Group Life and/or Accidental Death and Dismemberment Claim Form

EQUITABLE

Equitable Financial Life Insurance Company
Equitable Financial Life Insurance Company of America
For Assistance Call (866) 274-9887; Fax (469) 417-1973

Regular Mail: Equitable's Employee Benefits Group - P.O. Box 2107, Grapevine, TX 76099-2107
Express Mail: Equitable's Employee Benefits Group - 8500 Freeport Pkwy 4th Floor, Irving, TX 75063

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

Who is responsible for completing this form?

1. **Employer Statement** This section of the form should be completed by the employer who should mail it to the address noted above. The following information should also be provided.
    a. A copy of the death certificate (a photocopy is acceptable)
    b. The original enrollment form and any other enrollment forms indicating any change in coverage and
    c. The most recent beneficiary designation form.
2. **Accidental Death Statement:** If the claim is related to an accidental death; this section of the form should be completed by the employee or beneficiary. The completed form should be mailed to the address noted above.
3. **Dismemberment Statement:** If the claim is related to dismemberment; the first section should be completed by the beneficiary and the remaining sections should be completed by the attending physician. Please be aware any expenses charged by the physician are the responsibility of the beneficiary. This form should be mailed to the address noted above.

Questions?

If you have questions about the claim process or need help to complete these forms, please call the above toll-free number. Our customer representatives are available to help.

Policy Number

Employer Name

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To be completed by the Beneficiary

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Fraud Warning

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

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EMPLOYER STATEMENT – To be completed by the Employer (PLEASE PRINT)

A. Information About the Type of Claim – Please check all that apply and provide the policy and group numbers

Type of Coverage Being Claimed	Type of Claim Submitted	Class	Location
☐ Life Insurance	☐Employee Death ☐Dependent Death		
☐ Accidental Death	☐Employee Death ☐Dependent Death		
☐ Dismemberment	☐Employee ☐Dependent		

B. Information About the Employer

Employers Name

Street Suite

City State Zip Code

C. Information About the Employee – The term "Employee" refers to employees, member and/or retirees.

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

Street Suite

City State Zip Code

Social Security Number Date of Birth (MM DD YYYY) Original Date of Hire (MMDDYYYY) Date of Death (MMDDYYYY)

Home Telephone Number Cellular Telephone Number

Date Employee Entered Eligible Class (MMDDYYYY)	Termination & Rehire Dates (MMDDYYYY) Termination: Rehire:	
If this employee is or has been known by another name(s) (such as a nickname, maiden name, etc.) Please provide name(s)		
Employment Status __ Full-time __ Part-time __ Retired __ Exempt __ Non-Exempt	Hours Worked Per Week:	If eligibility is not based on hours worked, please describe
Salary/Rate of Pay __ Hourly __ Salary Amount $_____ __Weekly __Bi-weekly __Semi-monthly	Job Title/Class	

Please provide the following salary verification documentation. This information is necessary to accurately determine the amount of the insurance benefit.

If the definition of annual earnings is:	**Then provide as stated in your policy**
W-2	A copy of the prior year W2 and the last payroll statement for the same year
Salary with commissions and/or bonus	• Payroll reports • Documentation of commissions and/or bonuses
Last Date Physically at Work (mmddyyyy)	Reason for Stopping Work
Is the employee receiving any company sponsored retirement benefits? ☐ Yes ☐ No	If yes, when did the employee retire (mmddyyyy)?
If yes, please describe the retirement benefits:	

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EMPLOYER STATEMENT (Continued)

Employee's Name _____ Date of Birth (mmddyyyy) _____

Amount of Insurance – Only required for self-administered groups

	Basic	**Effective Date of Coverage** (mmddyyyy)	**Voluntary/Supplemental**	**Effective Date of Coverage** (mmddyyyy)
Life Insurance	$_____	_____	$_____	_____
Accidental Death & Dismemberment	$_____	_____	$_____	_____
Dependent Life	$_____	_____	$_____	_____
Dep – Accidental Death & Dismemberment	$_____	_____	$_____	_____

Changes to the Amount of Insurance – Only required for self-administered groups

	Amount of last change	Date of last change (mmddyyyy)
Basic Life	$_____	☐ Increase ☐ Decrease _____
Voluntary/Supplemental Life	$_____	☐ Increase ☐ Decrease _____
Dependent Life	$_____	☐ Increase ☐ Decrease _____
Basic AD&D	$_____	☐ Increase ☐ Decrease _____
Voluntary/Supplemental AD&D	$_____	☐ Increase ☐ Decrease _____
Dependent AD&D	$_____	☐ Increase ☐ Decrease _____

Date the premium payment was paid through for this employee (mmddyyyy)—Only required for self admin groups	**Was this employee terminated?** ☐ Yes ☐ No If yes, termination date (mmddyyyy):

D. Information About the Dependent – Please completed this section if the claim is for the death of the employee's dependent.

Dependent Name (Last Name, First Name, MI)

_____

Relationship to Employee

☐ Spouse * ☐ Child

Dependent Date of Birth (mmddyyyy) _____

Dependent Date of Death (mmddyyyy) _____

Dependent Social Security Number _____

Dependent Gender

☐ Male ☐ Female

Dependent Effective Date of Coverage (mmddyyyy) _____

Changes to the Amount of Insurance – Only required for self-administered groups

	Amount of last change	Date of last change (mmddyyyy)
Basic Life	$_____	☐ Increase ☐ Decrease _____
Supplemental Life	$_____	☐ Increase ☐ Decrease _____
Voluntary Life	$_____	☐ Increase ☐ Decrease _____
Dependent Life	$_____	☐ Increase ☐ Decrease _____
Basic Accidental Death & Dismemberment	$_____	☐ Increase ☐ Decrease _____
Supplemental Accidental Death & Dismemberment	$_____	☐ Increase ☐ Decrease _____
Voluntary Accidental Death & Dismemberment	$_____	☐ Increase ☐ Decrease _____
Dependent Accidental Death & Dismemberment	$_____	☐ Increase ☐ Decrease _____

Date the premium payment was paid through for this dependent (mmddyyyy) - Only required for self-administered groups	**Was the employee in active employment at the time of the dependent's death?** ☐ **Yes** ☐ **No**

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

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EMPLOYER STATEMENT (Continued)

Employee's Name _____ Date of Birth (mmddyyyy) _____

E. Information About the Employee's Beneficiary(ies) – If claim is for the death of the employee, please complete this section. If there are more than three. Please provide the following information for each additional beneficiary on a separate sheet of paper and include it with this form.

Name, Address & Telephone Number	Relationship	Social Security Number	Date of Birth	Percentage
Name				
Street				
City, State, Zip, Telephone #				
Name				
Street				
City, State, Zip, Telephone #				
Name				
Street				
City, State, Zip, Telephone #				
				Total Must Equal 100%

A copy of the most recent beneficiary designation form is enclosed ____ Yes ____ No If no, please explain._____

F. Information About Minor Beneficiary – If any of the above beneficiaries are minor children, please complete this section. If there is more than one, please provide the following information for each additional minor beneficiary on a separate sheet of paper and include it with this form.

Name of Minor Child (Last Name, Suffix, First Name, MI)

Adult Representative of Minor Child (Last Name, Suffix, First Name, MI)

Mailing Address of Adult Representative

City, State, Zip, Telephone Number of Adult Representative

G. Information About and Signature of Administrator (Please print)

The above statements are true and complete to the best of my knowledge and belief.

Administrator's Name

Administrator's Name	Telephone Number	Fax Number

Signature **Date Signed**

Policy Number _____

Employer Name _____

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Accidental Death Statement (Please Print)
To be completed by: - the beneficiary or next of kin, if the claim is related to the accidental death of the employee
- the employee, if the claim is related to the accidental death of a dependent
Please attach copies of any police and/or emergency medical services reports.

A. Information About the Employee

Employee Name (Last Name, First Name, MI) | Date of Birth (mmddyyyy)

B. Information About the Deceased

Deceased Name (Last Name, Suffix, First Name, MI)

Deceased Social Security Number | Deceased Date of Birth (mmddyyyy) | Date of Death (mmddyyyy)

Relationship to the Employee ☐ Self ☐ Spouse ☐ Civil Union Partner ☐ Domestic Partner ☐ Child

C. Information About the Accident

Date of the accident (mmddyyyy) | Time of accident:

Where did the accident happen?

Describe how the accident happened

D. Information About the Responding Authorities

Names of Public Agencies (Fire Dept., Police Dept., EMS, etc.)	Telephone Number
Names of Public Agencies (Fire Dept., Police Dept., EMS, etc.)	Telephone Number
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E. Information About Physicians/Hospitals

Please provide the following information about all the physicians/hospitals who attended the deceased for injuries sustained in this accident. If there were more than three, please share the following information for each additional physician/hospital on a separate sheet of paper and include it with the form.

Physicians/Hospital Name	Mailing address	Telephone

Policy Number

Employer Name

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Accidental Death Statement (Continued)

F. Information About Previous Medical Conditions

Please provide the following information about all physicians who treated the deceased for any medical condition in the last five years. If there were more than five, please share the following information for each additional physician on a separate sheet of paper and include it with this form.

Physician Name, Specialty, Address and Telephone Number	Medical Condition Treated

G. Signature

The above statements are true and complete to the best of my knowledge and belief

Print Name	Telephone Number
Signature	**Date Signed**

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Dismemberment Statement (Please Print)
Please be aware any expensed charged by the physician is the responsibility of the beneficiary.
Please attach copies of any police and/or emergency medical services reports.

ATTENDING PHYSICIAN'S STATEMENT

To be completed by Employee
Patient's Name _____ Date of Birth _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

To be completed by Physician
Type of Injury _____ On what date did you first examine and treat the patient for this injury? _____
Had patient previously had medical attention for this injury? ☐ Yes ☐ No If "Yes," by whom? _____
Describe the injury and its affected body part(s). _____ Date of injury _____

What complications, if any, have arisen?
_____

What surgery was performed?. _____ Date of surgery _____

Name of Surgeon
_____

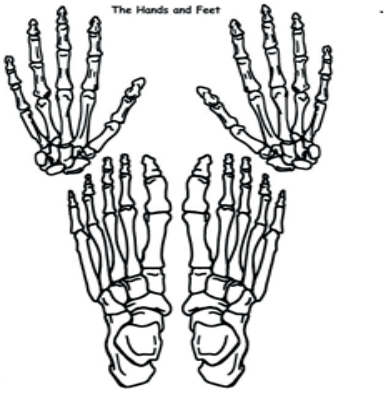
Name and address of Hospital _____ Hospitalized From: _____ To: _____

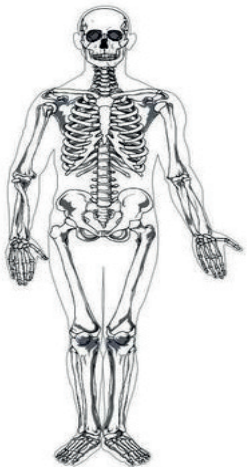
_____

Was the injury described above, of itself, and independent of all other causes, solely responsible for the loss? Yes _____ No _____
If "No", give the particulars of any contributing cause or causes:

_____

Was claimant under the influence of alcohol and/or other drugs at the time of the accident or injury? Yes _____ No _____ Unknown _____
If the injury described above caused an amputation or loss of body usage, is this amputation or loss irrecoverable? Yes _____ No _____
Please indicate location of amputation or area of injury on the chart below:





Add any necessary comments below.

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ATTENDING PHYSICIAN'S STATEMENT (page 2)

Loss of Hearing/Speech or Sight

In your medical opinion, has this patient sustained completed and irrecoverable hearing loss due to an injury? Yes_____ No_____

Right ear_____ Left ear_____ Both ears_____

Please provide copies of auditory test results.

In your medical opinion, has this patient sustained complete and irrecoverable loss of speech due to an injury? Yes_____ No_____

Please provide copies of speech test results.

Please indicate best corrected visual acuity and/or area of injury as of _____ (Date).

Right eye: _____ Corrected _____ Uncorrected

Left eye: _____ Corrected _____ Uncorrected

Physician Name: (please print)

Address: City State Zip

Telephone number: Fax number: Taxpayer's Identification number:

Physician's Signature: Specialty/Degree: Date

Please return the completed form(s) to: Equitable
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