

### Part I – Personal Information

Title:  Mr.  Mrs.  Miss  Ms.  Other \_\_\_\_\_

Applicant Last Name  First Name / Middle Name

Birthdate (mm/dd/yyyy)  Age  yrs Social Security Number  Gender  Male  Female

Street Address

City  State  Zip

Daytime Phone: (  ) -  -  Evening Phone: (  ) -  -

### Part II – Policy Information

Face Amount \$  ,

Level Benefit (*Legacy I*)  Increasing Benefit (Graded) (*Legacy II*)

Accidental Death Rider  Return Of Premium Benefit (Modified) (*Legacy III*)

Nursing Home Waiver of Premium Rider

Will this policy replace an existing life insurance policy or annuity (if yes, complete Replacement Notice)?  Yes  No

In the past 12 months, have you smoked cigarettes or used any other tobacco products?  Yes  No

### Part III – Beneficiary Designation

Primary Beneficiary  Relationship to Applicant

Street Address

City  State  Zip

Contingent Beneficiary  Relationship to Applicant

Street Address

City  State  Zip

Owner, if other than Applicant  Relationship to Applicant

Street Address

City  State  Zip

## Part IV – Alternate Payor

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

- I elect NOT to designate an additional person to receive notification.
- I elect to designate an additional person.

First Name - MI - Last Name

Phone

Address

City

State

Zip

## Part V – Premium Payment & Administration

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

\$ ,. -- (mm-dd-yyyy)

**RENEWAL:**  Direct Bill

Bank Draft Account Type:  Checking  Savings

**Mode:**  Annual  Semi-Annual  Quarterly  Monthly Bank Draft

I authorize Bank Draft payments.

Bank Routing # (9 digits):

Bank Account # (do not include check #):

Select Draft Date:

Bank Name: \_\_\_\_\_

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).

Payor if not Applicant:  List Bill  Other \_\_\_\_\_

Name

Address

City

State

Zip

**Automatic Policy Loan:**

Yes  No

**Payment Plan:**

Single Pay

10-Pay

Continuous

## Part VI – Agreement & Acknowledgement

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

- Life Buyers Guide
- Replacement Notice, if applicable
- Notice of Information Practices and Privacy Policy

I 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 the Company will conduct a telephone interview with me regarding the answers. 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 application are incorrect or untrue, the Company has the right to deny benefits or rescind your policy.

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

Signed Applicant: \_\_\_\_\_ Owner (if not applicant) \_\_\_\_\_

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

Send policy to:  Applicant  Agent

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## Part VII – Agent Supplement

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <b>Yes</b>               | <b>No</b>                | <b>All questions must be completed.</b>  |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Did you personally interview the applicant and witness all signatures?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. State the name and relationship of any other person present when this application was taken.<br>Name _____ Relationship _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Did you review the application for correctness and any omissions?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Did the applicant(s) review the application for correctness and any omissions?  |

Agent #1 Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent #2 Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent #1 Name (please print)	Agent #	Split %
<input type="text"/>	<input type="text"/>	<input type="text"/>

Agent #2 Name (please print)	Agent #	Split %
<input type="text"/>	<input type="text"/>	<input type="text"/>

## Agent Checklist

The following Checklist is intended as a helpful reminder to you of the Forms to be submitted with an Application. Applications submitted without ALL required Forms delay the underwriting process until the Forms are submitted. *Forms to be submitted to the Home Office are marked "Return to Company" and have a bar code in the middle bottom area. All forms to be left with the Applicant are marked "Leave with Applicant" in the middle bottom.*

### Forms for the Home Office

Please print clearly.

- Application** (A-LF 07) — *All* Sections must be completed
- Health Information Authorization** (HHA-04) — for the release of health information
- Replacement Notice** (LRN-(01)) — complete both Notices - when not a replacement case, destroy both forms

### Forms for the Applicant

- Notice of Information Practices & Privacy Policy
- Receipt
- Replacement Notice (if needed) (LRN-(01))

### Other Items to Remember

Additional Forms can be ordered by calling 1-800-352-5125 or by visiting our exclusive agent website: [www.EquiLine.com](http://www.EquiLine.com).

## DISCLOSURE STATEMENT REGARDING ACCELERATED DEATH BENEFITS

### USE IN FOLLOWING STATES: AL, AZ, AR, IL, OH, OR

This policy contains an accelerated death benefit. Upon written certification of the insured's physician that the life expectancy of the insured is 12 months or less, with such written certification accepted by us, we will pay a lump sum equal to the face amount of the policy adjusted to present value, minus any indebtedness.

Upon the payment of the accelerated death benefit the policy will end. Accelerated death benefits do not include any accidental death benefits. An administrative expense of no more than \$150 may be charged at the time this benefit is requested. You are advised to review your policy for all the specific conditions regarding the accelerated death benefit.

Any cash values, loan values and the death benefits of this policy will be reduced if you receive accelerated death benefits. The payment of accelerated death benefits may be taxable. You should seek the advice of a personal tax advisor to make that determination.

You will receive a benefit payment notice upon the payment of Accelerated Death Benefits.

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Agent

\_\_\_\_\_  
Agent #

DS-ADB

Return to Company

# Health Information Authorization

This Authorization complies with the HIPAA Privacy Rule

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided services, treatment or payment to me, or on my behalf, within the past 10 years ("My Providers"), or consumer reporting agency, or the Medical Information Bureau, to disclose my entire medical record and any other protected health information concerning me to Equitable Life & Casualty Insurance Company ("Equitable") and its agents, employees and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

**My protected health information is to be disclosed under this Authorization so that Equitable may:** **1)** underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; **2)** obtain reinsurance; **3)** administer claims and determine or fulfill their responsibility for coverage and provision of benefits; **4)** administer coverage; and **5)** conduct other legally permissible activities that relate to any coverage I have or have applied for with Equitable.

For a period of 120 days from the date of this Authorization I authorize my Equitable Agent to receive certain protected health information about me that is related to an adverse underwriting decision or counteroffer for alternative coverage made during the underwriting of my application.

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to: **Equitable at 3 Triad Center, Salt Lake City, Utah 84180, Attention: Privacy Officer.** I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Equitable has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Equitable may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I will receive a copy of this authorization.

_____	_____
Name of Applicant (please print)	Signature of Applicant or Personal Representative
_____	_____
Date of Birth	Date
_____	
Description of Personal Representative's Authority or Relationship to Applicant (if applicable)	

**IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

Equitable Life & Casualty Insurance Company  
3 Triad Center, Salt Lake City, UT 84180-1200

**REPLACING YOUR LIFE INSURANCE POLICY?**

Are you thinking about buying a new policy and discontinuing or changing an existing policy? If you are, your decision could be a good one - or a mistake. You will not know for sure unless you make a careful comparison of your existing policy and the proposed policy.

Make sure you understand the facts. Georgia law gives you the right to obtain a policy summary statement from your existing insurer at any time. Ask the company or agent that sold you your existing policy to give you information about it.

The reverse side contains a check list of some of the items you should consider in making your decision. TAKE TIME TO READ IT.

Do not let one agent or insurer prevent you from obtaining information from another agent or insurer which may be to your advantage.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

If you wish a policy summary statement from your existing insurer, or insurers, check this box.

We are required to notify your existing company that you may be replacing their policy.

	INSURER NAME	CONTRACT OR POLICY NUMBER	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Applicant's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Address

\_\_\_\_\_  
Agent Address, Telephone No. and License Number

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Agent's Signature

\_\_\_\_\_  
Agent's Printed Name

\_\_\_\_\_  
Date

**ITEMS TO CONSIDER**

1. If the policy coverages are basically similar, premiums for a new policy may be higher because rates increase as your age increases.
2. Cash values and dividends, if any, may grow slower under a new policy initially because of the initial costs of issuing a policy.
3. Your present insurance company may be able to make a change on terms which may be more favorable than if you replace existing insurance with new insurance.
4. If you borrow against an existing policy to pay premiums on a new policy, death benefits payable under your existing policy will be reduced by the amount of any unpaid loan, including unpaid interest.
5. Current interest rates are not guaranteed. Guaranteed interest rates are usually considerably lower than current rates. What rates are guaranteed?
6. Are premiums guaranteed or subject to change--up or down?
7. Participating policies pay dividends that may materially reduce the cost of insurance over the life of the contract. Dividends, however, are not guaranteed.
8. **CAUTION**, you are urged not to take action to terminate, assign, or alter your existing life insurance coverage until after you have been issued the new policy, examined it and have found it to be acceptable to you.

and

**REMEMBER**, you have thirty (30) days following receipt of this individual life insurance policy to examine its contents. If you are not satisfied with it for any reason, you have the right to return it to the insurer at its home or branch office or to the agent through whom it was purchased, for a full refund of premium.

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1.				
2.				
3.				

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Applicant's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Address

\_\_\_\_\_  
Agent Address, Telephone No. and License Number

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Agent's Signature

\_\_\_\_\_  
Agent's Printed Name

\_\_\_\_\_  
Date

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## 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**

## Receipt

# Receipt

*Please Note: All premium checks must be made payable to Equitable Life & Casualty Insurance Company. Do not make checks payable to the insurance agent or leave the payee line blank.*

Received from \_\_\_\_\_  
the sum of \$ \_\_\_\_\_ for \_\_\_\_\_ months premium, with this application. If for any reason the application is not approved and the policy is not issued, this premium is to be refunded. No liability is created or assumed by the Company, except for refund of this premium, until the policy applied for has been issued.

Dated \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_  
*Agent's Signature*

Equitable Life & Casualty Insurance Company, 3 Triad Center, Salt Lake City, UT 84180-1200

