



## Part IV – Premium Payment & Administration

Payor (if not Applicant):

Name

Address

City

State

Zip

**INITIAL** Premium Paid:  Annual  Semi-Annual Requested Effective Date (if other than Application Date)

\$  ,   .   Quarterly  2 months (for MBD)  -  -   (mm-dd-yyyy)

**RENEWAL:**  Direct Bill  Bank Draft (Account Type:  Checking  Savings): **(must include \$35 application fee)**

Bank Routing # (9 digits):  Bank Account # (do not include check #):  Select Bank Draft Day:

Bank Name: \_\_\_\_\_  I authorize Bank Draft payments.

Name(s) of Depositor(s): \_\_\_\_\_

Please include a voided check. The first draft will occur on the premium-due date after the policy has been issued. Subsequent drafts will occur on or shortly following the selected draft day requested above (never before).

## Part V – Alternate Payor (Protection Against Unintended Lapse)

I understand that an Alternate Payor is a person other than myself who will receive notice of lapse or termination of my insurance policy for nonpayment of premium. My Alternate Payor will not be notified until thirty (30) days after a premium is due and unpaid.

I elect NOT to designate an Alternate Payor.  I elect to designate an Alternate Payor, named below.

Last Name

First Name

MI

Phone

 (   ) -   -  

Address

City

State

Zip

## Part VII – Agreement & Acknowledgement

As part of the Application process, Equitable Life & Casualty has certain information that you should review as part of your decision to purchase this policy. Please indicate your receipt of this information:

- Outline of Coverage  If over age 65, a Guide to Health Insurance for People on Medicare  
 Replacement Notice (if applicable)  Notice of Our Information Practices and Privacy Policy  
 Shoppers Guide To Cancer Insurance

I HAVE READ AND FULLY UNDERSTAND the questions and my answers on this Application. To the best of my knowledge and belief they are true and complete. I understand and agree the policy applied for will not take effect until issued by the Company, and that the agent is not authorized to extend, waive or change any terms, conditions or provisions of the policy.

**Caution:** If your answers on this applications are incorrect or untrue, the Company may have the right to deny benefits or rescind your policy. Review your policy carefully.

Signed at (City and State): \_\_\_\_\_

Date:  -  -

Signed Applicant: \_\_\_\_\_

Spouse: \_\_\_\_\_

Witnessed by Agent: \_\_\_\_\_

Send policy to  Applicant  Agent



**Equitable Life & Casualty Insurance Company**  
 3 Triad Center, Salt Lake City, Utah 84180-1200  
**Supplemental Application - Cancer Insurance**

**Part I – Dependent Child Information**

Dependent Child (1 ) Last Name		Given Name (First / Middle)	
<input type="text"/>		<input type="text"/>	
Date of Birth	Age	Gender	
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent Child (2) Last Name		Given Name (First / Middle)	
<input type="text"/>		<input type="text"/>	
Date of Birth	Age	Gender	
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent Child (3) Last Name		Given Name (First / Middle)	
<input type="text"/>		<input type="text"/>	
Date of Birth	Age	Gender	
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	

*(Use additional sheets if needed)*

**Part II – Initial Medical Questions**

***Please answer yes or no and circle the applicable condition to the left.***

	Child (1)		Child (2)		Child (3)	
	Yes	No	Yes	No	Yes	No
In the past 10 years, has any person to be insured had, been diagnosed as having, been advised to seek treatment for, received medication or, or been treated by a medical practitioner for:						
1. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS or AIDS related condition (ARC))?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Leukemia, Hodgkins disease, malignant melanoma, sarcoma, lymphoma, or any internal cancer, or had radiation or chemotherapy for any of these conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the past 24 months, has any person to be insured experienced any symptoms that would have caused a person to seek medical advice from a medical practitioner, or to have or schedule a diagnostic test for any of the conditions listed above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Supplemental Application - Cancer Insurance  
(continued)**

**Part III – Supplemental Application Agreement & Acknowledgement**

I HAVE READ AND FULLY UNDERSTAND the questions and my answers on this Application. To the best of my knowledge and belief they are true and complete. I understand and agree the policy applied for will not take effect until issued by the Company, and that the agent is not authorized to extend, waive or change any terms, conditions or provisions of the policy.

**Caution:** If your answers on this applications are incorrect or untrue, the Company may have the right to deny benefits or rescind your policy. Review your policy carefully.

Signed at (City and State): \_\_\_\_\_ Date:   -   -

Dependent Child 1 Signature (if age 16 or over): \_\_\_\_\_

Dependent Child 2 Signature (if age 16 or over): \_\_\_\_\_

Dependent Child 3 Signature (if age 16 or over): \_\_\_\_\_

Parent's Signature (if dependent is under age 16): \_\_\_\_\_

Witnessed by Agent: \_\_\_\_\_

**EQUITABLE LIFE & CASUALTY  
INSURANCE COMPANY  
3 Triad Center  
Salt Lake City, UT 84180-1200**

**SAVE THIS NOTICE! IT MAY BE IMPORTANT  
TO YOU IN THE FUTURE!**

**NOTICE TO APPLICANT REGARDING REPLACEMENT  
OF ACCIDENT AND SICKNESS INSURANCE**

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Equitable Life & Casualty Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

- (1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.
- (2) You may wish to secure the advice of your present insurer or its agents regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
- (3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

\_\_\_\_\_

Date

\_\_\_\_\_

Agent Name (Print)

\_\_\_\_\_

Applicant's Signature

\_\_\_\_\_

Agent Signature

**EQUITABLE LIFE & CASUALTY  
INSURANCE COMPANY  
3 Triad Center  
Salt Lake City, UT 84180-1200**

**SAVE THIS NOTICE! IT MAY BE IMPORTANT  
TO YOU IN THE FUTURE!**

**NOTICE TO APPLICANT REGARDING REPLACEMENT  
OF ACCIDENT AND SICKNESS INSURANCE**

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Equitable Life & Casualty Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

- (1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.
- (2) You may wish to secure the advice of your present insurer or its agents regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
- (3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

\_\_\_\_\_

Date

\_\_\_\_\_

Agent Name (Print)

\_\_\_\_\_

Applicant's Signature

\_\_\_\_\_

Agent Signature

**Equitable Life & Casualty**  
**3 Triad Center**  
**Salt Lake City, Utah 84180-1200**  
**1-800-352-5150**

**OUTLINE OF COVERAGE**  
**SPECIFIED DISEASE COVERAGE**  
**CANCER POLICY**  
**Policy Form 571**

This IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company.

**(1) THIS POLICY PROVIDES LIMITED BENEFITS.** This is a supplement to health insurance. Benefits provided are supplemental and are not intended to cover all medical expenses. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance.

**(2) PLEASE READ YOUR POLICY CAREFULLY:** This Outline of Coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

**(3) SPECIFIED DISEASE COVERAGE – CANCER ONLY:** Policies of this category are designed to provide coverage for specific losses resulting from cancer. Coverage is provided by the benefits outlined in Section 4, below; the benefits described in Section 4 may be limited by the limitations contained in Section 5.

**(4) BENEFITS PROVIDED UNDER THE POLICY:**

**FIRST OCCURRENCE BENEFIT:** We will pay **\$1000** when a covered person is diagnosed for the first time as having any internal cancer, even when cancer is not diagnosed until after death. This benefit is payable only once for any covered

person. This benefit is NOT payable if you have been diagnosed or treated for internal cancer before your effective date of coverage or prior to satisfying the 30-day eligibility requirement. We will not pay this benefit for skin cancer.

**HOSPITAL CONFINEMENT BENEFIT** (including U.S. Government Hospital): We will pay **\$100** for each of the first 90 days you are confined as an inpatient to a hospital due to cancer. Beginning with the 91st consecutive day, the daily benefit will be **\$250**. A “day” means a 24-hour period. This benefit will be calculated based on the number of days the hospital charges you for room and board. Separate confinements within 30 days of each other are considered the same period of confinement.

**Exception:** If you are confined to a U.S. Government Hospital, we will pay this benefit while you are so confined in lieu of all other benefits with the exception of the First Occurrence and Transportation Benefits, unless you are actually charged and are legally required to pay for such services.

**INPATIENT DRUGS BENEFIT:** We will pay actual charges up to **\$20** each day for drugs administered to you while you are confined as an inpatient in a hospital due to cancer, up to the number of days for which you receive benefits under the Hospital Confinement Benefit. Such drugs, at the time of administration, must be approved by the U.S. Food and Drug Administration. This benefit is not payable for drugs which are paid under the Radiation/Chemotherapy Benefit.

**ATTENDING PHYSICIAN BENEFIT:** We will pay actual charges up to **\$20** each day you use the services of an attending physician while you are confined as an inpatient in a hospital due to cancer, up to the number of days for which you receive benefits under the Hospital Confinement Benefit. An attending physician is a doctor, other than your surgeon, who performs cancer treatment services for you while you are confined and charges you for those services.

**SURGICAL PROCEDURE BENEFIT:** We will pay **\$100 to \$2,000** for your cancer surgery performed by a doctor based on the Surgical Schedule in your Policy, including surgical biopsies resulting in a pathological diagnosis of cancer. We will not pay for diagnostic or follow-up surgery which does not definitively diagnose or treat cancer.

If you have more than one surgical procedure performed at the same time through the same incision, we will pay only for the one surgical procedure performed for which the largest benefit amount in the Surgical Schedule is payable. If you have a surgical procedure performed which is not in the Surgical Schedule, we will pay a benefit amount based on the difficulty of the procedure as compared to the difficulty of the procedures shown. Regardless of the difficulty of the surgical procedures, we will pay no less than the smallest or more than the largest amount shown in the Surgical Schedule for any surgical procedure.

**Breast Reconstruction Surgery:** We will pay for reconstructive breast surgery performed within three years of a mastectomy for which we paid a Surgical Procedure Benefit. We will pay actual charges up to the Surgical Procedure Benefit we paid for the mastectomy.

**ANESTHESIA BENEFIT:** We will pay the actual charge incurred up to **25%** of the amount allowed per person as outlined in the Surgical Schedule.

If you have more than one cancer surgical procedure performed at the same time, we will pay an Anesthesia Benefit only for the one surgical procedure performed for which the largest benefit amount is payable. If anesthesia is administered during a cancer surgical procedure that is not listed in the Surgical Schedule, we will pay a benefit amount equal to **25%** of the amount we pay for such surgery. We will pay no less than **25%** of the smallest and no more than **25%** of the largest amount shown in the Surgical Schedule.

**SECOND AND THIRD SURGICAL OPINION BENEFIT:** We will pay actual charges up to **\$100** for a second surgical opinion if surgery is recom-

mended due to the positive diagnosis of cancer and you choose to obtain a second physician's opinion. If the second opinion fails to confirm the need for the recommended surgery, we will pay for a third physician's opinion. Second or third opinions must be rendered before surgery is performed. The physicians rendering such opinions must not be in practice with or otherwise affiliated with each other or the physician rendering the initial opinion. This benefit is not payable for second or third opinions related to skin cancer treatment.

**BLOOD AND PLASMA BENEFIT:** We will pay **\$40** for each unit of whole blood, plasma, red cells, packed cells or platelets You receive for definitive cancer treatment. We will pay for processing, administration, storage, laboratory charges or blood components replaced by donors.

**RADIATION/CHEMOTHERAPY BENEFIT:** We will pay actual charges up to **\$100** for each day you receive radiation therapy and chemotherapy injected by medical personnel as part of your definitive cancer treatment.

For self-injected medications, medications dispensed by pump or implant or oral chemotherapy, we will pay actual charges up to **\$100** per filled prescription with a monthly maximum of **\$500**.

At the time of administration these treatments must be fully or investigationally approved for the treatment of cancer by the U.S. Food and Drug Administration or the National Cancer Institute, recognized for treatment of the indication in at least one standard reference compendium, or recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in either the United States or Great Britain. These treatments may be performed on an outpatient or inpatient basis. Laser surgery is not considered radiation treatment and will only be paid through the appropriate surgery benefit. Oral chemotherapy taken on an outpatient basis is payable only once per prescription on the date filled. We will not pay for any treatment planning,

treatment management, or any type of laboratory results, x-ray or other imaging used for diagnosis or disease monitoring, or other diagnostic tests related to these treatments. Benefits are not payable for any devices or supplies such as intravenous solutions and needles related to these treatments.

**ANTI-NAUSEA MEDICATION BENEFIT:** We will pay actual charges up to **\$50** each calendar month for anti-nausea drugs prescribed by a doctor while receiving radiation or chemotherapy for the treatment of cancer.

**BREAST PROSTHESIS BENEFIT (SURGICAL AND NON-SURGICAL):** We will pay actual charges up to **\$1,000** for each surgically implanted breast prostheses. Non-surgically implanted breast prostheses are limited to the actual charges up to **\$250** lifetime maximum for each covered person. All prostheses must be prescribed by a doctor and obtained within three years of the date of the cancer surgery or treatment for which we paid a benefit under the Policy.

**AMBULANCE BENEFIT:** We will pay actual charges up to **\$50** for each confinement to a hospital due to cancer. Any air ambulance service must be necessary to protect your health and safety when other reasonable and customary travel methods are not available.

Separate confinements within 30 days of each other are considered the same period of confinement.

**TRANSPORTATION BENEFIT:** We will pay actual charges up to **\$250** for each confinement for one-way trip for your coach class plane, train or bus fare for travel within the U.S. more than 100 miles one-way from your residence to receive definitive cancer treatments prescribed by your local physician that are not available within 100 miles one-way from your residence, or for consultation at a Comprehensive or Clinical Cancer Center as recognized by the National Cancer Institute. This benefit pays for an unlimited number of trips.

**HOSPICE BENEFIT:** We will pay **\$50** each day you receive inpatient Hospice care due to cancer. You must be diagnosed as terminally ill, no longer be receiving definitive cancer treatment, and be expected to live six months or less.

We will not pay this benefit for any day you are confined to a Hospital or a skilled nursing/extended care facility. This benefit is in lieu of all other benefits of the policy.

### (5) LIMITATIONS AND EXCLUSIONS

Subject to the 30-day eligibility period, your Policy provides benefits only for loss due to cancer and definitive cancer treatment.

Benefits are not payable for:

- Any other disease, sickness or incapacity, even if the disease or condition was caused, complicated or aggravated by Cancer or Cancer treatment;
- Losses occurring before or during the 30-day eligibility period;
- Losses occurring while the Policy is not in force; or,
- If any Cancer is diagnosed during the first 30 days after Your Effective Date of coverage, We will only pay benefits for Loss due to Cancer commencing 12 months after Your Effective Date of coverage.

Cancer must be pathologically diagnosed; however, we will accept a clinical diagnosis when a pathological diagnosis is detrimental to your health.

Hospitalization for cancer must begin at least 30 days after your effective date of coverage. If cancer is first diagnosed while you are hospitalized, you will be eligible for benefits retroactively to the date you were admitted to the hospital, but not for more than 30 days prior to the date of diagnosis. If skin cancer is diagnosed while you are hospitalized, you will be eligible for benefits only for the day(s) you actually received treatment for skin cancer. If cancer is not diagnosed until after you die, you will be eligible for benefits beginning on the date of admission for a period of continuous

## Outline of Coverage

hospitalization ending in your death, but not for more than 30 days prior to the date of your death. A "hospital" is not a bed, unit or a facility that functions as: a skilled nursing facility; a nursing home; an extended care facility; a convalescent home; a rest home or a home for the aged; a sanatorium; a rehabilitation center; a place primarily providing care for alcoholics or drug addicts; or a facility for the care and treatment of mental diseases or mental disorders.

**(6) SUMMARY OF CLAIMS DETERMINATION PROCESS:** As provided for in the Eligibility for Benefits and the Limitations and Exclusions sections of your Policy, the following steps are taken in order to determine eligibility under any claim filed:

1. determine when the claim was incurred, and whether the loss is covered by the Policy. This step may require the collection of medical records, a death certificate, autopsy findings from a medical examiner or coroner, and information regarding medical history from physicians, hospitals, other insurance companies, government agencies and medical records copying services.
2. determine if the claim was incurred at a time when your coverage was in force, and not during the eligibility period or during a lapse in coverage.
3. determine if any Policy exclusions exist for the claim.

**(7) RENEWABILITY OF THIS POLICY:** The Policy is continuously renewed during the Insured's lifetime by the payment of premiums when due or within the grace period.

**(8) PREMIUM:** Your initial premium depends on the optional benefits you selected. We will not change the premium for your policy during your first year of coverage. Thereafter, we reserve the right to change premium rates for all policies of the same class.

We will notify you in writing at least 60 days before any premium change.

Annual Premium for Basic Policy \$ \_\_\_\_\_

Premium for optional  
Return of Premium Rider \$ \_\_\_\_\_

**Total Annual Premium** \$ \_\_\_\_\_

### **(9) OPTIONAL RIDERS AVAILABLE:**

#### RETURN OF PREMIUM BENEFIT:

The company will return a percentage of premiums paid under the following circumstances:

1. If the policy lapses, for any reason, after the end of the 15th policy anniversary, 80% of premiums, minus any claims paid, will be returned; or
2. If the insured dies after the 5th policy anniversary and before the 15th policy anniversary, 50% of the premiums, minus any claims paid, will be returned.

THIS OUTLINE OF COVERAGE IS A BRIEF SUMMARY OF THE BENEFITS PROVIDED. PLEASE CONSULT THE POLICY TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

PLEASE RETAIN THIS OUTLINE OF COVERAGE FOR YOUR RECORDS.

## NOTICE OF OUR INFORMATION PRACTICES AND PRIVACY POLICY

With your application for insurance we receive personal information about you. You also authorized us to collect your health information. We keep and protect all such information as confidential and do not disclose it to any other persons, entities or organizations unless authorized by you in writing or as allowed or required by law.

### Information We Collect And Receive

Personal information we receive about you comes directly from you, such as your name, address, birth date, Social Security number, telephone number, or e-mail address. Health (medical) information about you comes from you and your health care providers (doctors, clinics, hospitals, laboratories, etc.) based on your written Authorization. We may also review information about you on file with the MIB Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members.

### What We Do With This Information

Your personal information is entered in our system to identify you as our customer. Other uses of your personal and health information include underwriting your application for insurance and assisting you in a claim for benefits. Your Equitable agent, as our business associate, may have access to your health information during the underwriting process, as authorized by you, and access to your personal information for assistance with your insurance needs.

Under our established procedures, if upon the consideration of your medical information we determine you do not meet our underwriting guidelines for the issuance of a policy, the medical reason(s) for a declination of coverage may be disclosed to the person or entity (usually your doctor) who maintains your medical information. Your doctor can then discuss with you, through a private consultation, the medical reason(s) for our decision.

### How We Protect This Information

Our employees and agents are required to keep your personal and health information confidential. Our intention is to request or access only the minimum amount of information necessary. We maintain all your personal or health information in a secured database, with security and procedural measures in place, in compliance with federal law, to safeguard your protected information and alert us if and when unauthorized access is attempted.

We do not disclose your personal or health information with any nonaffiliated third party (person, entity or organization) without your written permission, unless allowed or required by law. Under no circumstances will any information be disclosed to any nonaffiliated party for marketing purposes, such as telemarketing, direct mail or electronic mail marketing.

### How You Can Access This Information

Write to us and request copies of the personal information we have about you in our records. You can also find out who we have disclosed this information to and for what reason. If you believe any personal or health information we have about you is incomplete, inaccurate or incorrect, you have the right to request that we correct or delete it. If your request concerns health information we received from a doctor, hospital or other medical provider, we will refer you to that person or entity. You may, in a private consultation with them, have the necessary corrections made to your health information and sent to us.

### The MIB Inc.

Information regarding your insurability will be treated as confidential. Equitable Life & Casualty Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB, toll free, at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Equitable Life & Casualty Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

If you have any questions about this Notice, we can be contacted at:

**Equitable Life & Casualty Insurance Company**  
**3 Triad Center, Salt Lake City, UT 84180-1200**  
**ATTN: Privacy Officer**  
Telephone (toll free): 1-800-352-5150

**Leave with Applicant**