

Application to Equitable Life & Casualty Insurance Company - Salt Lake City, Utah

Please print the following information for EACH person to be insured:

Policy No. _____

Name	Sex	Date of Birth Mo/Day/Year	Age	Social Security Number
Applicant		/ /		
Spouse		/ /		

Address _____ City _____ State _____ Zip _____

Telephone: (_____) _____ Best Time to Call: _____

Alternate Payor _____ Relationship: _____

Address _____ City _____ State _____ Zip _____

Are you eligible for Medicaid? If Yes, coverage is NOT available: Applicant: Yes No Spouse: Yes No

Duration	Daily Amount	Deductible Period
100 Days <input type="checkbox"/> 150 Days <input type="checkbox"/> 200 Days <input type="checkbox"/> 300 Days <input type="checkbox"/>	\$ _____	20 Days <input type="checkbox"/> 0 Days <input type="checkbox"/>

Mode of Payment: Annual Semi-Annual Quarterly Monthly Bank Draft Total Initial Premium: \$ _____

List other insurance coverage with us and other companies for Nursing Care expenses:

Name of Company	Policy No.	Type of Insurance	Amount of Coverage	Replaced, Cancelled, or Added to

Answer the following "Yes/No" questions: (Note, if the answer to any question is "Yes," a policy cannot be issued to the person to whom such answer applies.)

	Applicant		Spouse	
	Yes	No	Yes	No
1. Do you require assistance or supervision of any kind to perform daily activities such as walking, eating, bathing, dressing, shopping, housekeeping or cooking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have or have you had Parkinson's or Paget's disease, Alzheimer's disease, Multiple Sclerosis, myasthenia gravis, senility, dementia, brain disease or psychosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. During the past TWO YEARS, have you:				
a. Had or been treated for leukemia, Hodgkin's disease, malignant melanoma, internal cancer, cirrhosis of the liver or Systemic Lupus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Had or been treated for stroke, CVA (cerebrovascular accident), TIA (transient ischemic attack), heart attack, heart valve surgery, alcohol or drug related problem, or a condition requiring oxygen at home? .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Been advised to have surgery for joint replacement, or for a disease of the arteries or veins, but have not had such surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Been bedridden, confined to a wheelchair, had an amputation caused by a sickness, or had or been advised to have kidney dialysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Been confined to a nursing facility, received home care or been hospitalized three (3) or more times? .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Had a doctor recommend confinement to a nursing home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 any misstatements as to the health or physical condition of each Applicant that are material to the risk assumed may cause this policy to become null and void within the contestable period. I understand the Company may conduct a telephone interview with each Applicant regarding the answers. I understand and agree the policy applied for will not take effect until issued by the Company. No agent is authorized to extend, waive or change any terms, conditions or provisions of the policy.

I HEREBY AUTHORIZE any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility or other organization, institution or person, including Medical Information Bureau, that has any records or knowledge of the health of each Applicant to give to Equitable Life & Casualty Insurance Company any such information. This authorization and photocopy of it shall be valid for a period of 30 months after the date it is signed.

I have received an Outline of Coverage and, if over age 65, a Medicare Buyers Guide.

Dated at (City and State) _____ this _____ Date of _____ 19 _____

Signed (Applicant) _____ Signed (Spouse, if applying) _____

Signed (Agent) _____ Agent Number _____ Send policy to: Agent Applicant