Equitable Life & Casualty Insurance Company
PO Box 2460, Salt Lake City, Utah 84110
Application - Short Stay Nursing Facility, Assisted Living & Home Care 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 | Weight | 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)

PRIMARY CARE PHYSICIAN

Dr. Name (Last) | First | MI

Street Address

City | State | Zip

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Part II — Benefits Selection

❒ **Comprehensive Policy** ❒ **Facility Only Policy**

Daily Amount	Benefit Period	Waiting Period
$___ ($50 up to $300 in $10 increments)	☐ 100 days ☐ 150 days ☐ 200 days ☐ 250 days ☐ 300 days ☐ 350 days	☐ 0 Day ☐ 15 Days ☐ 30 Days

Optional Benefits

Simple Inflation Protection Benefits Endorsement: Increase Amount: ❒ 3% ❒ None

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

Part IV — Premium Payment & Administration

INITIAL Premium Paid:
$,.

For _____ Months

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

OR ☐ Draft Initial Premium ☐ Draft Immediately ☐ Draft Date -- -- ---- *(must be on or prior to the policy effective date)*

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 approved by Equitable Life & Casualty (unless specified otherwise).

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

Name

Address

☐ I authorize Bank Draft Payments

City State Zip

Payor's Signature _____

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

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?
☐	☐	5.	Will this policy replace any other coverage the applicant currently has in force? (If so, please complete a Replacement Notice.)

Agent #1 Signature_____ Date _____

Agent #2 Signature_____ Date _____

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

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

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 ever use a hospital bed, 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. Have you been diagnosed with a terminal illness which is expected to end your life within the next 12 months?	☐	☐
5. In the past 12 months:		
a. Have you been confined in a hospital, or have you had heart surgery including bypass, angioplasty, stent placement or heart valve surgery?	☐	☐
b. Have you had a balance disorder or have you fallen more than 2 times?	☐	☐
6. 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 received Worker's Compensation, Social Security Disability benefits or other long-term disability benefits?	☐	☐
7. 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, paralysis or myasthenia gravis	☐	☐
d. Psychosis or Schizophrenia	☐	☐
e. Diabetes with complications such as retinopathy (eye disease) or neuropathy (numbness/tingling in hands or feet)	☐	☐
f. Internal cancer, leukemia, lymphoma or melanoma	☐	☐
g. Osteoporosis with related fracture(s)	☐	☐
h. Systemic lupus, kidney failure, cirrhosis of the liver, hydrocephalus or connective tissue disease	☐	☐
i. Stroke or cerebrovascular accident (CVA), transient ischemic attack (TIA), congestive heart failure, atrial fibrillation, peripheral vascular disease or cardiomyopathy	☐	☐
j. Amputation due to disease, alcohol or drug abuse	☐	☐

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, pharmacy benefit managers, 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 Producer 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. **5**

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 PO Box 2460, Salt Lake City, Utah 84110, 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.

_____	_____
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)

EQUITABLE LIFE & CASUALTY
INSURANCE COMPANY
PO Box 2460
Salt Lake City, UT 84110-2460

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

Return to Company
03011000200 1

EQUITABLE LIFE & CASUALTY
INSURANCE COMPANY
PO Box 2460
Salt Lake City, UT 84110-2460

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The above “Notice to Applicant” was delivered to me on:

_____	_____
Date	Agent Name (Print)
_____	_____
Applicant’s Signature	Agent Signature

RN-30

Leave with Applicant

Equitable Life & Casualty Insurance Company
PO Box 2460, Salt Lake City, UT 84110
1-800-352-5150

OUTLINE OF COVERAGE
LIMITED BENEFIT HEALTH COVERAGE
SHORT TERM NURSING FACILITY, ASSISTED LIVING FACILITY and HOME CARE BENEFITS
Policy Form 792 NE

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 8.

(3) BENEFITS PROVIDED UNDER THE POLICY:

Note: You have the option to select a policy that provides for Facility Care Benefits only (Form 792 FC). If you select such a policy, any reference herein to Home Care Benefits are not applicable. Your application will show if you selected Facility Care Benefits only.

FACILITY CARE BENEFITS: When you are eligible for benefits, we will pay you the Eligible Charges you incur, up to your Daily Amount, for each day of your stay in a Nursing Facility, Assisted Living Facility or Hospice Care Facility.

We will pay this benefit up to the Maximum Benefit Period. Payment of benefits is subject to the Waiting Period and to all provisions of the policy. The Waiting Period will not apply to a stay in a Hospice Care Facility.

ROOM RESERVATION: When you are eligible for benefits, we will pay you the Eligible Charges you incur, up to your Daily Amount, to reserve your room when you are admitted as an inpatient to a hospital during a covered stay in a Nursing Facility, Assisted Living Facility or Hospice Care Facility.

We will pay this benefit for up to fifteen (15) days in any twelve (12) month period. Days for which we pay this benefit are subject to the Waiting Period and count toward the Maximum Benefit Period.

ALTERNATE CARE: We may agree to pay benefits for stays in facilities not covered in the policy. When you are eligible for benefits, these benefits may be paid when:

a) All facilities that are covered in the policy are unavailable to you within a fifty (50) mile radius of your Home;
b) They are a cost effective option appropriate for your needs; and
c) We approve the payment of this benefit to you.

Days for which we pay this benefit are subject to your Waiting Period and count toward the Maximum Benefit Period.

HOME CARE BENEFITS: When you are eligible for benefits, we will pay you the Eligible Charges you incur, up to your Daily Amount, for each day you receive at least one (1) hour of Home Care Services in your Home from a Home Care Provider.

We will pay this benefit up to the Maximum Benefit Period. Payment of this benefit is subject to the Waiting Period and all provisions of the policy.

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RESPITE CARE: When you are eligible for Home Care Benefits, we will pay you the Eligible Charges you incur, up to your Daily Amount, for each day that Nursing Care Services or Home Care Services are provided to you when an informal, unpaid caregiver is temporarily relieved from providing those services to you.

We will pay this benefit up to a lifetime maximum of ten (10) days. Days for which we pay this benefit will count toward the Maximum Benefit Period but will not be subject to the Waiting Period.

RESTORATION OF MAXIMUM BENEFIT PERIOD: We will restore the days benefits were paid to you under the policy following a period of one hundred eighty (180) consecutive days, during all of which:

a) You were not confined to a Nursing Facility, Assisted Living Facility or Hospice Care Facility;
b) You did not receive a Home Care Service;
c) You were able to perform five (5) or more Activities of Daily Living (ADLs) without the Hands-On Assistance of another person; and
d) If you are cognitively impaired you did not require or receive the assistance or supervision of another person.

We reserve the right, at our expense, to perform an interview or Assessment, require a physical examination, or order medical records to verify you met the requirements above.

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

Daily Amounts – $50 to $300 in $10 increments.

Maximum Benefit Periods – 100, 150, 200, 250, 300 or 350 days.

Waiting Periods – 0, 15, or 30 days.

(4) OPTIONAL BENEFIT BY ENDORSEMENT: The following optional benefit is available for an additional premium. This benefit, if purchased, will be added as an endorsement to the policy:

Simple Inflation Protection: Your original Daily Amount will increase by 3% each year on your policy anniversary date, as selected by you on your application. Your premium will not increase with the increase in your Daily Amount, subject to our limited right to increase premiums.

(5) ELIGIBILITY FOR BENEFITS: Benefits under the policy are to be paid only when you are determined to be eligible for benefits.

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

a) You cannot perform, without the Hands-On Assistance of another person, two (2) or more of the Activities of Daily Living (ADLs); or
b) You have a Cognitive Impairment.

In addition, benefits will be payable to you only when:

a) Your eligibility for benefits begins while the policy is in force; and
b) The services you receive are in keeping with your Plan of Care.

(6) ELIGIBILITY DOCUMENTATION:
COMPREHENSIVE MINIMUM DATA SET (MDS) ASSESSMENT: 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: We must be provided with a written Assessment performed by an Assessment Provider that verifies your eligibility for benefits:

a) If the Nursing Facility in which you reside is not a Medicare or Medicaid certified Nursing Facility and is not required by state law to use the Comprehensive MDS Assessment; or
b) If you reside in an Assisted Living Facility or Hospice Care Facility; or
c) If you require the need for Home Care Services.

We will pay all costs associated with the performance of an Assessment.

PLAN OF CARE: When you are eligible for Facility Care Benefits or Home Care Benefits, a Plan of Care will be developed by you and a Care Planner. A Plan of Care is not required for a stay in a Hospice Care Facility.

Your Plan of Care can be modified by you and the Care Planner as required to reflect changes in your functional or cognitive abilities and your care service needs.

We will pay all costs associated with the development of your Plan of Care and any changes to your Plan of Care.

(7) IMPORTANT DEFINITIONS:
ACTIVITIES OF DAILY LIVING (ADLs):

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, including undergarments, and any necessary braces, fasteners or artificial limbs. It does not include putting on or taking off shoes and socks.
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: A comprehensive, written evaluation that includes generally accepted tests and instruments that use objective measures and produce verifiable results that will determine if you are eligible for benefits.

ASSESSMENT PROVIDER: An agency, entity or a person designated and approved by us to perform an Assessment. A person assigned to perform an Assessment will be a licensed health care practitioner.

ASSISTED LIVING FACILITY: A place which is a separate facility or distinct part of a health care facility, which is licensed by the state, is operating pursuant to law and meets all the following criteria:

a) Provides continuous room and board that include three (3) meals a day and accommodation of special dietary needs;
b) Provides assistance with Activities of Daily Living and social care to ambulatory residents who require protected living arrangements, or coordinated supportive personal and health care services to semi-independent residents;
c) Has at least one (1) trained and ready-to-respond staff member actively on duty in the facility twenty-four (24) hours per day to provide the services and care;
d) Has formal arrangements with a physician or nurse to furnish medical care in emergencies, and
e) Has appropriate methods and procedures to assist residents in handling and administering medications.

An Assisted Living Facility may be known as a residential care facility, personal care facility or adult foster home.

CARE PLANNER: Means a licensed health care practitioner employed or contracted by us and trained to assess physical functional capacity and/or cognitive functional ability and coordinate the overall care needs of physically and/or cognitively impaired individuals.

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COGNITIVE IMPAIRMENT: The deterioration or loss of your intellectual or mental capacity, as determined by clinical tests and evidence, resulting in your need for the continual assistance or supervision by another person to properly care for yourself, including supervision and assistance that is necessary to protect you from threats to your health or safety or the health and safety of others.

COMPREHENSIVE MINIMUM DATA SET (MDS) ASSESSMENT:
A 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.

ELIGIBLE CHARGES: Those expenses for services provided to You in keeping with your Plan of Care and that you are obligated to pay as a resident of a Nursing Facility, Assisted Living Facility or Hospice Care Facility; or as a recipient of Home Care Services.

Eligible Charges are limited to your Daily Amount and must be consistent with charges for identical or similar services provided to all persons who receive such services.

Eligible Charges DO NOT include expenses for: physician services; hospital (inpatient or outpatient) services; radiology or laboratory services; prescription or non-prescription drugs; medical supplies; or items and services requested by you for your appearance, comfort, convenience or entertainment.

HANDS-ON ASSISTANCE: The continual physical assistance of another person without which you would be unable to perform any two (2) or more of the Activities of Daily Living (ADLs).

HOME: The place that you maintain as an independent residence or that a member of your immediate family with whom you live maintains as an independent residence. Your Home is not a hospital, a Nursing Facility, Assisted Living Facility, Hospice Care Facility or any other institutional setting.

HOME CARE PROVIDER: An organization or agency licensed by your state to provide Home Care Services, and operates under that license according to law; or, if licensing is not required, is an organization, agency or person approved by us to provide Home Care Services to you.

A Home Care Provider cannot be a member of your immediate family and must not have a financial interest or relationship with you or any member of your immediate family, other than an arrangement to provide Home Care Services.

HOME CARE SERVICES: Professional and personal care services you receive from a Home Care Provider in your Home, including: nursing care; physical therapy; occupational therapy; speech therapy; and nutritionist services.

Home Care Services also include homemaker services for one or more of the following personal support services provided to you: meal preparation; laundry; light housekeeping; shopping for food, medications or medical supplies; and, transportation to and from appointments.

HOSPICE CARE FACILITY: A place which is a separate facility or distinct part of a health care facility, is operated pursuant to law, and provides Hospice Care on an inpatient basis.

MAXIMUM BENEFIT PERIOD: The total number of days for which we will pay benefits under the policy.
The Maximum Benefit Period will be reduced by one day for each day we pay Facility Care Benefits, subject to the Restoration of Your Maximum Benefit Period provision.

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

NURSING HOME: 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.

PLAN OF CARE: A written individualized plan of services that specifies your care needs, the type, frequency and providers of services appropriate to meet those needs, and the costs, if any, of those services. You choose the providers of the services you receive. Your Plan of Care may contain services which you choose to receive but which are not covered services payable under the policy, including informal care provided by family or friends.

WAITING PERIOD: The number of days of a stay in a Nursing Facility or Assisted Living Facility , or the number of days in which you receive Home Care Services, required before benefits are payable. You need to satisfy your waiting period only once during your lifetime.

(8) LIMITATIONS AND EXCLUSIONS:
Pre-existing Condition Limitation: No benefits are payable for any loss that begins within the first six (6) months after the Effective Date of your policy which is caused by a Pre-Existing Condition. A Pre-Existing Condition is a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within six (6) months prior to the Effective Date of your policy.
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 if caused by the orders of a Physician;
d) For a 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 insane;
f) For any stay in a facility which is not a Nursing Facility, Assisted Living Facility or Hospice Care Facility, as defined herein, except as provided under the Alternate Care benefit;
g) For services which you are not liable or which no charge is normally made in the absence of insurance;
h) For services provided to you by an individual or organization not employed by or contracted with a Nursing Facility, Assisted Living Facility, Hospice Care Facility or Home Care Provider;
i) For services and supplies not included in your Plan of Care or your Itemized Billing Statement;
j) For services provided to you by a member of Your Immediate Family; or
k) For services for mental illness or nervous disorders (other than Alzheimer's disease or similar forms of irreversible dementia).

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

(10) PREMIUM: The total annual premium for your policy, including any endorsement, is shown on the Policy Schedule.

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. IT IS NOT AN INSURANCE CONTRACT. PLEASE CONSULT THE POLICY TO DETERMINE ALL GOVERNING CONTRACTUAL PROVISIONS, INCLUDING ANY LIMITATIONS OR EXCLUSIONS. PLEASE RETAIN THIS OUTLINE OF COVERAGE FOR YOUR RECORDS.

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EQUITABLE LIFE & CASUALTY
INSURANCE COMPANY
PO Box 2460
Salt Lake City, UT 84110-2460

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 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
PO Box 2460, Salt Lake City, UT 84110-2460
ATTN: Privacy Officer
Telephone (toll free): 1-800-352-5150

Leave with Applicant

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.

Date Receipt and Outline of Coverage was prepared _____, 20 _____

by _____

Agent's Signature

Equitable Life & Casualty Insurance Company, PO Box 2460, Salt Lake City, UT 84110-2460

Equitable