Ins-Special, Inc
7505 State Hwy 37 / PO Box 218
Purdy MO 65734
800-789-0182
www.insspecial.com

Equitable Life & Casualty Insurance Company
3 Triad Center, Salt Lake City, Utah 84180
Application - Short Term Nursing Home Policy

☐ New Business
☐ Coverage Change

Part I – Personal Information

Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other ________

Last Name First Name MI

Birthdate (mm/dd/yyyy) Social Security Number Age: Height ft in Weight lbs Gender ☐ Female ☐ Male

Street Address

Joint Discount: ☐ Yes ☐ No

City State Zip

Policyowner Discount Name ____________

Daytime Phone: ( ) - -

Evening Phone: ( ) - -

Best Time to Call: ____________

E-Mail Address: ____________

Will this Policy replace an existing Accident and Health insurance policy? ☐ Yes ☐ No (If yes, complete a replacement notice)

Company	Type of Policy	Policy Number

DOCTOR LAST SEEN

Dr. Name (Last) First / Middle

Street Address

City State Zip

1

Part II Benefits Selection

Daily Amount
$ ($50 up to $300 in $10 increments)

Benefit Period
☐ 100 days
☐ 150 days
☐ 200 days
☐ 250 days
☐ 300 day
☐ 350 days

Waiting Periods
☐ 0 Day
☐ 30 Days
☐ 90 Days

Part III – Alternate Payor

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.

Alternate Payor – (First Name - MI - Last Name)

Address

City State Zip

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Part IV Premium Payment & Administration

Payor (if not Applicant): ☐ List Bill ☐ Other ____________

Name

Address

City State Zip

Payor's Signature ____________

INITIAL Premium Paid: **(must include $20 application fee)**

$ __,___.__ ☐ _____ Months

OR ☐ Draft Initial Premium

Requested Effective Date
(if other than Application Date)
__-__-____ (mm-dd-yyyy)

RENEWAL: ☐ Direct Bill ☐ Bank Draft (Account Type: ☐ Checking ☐ Savings):

PREMIUM Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly Bank Draft

Bank Routing # (9 digits): Bank Account # (do not include check #): Select Bank Draft Day: (1st -28th)

Bank Name: ____________ ☐ I authorize Bank Draft Payments

Name(s) of Depositor(s): ____________

If paying premium by Bank Draft, please include a voided check. The first draft will occur on the date your application is received by Equitable Lilfe & Casualty. Subsequent drafts will occur on or shortly following the selected draft day requested above (never before).

Part V 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
- ☐ Replacement Notice (if applicable)
- ☐ Notice of Our Information Practices and Privacy Policy
- ☐ If over age 65, a Guide to Health Insurance for People on Medicare

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 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: ____________ Send policy to: ☐ Applicant ☐ Agent

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Agent Supplement

All questions must be completed.

Yes	No	
☐	☐	1. Did you personally interview the applicant?
		2. State the name and relationship of any other person present when this application was taken. Name ______ Relationship ______
☐	☐	3. Did you review the application for correctness and any omissions?
☐	☐	4. Did the applicant review the application for correctness and any omissions?

Agent #1 Signature ______ Date ______

Agent #2 Signature ______ Date ______

Agent #1 Name (please print) ______ Agent # ______ Split % ______

Agent #2 Name (please print) ______ Agent # ______ Split % ______

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.*

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Forms for the Home Office

- ☐ **Application** (A-790) — *All* Sections must be completed
- ☐ **Health Information Authorization** (HHA-04) — for the release of health information
- ☐ **Replacement Notice** (RN-30) — complete both Notices

Forms for the Applicant

- ☐ Health Information Authorization(HHA-04)
- ☐ Outline of Coverage (OLC 790 MO (Rev))
- ☐ MDN-790
- ☐ Replacement Notice (if needed) (RN-30)
- ☐ Receipt

Other Items to Remember

Applicants age 65 or older receive the **Guide to Health Insurance for People with Medicare.** *Additional Forms can be ordered by calling 1-800-352-5125 or by visiting our exclusive producers website: www.EquiLine.com.*

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Health Information Authorization (Applicant)

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.

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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 have received 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)

Initial Medical Questions - Agent Use ONLY

Please check "Yes" or "No" beside each question. If the answer to any question is "Yes", a policy cannot be issued.	**Yes**	**No**
1. Do you require supervision or assistance with activities of daily living such as walking, eating, bathing, dressing, toileting, moving into or out of a bed or chair or with taking medication?	☐	☐
2. Do you use a walker, wheelchair, quad cane, motorized personal transport, chair lift or oxygen?	☐	☐
3. Have you ever had an organ transplant (other than corneal) or a defibrillator implanted?	☐	☐
4. In the past 12 months, have you been confined in a hospital or had heart surgery including bypass, angioplasty, stent placement or heart valve surgery?	☐	☐
5. In the past two years:		
a. Has a medical professional scheduled or advised you to have surgery requiring general anesthesia, or undergo testing and you have not done so?	☐	☐
b. Have you resided or been advised to reside in a Nursing Home or Assisted Living Facility?	☐	☐
c. Have you received or been medically advised to receive Home Health Care or Adult Day Care services?	☐	☐
d. Have you had a balance disorder or difficulty walking?	☐	☐
6. In the past two years, have you had, been diagnosed, received treatment or taken medication for any of the following conditions?		
a. Alzheimer's disease, dementia or memory loss	☐	☐
b. Acquired Immune Deficiency Syndrome (AIDS) or HIV positive	☐	☐
c. Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis, Muscular Dystrophy, Parkinson's disease or myasthenia gravis	☐	☐
d. Psychosis or Schizophrenia	☐	☐
e. Diabetes with complications such as retinopathy (eye disease) neuropathy (numbness/tingling in hands or feet) or kidney failure	☐	☐
f. Internal cancer, leukemia, lymphoma or melanoma	☐	☐
g. Osteoporosis with related fracture(s)	☐	☐
h. Systemic lupus, kidney failure, cirrhosis of the liver or hydrocephalus	☐	☐
i. Stroke or cerebrovascular accident (CVA), TIA, congestive heart failure or atrial fibrillation	☐	☐
j. Amputation due to disease	☐	☐

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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

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RN-30

Return to Company

7900020001

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

____________________ Date

____________________ Agent Name (Print)

____________________ Applicant's Signature

____________________ Agent Signature

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RN-30

OUTLINE OF COVERAGE
LIMITED BENEFIT HEALTH COVERAGE
SHORT STAY NURSING HOME BENEFITS
Policy Form 790

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. **THIS IS NOT A LONG TERM CARE INSURANCE POLICY.**

(1) 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!**

(2) LIMITED BENEFIT HEALTH COVERAGE: Limited Benefit Health Coverage is designed to provide, to persons insured, limited or supplemental coverage. The policy benefits are outlined in Section 3 below; the benefits described in Section 3 may be limited by the limitations contained in Section 5.

(3) BENEFITS PROVIDED UNDER THE POLICY:
NURSING HOME BENEFITS: We will pay you the Daily Amount you selected for each day of your stay in a Nursing Home when you are determined to be eligible for benefits (see Eligibility for Benefits).

We will pay Nursing Home Benefits up to the Maximum Benefit Period. Payment of benefits is subject to the Waiting Period and to all provisions of the policy. This benefit is subject to the Waiting Period and the Maximum Benefit Period.

BENEFITS DUE TO COGNITIVE IMPAIRMENT: We will pay benefits to you for Nursing Home stays when you are eligible for benefits due to Cognitive Impairment, such as Parkinson's disease, Alzheimer's disease, dementia, or biologically based brain diseases and serious mental illnesses.

ALTERNATE CARE: We may agree to pay benefits for Nursing Care Services provided in facilities not specifically covered in the policy. These benefits may be payable when they are in lieu of services provided in facilities covered in the policy that are unavailable to you and are a cost effective alternative appropriate for your needs. Alternate Care benefits are subject to your Waiting Period, if any; and Maximum Benefit Period. Our approval of Alternate Care is required before benefits are payable.

ELIGIBILITY FOR BENEFITS: You are eligible for benefits under the policy when we receive Eligibility Documentation which establishes that:

a) Your stay in a Nursing Home is reasonable and necessary because you cannot perform, without the Hands-on Assistance of another person, two (2) or more of the Activities of Daily Living (ADL's), or
b) Your stay in a Nursing Home is reasonable and necessary due to your Cognitive Impairment.

In addition to our receipt of the Eligibility Documentation, benefits will be payable only when:

a) Your stay in a Nursing Home begins while the policy is in force; and
b) You receive Nursing Care Services.

ELIGIBILITY DOCUMENTATION:
MDS: If the Nursing Home in which you reside is a Medicare or Medicaid certified Nursing Home or is required by state law to use the Comprehensive MDS Assessment, we must be provided with a completed Comprehensive MDS Assessment verifying your eligibility for benefits under the policy. A Comprehensive MDS Assessment will be completed by the Nursing Home staff within the initial fourteen (14) days of your stay.

ASSESSMENT AT OUR EXPENSE: If the Nursing Home in which you reside is not a Medicare or Medicaid Certified Nursing Home and is not required by state law to use the Comprehensive MDS Assessment, we must be provided with a written Assessment verifying your eligibility for benefits. We will pay all costs associ-

ated with the performance of the Assessment by an Assessment Provider.

ASSESSMENT AT YOUR EXPENSE:. At your option, you may have an Assessment completed prior to your stay in any Nursing Home. If you choose to receive such an Assessment, you will be responsible for all costs associated with the performance of the Assessment.

BENEFIT LEVELS:
The daily amounts, maximum benefit periods and waiting periods available with the policy are as follows:

Daily Amounts: You may select a daily amount from $50 to $300 in $10 increments.
Maximum Benefit Periods: You may select a maximum benefit period of 100, 150, 200, 250, 300 or 350 days.
Waiting Periods: You may select a waiting period of 0, 30 or 90 days.

(4) IMPORTANT DEFINITIONS:
ACTIVITIES OF DAILY LIVING (ADLs): Means, for the purpose of benefit determination:

a) Bathing – Your ability to wash yourself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower. It does not include only washing your hair or back.
b) Continence – Your ability to maintain control of bowel and bladder function; or when you are unable to maintain control of bowel or bladder function, your ability to perform associated personal hygiene, including caring for a catheter or a colostomy bag.
c) Dressing – Your ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.
d) Eating – Your ability to feed yourself by getting food into your body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously. It does not include meal preparation or setup.
e) Toileting – Your ability to get to and from the toilet, to get on and off the toilet, and to perform associated personal hygiene.
f) Transferring – Your ability to move into or out of a bed, a chair or a wheelchair. It does not include the task of getting into or out of a tub or shower.

ASSESSMENT: Means a comprehensive, written evaluation done to determine if, or verify that, you are unable to perform two (2) or more ADLs or you are cognitively impaired. The Assessment includes generally accepted tests and instruments that use objective measures and produce verifiable results that will determine if you are eligible for benefits under the policy.

ASSESSMENT PROVIDER: Means an agency, entity or a person designated and approved by Us that performs Assessments. Assessment Providers are Licensed Health Care Practitioners trained to perform Assessments.

COGNITIVE IMPAIRMENT: Means the deterioration or loss of your intellectual or mental capacity, as determined by clinical tests and evidence, resulting in your need for continual assistance or supervision by another person to properly care for yourself.

COMPREHENSIVE MINIMUM DATA SET (MDS) ASSESSMENT: Means the clinical assessment, developed for the U.S. Centers for Medicare & Medicaid Services (CMS), which requires the Full Minimum Data Set (MDS), Resident Assessment Protocols (RAPs) Utilization Guidelines and Care Plan, as defined by CMS, for all residents of Medicare or Medicaid certified Nursing Homes. Comprehensive MDS Assessments include all required MDS items (including State-designated sections), RAPs, and documentation in accordance with the Utilization Guidelines.

LICENSED HEALTH CARE PRACTITIONER: Means a physician (as defined in Sec. 1861(r)(1) of the Social Security Act), a registered professional nurse or a licensed social worker. A Licensed Health Care Practitioner may not be related to you by blood, adoption or marriage, nor may he or she be the proprietor of a Nursing Home.

MAXIMUM BENEFIT PERIOD: Means the maximum number of days for which we will pay benefits under the policy. Your Maximum Benefit Period is shown in the policy schedule.

MEDICARE: Means the federal program for health care reimbursement established under Title XVIII of The Social Security Act, as amended.

NURSING CARE SERVICES: Means those services which are performed under orders of a doctor for the purpose of meeting either the medical or personal care needs of the person residing in a Nursing Home, and are performed at the direction and under the supervision of a licensed registered or practical nurse.

NURSING HOME: Means a place which is a separate facility or distinct part of a health care facility which is licensed as a nursing home, is operated pursuant to law, provides continuous accommodations to persons who require daily Nursing Care Services, and maintains records of each patient or resident.

A Nursing Home does NOT include the following places or facilities:

a) a hospital;
b) an assisted living facility;
c) an adult foster home;
d) an Alzheimer's care facility or unit;
e) a residential care facility;
f) a personal care facility;
g) a hospice facility;
h) a sanatorium;
i) a place primarily providing care for alcoholism or substance abuse;
j) a place primarily providing care and treatment of mental disease or mental disorders;
k) a home for the aged, a rest home, a community living center, or a place that primarily provides domiciliary custodial. retirement or educational care;
l) a continuing care retirement community, an independent living unit, an apartment or your home; or
m) any other facility or entity not licensed as a nursing home in your state of residence.

PERIOD OF CARE: Means a period of time that begins with the first day benefits are payable, subject to the Waiting Period, if any, for a stay in a Nursing Home and ends on the last day of a stay in a Nursing Home. For the purpose of applying the Waiting Period, any two periods of care separated by less than 6 consecutive months will be considered to be one Period of Care.

WAITING PERIOD: Means the number of consecutive days of a stay in a Nursing Home required in each Period of Care before benefits are payable. Your Waiting Period is shown in the policy schedule.

(5) LIMITATIONS AND EXCLUSIONS:
The policy does not cover any loss:

a) Resulting from war or an act of war, whether declared or undeclared;
b) Occurring outside the territorial limits of the United States or its possessions;
c) Due to alcohol or drug use, except as ordered by a doctor;
d) For any stay in a U.S. government facility, where there is no charge to you;
e) Caused by a self-inflicted injury or attempted suicide, whether you are sane; or
f) For any stay in an assisted living facility, assisted living residence, or any other facility which is not a Nursing Home as defined in the policy.

(6) GUARANTEED RENEWABILITY OF THE POLICY: You have the right to continue your policy as long as you pay your premiums when due.

(7) PREMIUM: Total annual premium for your policy is __________. 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 at least 31 days before any premium change.

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.

3 Triad Center
Salt Lake City, Utah 84180

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before you Buy This Insurance

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

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 reinsureres 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, Massachusetts 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