); Schizoaffective disorder; Schizophrenia; Post-traumatic stress disorder (PTSD); Substance use disorder; Eating disorder; or Postpartum depression.
<input type="checkbox"/> Skin cancer	Pathology report documenting evidence of basal cell or squamous cell cancer of the skin
<input type="checkbox"/> Stroke	Neuroimaging studies, hospital discharge summary, and current assessment
<input type="checkbox"/> Sudden cardiac arrest	Documentation of the diagnosis by a physician or, if a pathological diagnosis, the documentation of tissue specimen, culture, or titer(s).
Childhood-specific Critical Illness	
<input type="checkbox"/> Autism	Documentation of diagnosis by a physician must include a clinical exam and testing based on the Diagnostic and Statistical Manual of Mental Disorders (DSM). It should also include a comprehensive assessment from a team of specialist physicians, including some or all of the following: psychologist, neurologist, psychiatrist, and/or speech therapist.
<input type="checkbox"/> Sickle Cell Disease	Documentation of diagnosis by a physician
<input type="checkbox"/> Cerebral palsy	Medical assessment by a physician confirming the diagnosis of cerebral palsy and documentation of developmental delays, physical findings, posture abnormalities, and any intellectual or behavioral difficulties
<input type="checkbox"/> Cleft lip / palate	Current assessment from a physician documenting the cleft lip or cleft palate by routine examination

<input type="checkbox"/> Complex congenital heart disease	Treatment notes from treating specialist(s) from date of diagnosis to at least two months post diagnosis to include appropriate diagnostic test results and laboratory reports
<input type="checkbox"/> Cystic fibrosis	Sweat chloride test and genetic testing confirming cystic fibrosis
<input type="checkbox"/> Down Syndrome	Genetic testing (chromosome study) which confirms the diagnosis of Down Syndrome
<input type="checkbox"/> Muscular dystrophy	Diagnosis of either Duchenne or Becker muscular dystrophy with confirmation by CPK blood test, muscle biopsy, electromyography, and genetic testing
<input type="checkbox"/> Spina Bifida	Current assessment documenting the diagnosis of spina bifida either by diagnostic testing (x-ray, MRI, CT) or by routine examination
<input type="checkbox"/> Type I diabetes Mellitus (DM)	Fasting blood glucose testing, oral glucose tolerance testing, hemoglobin A1C lab testing; a current assessment from the treating physician describing diagnosis and lab results, and requires being on insulin therapy
<input type="checkbox"/> PANDAS	Documentation of diagnosis by a specialist physician

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: