Group Employee Benefits Enrollment Form/Change Form

Regular Mail:
Equitable Employee Benefits Group
P.O. Box 1507
Secaucus, NJ 07096

Express Mail:
Equitable Employee Benefits Group
500 Plaza Drive, 6th Floor
Secaucus, NJ 07094

EQUITABLE

For Assistance Call (866) 274-9887
Email: EBCustomerservice@Equitable.com

Equitable Financial Life Insurance Company
Equitable Financial Life Insurance Company of America

SECTION 1. PROPOSED INSURED INFORMATION - PLEASE PRINT USING DARK INK

Employer Name and Address (ABC Company, Inc.)					
Group Number#	Class#	Subsidiary/Division/Dept/Loc#	Effective Date (subject to underwriting approval as needed)		
Employee Name *(First, MI, Last)*	Social Security Number (SSN)	◯ Male ◯ Female	◯ Single ◯ Married**	Date of Birth (DOB) *(mm/dd/yyyy)*	
Home Address (123 Any Street)	City (Anytown)	State (US)	Zip (12345)	County	Worksite Zip
Job Title	Annual Salary	Hours Per Week	◯ Salaried ◯ Hourly	Employment/Rehire Date	

Status Change

◯ New Enrollee
◯ Late Enrollee –
Reason:_____
◯ Change in Marital** Status/Date_____

◯ New Retiree
◯ Add/Remove Dependent(s)/ Date_____
◯ Other/ Date_____/ Date_____

COVERAGES ELECTED

The following coverages are only available if your Employer offers them. Please check the applicable insurance coverage(s) you are electing.
NOTE: If you are declining coverage offered by your Employer, please complete the Employee Waiver of Insurance section of this form .

SECTION 2. COMPLETE THIS SECTION IF APPLYING FOR LIFE - PLAN DESIGN COVERAGE OPTIONS

☐ Basic Life/AD&D
☐ Basic Dependent Life/AD&D-Spouse**
☐ Basic Dependent Life/AD&D-Child(ren)
☐ Waive*

☐ Voluntary Supplemental Life/AD&D – Enter Amount Requested
$ _____
☐ Voluntary Supplemental Life/AD&D -Spouse** – Enter Amount Requested
$ _____
☐ Voluntary Supplemental Life/AD&D -Child(ren) – Enter Amount Requested
$ _____
☐ Waive*

- Waivers are not allowed for non-contributory coverage.
- *** Note: Spouse includes the Proposed Insured's legally married spouse, or civil union partner or domestic partner if legally recognized in the governing jurisdiction*

SECTION 3. COMPLETE THIS SECTION IF APPLYING FOR DISABILITY INSURANCE

☐ Short-Term Disability Amount $_____

☐ Voluntary Short -Term Disability
Enter Amount Requested $_____

☐ Waive*

☐ Long-Term Disability Amount $_____

☐ Voluntary Long -Term Disability
Enter Amount Requested $_____

☐ Waive*

SECTION 4. SPOUSE AND DEPENDENT CHILDREN INFORMATION (COMPLETE IF PROPOSED INSURED IS APPLYING FOR DEPENDENT'S COVERAGE).

Person Proposed for Insurance (first, middle and last name)	Gender	Date of Birth (mm/dd/yyyy)	Social Security Number	Life
Spouse**	○ Male ○ Female			☐
Child	○ Male ○ Female			☐
Child	○ Male ○ Female			☐
Child	○ Male ○ Female			☐
Child	○ Male ○ Female			☐
Child	○ Male ○ Female			☐

SECTION 5. BENEFICIARIES

Indicate your beneficiary designation in the space below. If you need more space, please use another sheet.

(1) If you are married, or, where permitted by law, in a domestic partnership or civil union, a primary beneficiary designation of a person or organization other than your Spouse/partner may not be valid under your state law. Please consult your legal advisor before making such a designation.

(2) You may designate more than one primary or secondary beneficiary. Please be sure to indicate the percentage share that each beneficiaryshould receive. The total within each class – primary and secondary – must equal 100%.

PRIMARY BENEFICIARY(IES) Basic Life / Basic AD&D

Name (Last, First, MI)	Address (Street, City, State, Zip)	Social Security Number	Relationship	% of Benefit

SECONDARY/CONTINGENT BENEFICIARY(IES) Basic Life / Basic AD&D

Name (Last, First, MI)	Address (Street, City, State, Zip)	Social Security Number	Relationship	% of Benefit

PRIMARY BENEFICIARY(IES) Supplemental/Voluntary Life / Supplemental/Voluntary AD&D

Name (Last, First, MI)	Address (Street, City, State, Zip)	Social Security Number	Relationship	% of Benefit

[1] References herein to the "Company" refer to either Equitable Financial Life Insurance Company or Equitable Financial Life Insurance Company of America as the applicable issuing company.

SECONDARY/CONTINGENT BENEFICIARY(IES) Supplemental/Voluntary Life / Supplemental/Voluntary AD&D				
Name (Last, First, MI)	**Address (Street, City, State, Zip)**	**Social Security Number**	**Relationship**	**% of Benefit**

PLEASE NOTE: Equitable does not act or serve as a record keeper or a third party administrator in any capacity in connection with an employee's designation of beneficiaries under any group life insurance policy. Equitable assumes no responsibility for an employee's designation of beneficiaries or the transmission, maintenance or use of such information by the Benefits Administrator, Plan Sponsor or the employee. The Benefits Administrator and Plan Sponsor remain solely responsible for maintaining the Plan's official record of such designation and the accuracy of the information.

SECTION 6. ACKNOWLEDGEMENTS

By signing this Enrollment form, I understand and agree that:

(1) I authorize my Employer to make required deductions, if any, from my salary to pay the premium for my insurance as elected above once ineffect.
(2) All statements and answers I have given are complete and true to the best of my knowledge and belief.
(3) Coverage is not in effect until final approval is given by the Company1.
(4) No person, except an officer of the Company, is authorized to vary or modify a contract.
(5) I have read and acknowledge the applicable fraud warning attached.
(6) I, the undersigned agree that statements and answers in all parts of the enrollment form are true and complete to the best of my knowledge and belief.

SECTION 7. EMPLOYEE WAIVER OF INSURANCE

☐ I have been given the opportunity to apply for the group insurance plan coverage as presented to me, but do **NOT** wish to enroll in the insurance plans offered. Coverage offered by my Employer and not elected in the Insurance Coverage Election portion of this form is assumed to be coverage that I have refused. No waivers are allowed for non-contributory coverage. I understand that if I or my dependents decide to apply for this group insurance plan at a later date, Late entrant penalty and/or Evidence of Insurability will be required at my own expense. The Evidence of Insurability must be approved by the Company.

Sign Here

_____ _____

Signature **Date** **Employee/Applicant**

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FRAUD WARNINGS

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas, Louisiana, New Mexico, Rhode Island, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: Any person who knowingly presents false or fraudulent claim for the 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.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

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. Penalties may include imprisonment, fines or a denial of insurance benefits.

Florida: Any person who knowingly and with an intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Maryland: 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 fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York: Note: Does not apply to Life Insurance. 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.

Ohio: Any person who, with intent to defraud or knowing that he/she 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.

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.

Oregon: Any person who, with intent to defraud or knowing that he/she 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.

Pennsylvania: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or a 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.

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 (5,000) dollars and not more than ten thousand (10,000) dollars, 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.

All Other States: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

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