

Group Policy Number

Employer Name

**Regular Mail:**  
Equitable Employee Benefits  
Group - P.O. Box 2107,  
Grapevine, TX 76099-2107

**Express Mail:**  
Equitable Employee Benefits  
Group - 8500 Freeport Pkwy 4th Floor,  
Irving, TX 75063



# EQUITABLE

**Equitable Financial Life Insurance Company**  
Equitable Financial Life Insurance Company of America  
For Assistance Call (866) 274-9887; Fax (469) 417-1956  
Email: EQHLifeClaims@webtpa.com

## Employee Benefits Life Claim – Accelerated Benefit Option

Please send the completed form and all attachments to: **Equitable Employee Benefits**

### How to present a claim

**1. Disclosure Statement and Tax Certification** — Employees should first carefully read the Disclosure Statement below and sign and date the Acknowledgement. They should then read the Important Tax Information and Tax Certification (page 7) and complete, sign, and date the Tax Certification.

**2. Accelerated Benefit Option Claim Form** — Both the “Employee Statement” (page 2) and the “Group Contract Holder Statement” (page 4) attached to these instructions must be completed. Section 1 of the “Group Contract Holder Statement” must be completed if the claim is for an employee/member or for a dependent of an employee. The “Employee Statement” should be completed and returned to the benefits administrator (Group Contract Holder).

**3. Attending Physician Certification** — Medical evidence of terminal illness should be submitted on the Attending Physician’s Certification form. Please be aware any expenses charged by the physician are the responsibility of the beneficiary

This form should be completed by the physician and certify the nature of the employee’s or dependent’s illness. It should be mailed to Equitable Employee Benefits Group 8500 Freeport Pkwy 4<sup>th</sup> Floor, Irving, TX 75063

If you have any questions, please call our Group Life Claim Division at 866-274-9887 and a customer service representative will assist you.

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### To Be Completed by Employee

#### Disclosure Statement

The money received from the Accelerated Benefit Option can be used for any purpose. If you exercise this option and accept payment, you should be aware that such payment may adversely affect your eligibility for Medicaid or other government benefits or entitlements. In addition, the Accelerated Benefit Option payment, or a portion thereof, may be considered taxable income. Equitable recommends that assistance be sought from a personal tax advisor and/or an attorney regarding how election of this option may affect your personal situation. Equitable offers this option based on our interpretation of current law, which may change in the future.

By electing this option, the total amount of employee term life insurance otherwise payable at death, including any amount under an extended benefit, will be reduced by the amount paid under the Accelerated Benefit Option. Also, any amount that could otherwise have been converted to an individual insurance contract will be reduced by the amount paid under this option.

Receipt of accelerated benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children, and Supplemental Security Income. Prior to applying for accelerated benefits, certificateholders should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient’s spouse or dependents. Receipt of accelerated benefits may be taxable. Prior to applying for such benefits, certificateholders should seek assistance from a qualified tax advisor. No health care facility as defined in Section 20 of the Public Health law can require any person to accelerate payment of a benefit as a condition of admission to such health care facility or for providing any care in such facility. Insurers are prohibited from paying accelerated death benefits to the certificateholders for a period of 14 days from the date on which the certificateholder is provided a numerical computation of the accelerated benefit and an illustration of the effect of an accelerated benefit claim on contract values.

Acknowledgement: I have read the disclosure information above.

X \_\_\_\_\_  
Employee’s Signature

\_\_\_\_\_  
Date (MM DD YYYY)

X \_\_\_\_\_  
Beneficiary’s Signature (Required only if designation is irrevocable)

\_\_\_\_\_  
Date (MM DD YYYY)

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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**Fraud Warnings**

**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.

**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.

**Arizona and California:**

For your protection, Arizona or 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 subjects such person 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.

**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.

Signature \_\_\_\_\_ : Date: \_\_\_\_\_

**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 dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are 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

**I have read and understand the terms and requirements of the fraud warnings included as part of this form.**

X \_\_\_\_\_  
Employee's Signature

Date (MM DD YYYY)

Telephone Number

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### To Be Completed By Employee

**Employee Statement** Please complete in full.

Name  Social Security Number  Date of Birth (MM DD YYYY)

Email Address:

Home Address:

Mailing Address (if different):

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### Claimant's Information *(Should only be completed if different from employee)*

First Name  MI  Last Name

Social Security Number  Date of Birth (MM DD YYYY)  Date of Disability (MM DD YYYY)

Gender  Male  Female Relationship to Employee  Employee  Spouse\*  Child  Other State of Residence

Relationship to Employee  Telephone Number

Residence: Street  Apt.

City  State  ZIP Code

*\* Note: Spouse includes the Proposed Insured's legally married spouse, or civil union partner or domestic partner if legally recognized in the governing jurisdiction*

Last day worked prior to current disability (MM DD YYYY)  Date first treated by physician (MM DD YYYY)  Amount being claimed  \$

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## Accelerated Benefit Option Claim Form

(Use for employee/member and dependent claims.)

### To Be Completed by Employee Employee Statement (continued)

\*If claim is for a dependent, please provide the following information:

Name	Social Security Number	Date of Birth (MM DD YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>

List physicians consulted because of this disability	Period Treated	
Name	From (MM DD YYYY)	To (MM DD YYYY)
<input type="text" value="Dr."/>	<input type="text"/>	<input type="text"/>

Address

Name	From (MM DD YYYY)	To (MM DD YYYY)
<input type="text" value="Dr."/>	<input type="text"/>	<input type="text"/>

Address

List any hospital confinements for this disability	Period Confined	
Name of hospital	From (MM DD YYYY)	To (MM DD YYYY )
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

If you have any other Equitable policies, please show policy number(s) (complete as it pertains to employee or dependent):

Has this insurance been assigned?  Yes  No

Has any government agency required that you involuntarily exercise this option as a condition for obtaining or retaining a government benefit or entitlement?  Yes  No

Benefit will be made in a lump sum if approved.

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**Group Insurance Contract Holder Statement** To be completed by Employer/Plan Administrator. Please complete all five sections.

## 1 Employer/Plan Administrator *(To be completed by Employer)*

Employer Name:  Plan Administrator Name:

Street  Suite

City  State  Zip Code  Telephone

## 2 Employee Information

Date of Employment (mm dd yyyy)   Hourly  Full time  Part time  Salary  Date Last Worked (mm dd yyyy)

Occupation  Where Employed

If not actively at work immediately prior to disability, what was the reason? (Attach explanation, if applicable.)

- Disability
- Leave of Absence
- Vacation
- Discharge
- Resigned
- Retired
- Temporary Layoff
- Other

Street  Suite

City  State  Zip Code

## 4 Insurance Coverages

Complete only for the coverage that applies to this claim.

	Benefit Amount	Effective Date (DDMMYYYY)	Percentage to be Distributed (percentage not to exceed 75%. Some groups may exceed the 75%, please refer to the certificate language.)
<input type="checkbox"/> Basic Life	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Supplemental Life	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Voluntary Life	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Dependent Life	<input type="text"/>	<input type="text"/>	<input type="text"/>

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Employee/Member Salary Amount on Last Day Worked

\$

per

Hour  Week  Month  Year

Was insurance ever assigned?

Yes  No

Optional Term Life, if applicable, must be supported by proof of enrollment.

Maximum Amount Available Under the Accelerated Benefit Option

\$

Has insurance percentage increased in last year?  Yes  No

If yes, provide date (MM DD YYYY)

Was evidence of insurability required to secure current coverage?  Yes  No

Is there contributory insurance?  Yes  No

Date Last Premium Paid (MM DD YYYY)

## 5 Payment Information

Mail Payment to:  Employer at address listed above

Claimant at address listed below

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**Accelerated Benefit Option Claim Form Attending Physician's Certification** (Please print.)

**This section to be completed by the Employee**

The patient is responsible for the completion of this form without expense to Equitable

Name of Patient  Social Security Number  Date of Birth (MM DD YYYY)

Patient's Address

I hereby authorize release of information requested on this form by the named physician or health care provider for the purpose of processing healthcare claim(s) for services I have received.

X \_\_\_\_\_  
Patient's Signature Date (MM DD YYYY)

**This section to be completed by the Physician**

Date of first visit (MM DD YYYY)  Date of last visit (MM DD YYYY)  Date total disability began (MM DD YYYY)

Diagnosis  ICD Diagnosis  Present Condition

Is the patient's condition expected to result in death within 12 months?  Yes  No

Is the patient unable to perform two or more activities of daily living without assistance?  Yes  No

If Yes, please note:

Does the patient have a cognitive impairment requiring another person's active help or verbal guidance?  Yes  No

Objective Findings/medical records/include any results of current x-rays, EKG, or any other special test (please attach)

List any hospital confinements for this disability  
Name of hospital  Period Confined From (MM DD YYYY)  To (MM DD YYYY)

Name of Attending Physician (Please print.)  Degree/Specialty  Telephone Number

Physician's Address  Fax Number

X \_\_\_\_\_  
Signature Date (MM DD YYYY)

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**IMPORTANT TAX INFORMATION** (To be completed by Employee)

**1 Insured/Claimant's Information**

First Name  MI  Last Name

Social Security Number

**2 Employee's Information**

First Name  MI  Last Name

Street  Suite

City  State  Zip Code

Telephone

**3 Taxpayer Identification Number**

**Equitable requires your Taxpayer Identification Number. The Taxpayer Identification Number is either the Social Security Number or the Employer Identification Number. If you:**

- are an individual, your Taxpayer Identification Number is the Social Security Number.
- represent a trust or estate, the Taxpayer Identification Number is its Employer Identification Number.
- represent a minor, please provide the minor's Social Security Number.
- are applying for a Taxpayer Identification Number, please write "applied for" in the space provided.

**TAXPAYER IDENTIFICATION NUMBER/FORM W9 CERTIFICATION: Under penalties of perjury, I certify that (cross out any item that is not true):**

- 1. The number shown on the application is my correct Social Security/Tax ID number,**
- 2. I am not subject to backup withholding due to failure to report interest or dividend income,**
- 3. I am a U.S. citizen or other U.S. person (including a U.S. resident alien), and**
- 4. I am not subject to FATCA reporting**

**If you crossed out item 3 above, please indicate country of citizenship**

**and attach applicable IRS Form W-8(BEN, BEN-E, EXP, ECI, IMY).**

**Social Security Number or Taxpayer Identification Number of beneficiary**

X \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (MM DD YYYY)