

# Equitable Financial Life Insurance Company

## 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**  
 P.O. Box 1507  
 Secaucus, NJ 07096  
 Fax: 1-816-502-9118

Submit Completed Forms: [EOIprocessing@Equitable.com](mailto: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)<br>Current Amount | (B)<br>Total Amount Requested |
|---|-----------------------|-------------------------------|
| <input type="checkbox"/> Employee - Basic Life        | \$                    | \$                            |
| <input type="checkbox"/> Spouse - Basic Life          | \$                    | \$                            |
| <input type="checkbox"/> Employee - Supplemental Life | \$                    | \$                            |
| <input type="checkbox"/> Spouse - Supplemental Life   | \$                    | \$                            |
| <input type="checkbox"/> Employee - Voluntary Life    | \$                    | \$                            |
| <input type="checkbox"/> Spouse - Voluntary Life      | \$                    | \$                            |

\*Equitable is the brand name of Equitable Holdings, Inc. and its family of companies, including Equitable Financial Life Insurance Company (Equitable Financial) (NY, NY), Equitable Financial Life Insurance Company of America (AZ stock corp., admin. office: Jersey City, NJ), and Equitable Distributors, LLC.

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                       |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 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?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 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:   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 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?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 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? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | c. Sickle cell anemia, hemophilia, aplastic anemia, thrombocytosis, systemic lupus, polymyositis, myasthenia gravis, or mixed connective tissue disease?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 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?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | e. Chronic obstructive pulmonary disease (COPD), emphysema, cystic fibrosis, status asthmaticus, or any disease that requires oxygen?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 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?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 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)?  |

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**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)            |                          | Spouse (SP)              |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| Yes                      | No                       | Yes                      | No                       |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 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)?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. In the past 10 years, has any Proposed Insured pled guilty to or been convicted of a felony, or have felony charges outstanding against you?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 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?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 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?       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 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? |

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| Employee (EE)            |                          | Spouse (SP)              |                          | <b>Additional Questions.</b> 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.                           |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| Yes                      | No                       | Yes                      | No                       |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>8.</b> 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: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | a. High blood pressure, irregular heart-beat, heart murmur, or any other heart or circulatory system disorder?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | b. Neoplasm, nodule or polyp, precancerous condition, or dysplastic nevi?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | c. Thyroid, pituitary or other endocrine disorder?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | d. Hepatitis C, ulcer, ulcerative colitis, or other gastrointestinal disorder?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | e. Type II diabetes?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | f. Asthma, bronchitis, sleep apnea, or any other lung or respiratory disease?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | g. Rheumatoid arthritis, fibromyalgia, chronic fatigue syndrome, connective tissue disease, or any other autoimmune disorder?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | h. Headaches, epilepsy, seizures, fainting, dizziness, or optic neuritis?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | i. Anxiety, depression, post-traumatic stress disorder, or any mood, emotional, mental, or nervous disorder?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | j. Any disease of the blood cells or serum including, but not limited to, anemia, polycythemia, or bleeding or clotting disorders?   |

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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 |
|------------|--|--------------------------|----------------------|-----------------------------------|---|--|
|            | <input type="checkbox"/> EE<br><input type="checkbox"/> spouse |                          |                      |                                   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |  |
|            | <input type="checkbox"/> EE<br><input type="checkbox"/> spouse |                          |                      |                                   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |  |
|            | <input type="checkbox"/> EE<br><input type="checkbox"/> spouse |                          |                      |                                   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |  |
|            | <input type="checkbox"/> EE<br><input type="checkbox"/> spouse |                          |                      |                                   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |  |
|            | <input type="checkbox"/> EE<br><input type="checkbox"/> spouse |                          |                      |                                   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |  |

**E. EMPLOYEE AND SPOUSE ADDITIONAL QUESTIONS**

|   |   |  |  |  |
|---|---|--|--|--|
| <p><b>IF APPLYING FOR LIFE INSURANCE</b>, 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.</p> |   |  |  |  |
| Employee (EE)   | Spouse (SP)                                       |  | <p>1. Does any Proposed Insured currently consume alcohol? If "yes", please provide type, frequency, and amount consumed, in Section E.</p> <p>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.</p> <p>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.</p> |  |
| Yes No  | Yes No  |  |  |  |
| <input type="checkbox"/> <input type="checkbox"/>   | <input type="checkbox"/> <input type="checkbox"/> |  |  |  |
| <input type="checkbox"/> <input type="checkbox"/>   | <input type="checkbox"/> <input type="checkbox"/> |  |  |  |

**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) \_\_\_\_\_

**This authorization is valid for Equitable Financial Life Insurance Company**

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, 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) \_\_\_\_\_

**This authorization is valid for Equitable Financial Life Insurance Company**

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, 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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