Equitable Life & Casualty Insurance Company
PO Box 2460, Salt Lake City, Utah 84110-2460
Application - Medicare Supplement Insurance

☐ 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 ☐ Male ☐ Female

Medicare ID Number: _____ - _____ - _____

Street Address

_____

City _____ State ____ Zip _____

Best Time to Call (3 hour interval):_____ to _____ Weekend Calls: Yes ☐ No ☐

Daytime Phone: _____ Evening Phone: _____

Cell Phone: _____ E-Mail Address: _____

Part II – Plan Selection

Plan Applied For:

☐ A ☐ F ☐ G ☐ N

Policy Discount: ☐ Yes ☐ No

Policyowner Discount Name _____ Social Security Number _____

Part III – Eligibility

Federal law allows a 6 month open enrollment period beginning with the first day of the first month in which an applicant is both (1) age 65 or older; and (2) enrolled in Medicare Part B. If you are a qualified open enrollee, you may apply for and receive any Medicare Supplement Plan available from us.

Yes **No**

☐ ☐ 1) Are you covered under Medicare Part A?
a) If YES, what is your Part A effective date? _____/_____/_____

b) If NO, what is your eligibility date? _____/_____/_____

☐ ☐ 2) Are you covered under Medicare Part B?
a) If YES, what is your Part B effective date? _____/_____/_____

b) If NO, what is your eligibility date? _____/_____/_____

☐ ☐ 3) a) Did you turn 65 in the last 6 months?

Part IV – Medicare & Insurance Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you are eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with this Application. *Please mark "Yes" or "No" below with an "X", to the best of your knowledge.*

PLEASE ANSWER ALL QUESTIONS

Yes No

☐ ☐ 1) Are you applying during a guaranteed issue period? (If YES please attach proof of eligibility).

☐ ☐ 2) Are you covered for Medical Assistance through the state Medicaid program?
NOTE TO APPLICANT: If you are participating in a "Spend Down Program" and have not met your "Share of the Cost", please answer "NO" to this question.
If "Yes",

☐ ☐ a) Will Medicaid pay your premiums for this Medicare Supplement policy?

☐ ☐ b) Do you receive any benefits from Medicaid, OTHER THAN payments toward your Part B premium?

3) a) If you had coverage from any Medicare Plan other than Original Medicare within the past 63 days, for example, a Medicare Advantage plan, or a Medicare HMO or PPO, fill in your *"Effective"* and *"Paid-to"* dates below.
If you are still covered under this plan, leave *"Paid to"* blank.

Effective _____/_____/_____ Paid to _____/_____/_____ (mm/dd/yyyy)

☐ ☐ b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? (If "Yes" complete Replacement Notice.)
If so with which company? _____

Company Address: _____

☐ ☐ c) Was this your first time in this type of Medicare Plan?

☐ ☐ d) Did you drop a Medicare Supplement policy to enroll in the Medicare Plan?

☐ ☐ 4) a) Do you have another Medicare Supplement policy in force?
b) If so with which company? _____

Company Address: _____

What plan do you have?_____

☐ ☐ c) If so, do you intend to replace your current Medicare Supplement policy with this policy?
(If "Yes" complete Replacement Notice.)

☐ ☐ 5) Have you had coverage under any other health insurance within the past 63 days?
(for example, an employer, union, or individual plan)

a) If so, with what company? _____

What kind of policy? _____

b) What are your dates of coverage under the other policy?

Effective _____/_____/_____ Paid to _____/_____/_____ (mm/dd/yyyy)

Part V – General Information

1) You do not need more than one Medicare Supplement policy.
2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. Upon receipt of your request, we will return to you that portion of the premium attributable to the period of your Medicaid eligibility, subject to an adjustment for paid claims. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy or, if that is no longer available, a substantially equivalent policy will be reinstituted, effective as of the date of termination of Medicaid, if requested within 90 days of losing your Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
5) If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union based group health plan, your suspended Medicare Supplement policy or, if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing your employer or union based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid Program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low Income Medicare Beneficiary (SLMB).

Part VI – Premium Payment & Administration

INITIAL Premium:
$ ☐☐,☐☐☐.☐☐ For _____ Months
(Include $20 app fee)

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

☐ Draft Initial Premium ☐ 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 VII – Medical Questions

Complete this section by checking "Yes" or "No" for each question. For applicants who are applying as an Open Enrollee or meet guarantee issue requirements, these questions need not be answered. For all other applicants, if an answer to any part of questions 1 – 7 is "Yes", a policy will not be issued.

Tobacco Use: Have you used any tobacco products, including cigarettes, cigars, chewing tobacco or a pipe, in the past 12 months? ☐Yes ☐No

Yes	No	
		1. During the past 2 years, have you seen a physician, been diagnosed, treated or taken medication for:
❒	❒	a. Amyotrophic lateral sclerosis (ALS), multiple sclerosis, Parkinson's disease, systemic lupus or myasthenia gravis?
❒	❒	b. Organ transplant, chronic kidney disease, kidney failure or cirrhosis of the liver?
❒	❒	c. AIDS or HIV positive?
❒	❒	d. Alzheimer's disease, memory loss or dementia?
❒	❒	e. Leukemia, internal cancer, lymphoma, melanoma or multiple myeloma?
❒	❒	f. Heart valve disease, carotid artery disease, peripheral vascular disease, coronary artery disease, angina, cardiomyopathy, congestive heart failure or atrial fibrillation?
❒	❒	g. Skin ulcer or amputation due to disease?
❒	❒	h. Alcohol or drug abuse?
❒	❒	i. Complications of diabetes such as neuropathy (numbness, tingling or burning in arms or legs), Retinopathy (eye damage), any heart disorder (including hypertension/high blood pressure), or kidney damage or diabetes that is not under control?
		2. During the past 2 years, have you had:
❒	❒	a. A heart attack, heart surgery including angioplasty, bypass or stent placement or surgery for carotid artery or peripheral vascular disease?
❒	❒	b. A stroke or transient ischemic attack (TIA, mini-stroke)?
❒	❒	3. In the past 2 years, have you been hospitalized more than 2 times or been hospitalized for mental illness (such as anxiety or depression)?
❒	❒	4. Do you require the use of a wheelchair or have you ever had a defibrillator implanted?
❒	❒	5. In the past 2 years, has a doctor scheduled or recommended any tests, surgery or workup to rule out disease or to determine the cause of your health concerns that have not been completed?
❒	❒	6. In the past 12 months, have you used oxygen to assist with breathing (except when hospitalized)?
❒	❒	7. Have you been in a hospital, confined to a nursing home or assisted living facility or received home health care in the past 90 days? Has any of this care been medically advised?
		Additional Questions. Check "Yes" or "No" for each question.
❒	❒	8. In the past 2 years, have you had diabetes that required the use of insulin?
❒	❒	9. Do you have a mental illness (such as anxiety or depression) that requires psychiatric care?

DOCTOR YOU USUALLY CONSULT - Your Primary Care Physician

Name: _____ Address: _____

City, State, Zip: _____ Phone: _____

List ALL prescription medications taken at any time in the past 2 years.
(use additional sheets if necessary)

Prescription Name & Dosage	Reason Taking	Date Last Used (mm/yy)

Part VIII – Guarantee Issue Eligibility

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997: The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

- ☐ Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual *(eligible for Plans A and F)*; or

- ☐ Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual *(eligible for Plans A and F)*; or

- ☐ Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual *(eligible for Plans A and F)*; or

- ☐ Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, substantial violation of a material policy provision, or material misrepresentation *(eligible for Plans A and F)*; or

- ☐ Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then terminates coverage within 12 months of enrollment *(eligible for the same Plan you terminated with us, or if that Plan is no longer available Plans A and F)*; or

- ☐ Upon *first* becoming eligible for benefits under Part A at age 65, enrolls in a Medicare Advantage or PACE provider and then disenrolls within 12 months *(eligible for all plans available from us)*; or

- ☐ Enrolled in a Medicare Part D Plan during the initial Part D enrollment period while enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and terminate the Medicare Supplement policy *(eligible for Plans A and F)*.

Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

Part IX – Agreement & Acknowledgement

I wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with 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 the Company may 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: ☐☐-☐☐-☐☐☐☐

Applicant Signature: _____ Send policy to: ☐ Applicant ☐ Producer

Producer's Signature: _____ Producer Number: _____

Producer Phone: _____

Producer Supplement

All questions must be completed.

Yes	No		
☐	☐	1.	Did you meet with the applicant in person?
☐	☐	2.	Did you complete this application over the phone?
		3.	State the name and relationship of any other person present when this application was taken. Name _____ Relationship to Applicant _____
☐	☐	4.	Did you review the application for correctness and any omissions?
☐	☐	5.	Did the applicant review the application for correctness and any omissions?
☐	☐	6.	Are you related to the Proposed Insured? If Yes, provide relationship: _____

Listed below are all other health insurance policies I have (a) sold to the Applicant which are still in force; and (b) sold to the Applicant in the last 5 years which are no longer in force.

Company	Type of Policy	Effective Date	In Force
			❒ Yes ❒ No
			❒ Yes ❒ No
			❒ Yes ❒ No

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

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

Health Information Authorization

This Authorization complies with the HIPAA Privacy Rule

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, 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 and excludes information related to genetic tests or genetic services (except to pay a claim related to such tests or services).

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.

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)

HHA (12-MS) (Return to Company)

Replacement Notice

NOTICE TO APPLICANTS REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

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!

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage coverage and replace it with a policy to be issued by Equitable Life & Casualty Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your policy or Medicare Advantage coverage only if after due consideration and acceptance by the replacing insurer, you find that purchase of this Medicare Supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

STATEMENT TO APPLICANT BY AGENT: I have reviewed your current medical or health insurance coverage. To the best of my knowledge this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- ❒ Additional benefits.
- ❒ Same benefits, but lower premium.
- ❒ Fewer benefits and lower premiums.
- ❒ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ❒ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

- ❒ Other (please specify). _____

I call to your attention the following item for your consideration: If 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 and health history. Failure to include all material medical information on an application may provide a basis for the issuer 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, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____ _____
Producer's Signature Producers PRINTED name and address

_____ _____
Applicant's Signature Date

Producer: If this replacement notice is necessary, have the insured complete and sign this form and return it to us with all other forms

Replaced Company Name: _____

Replaced Company Address: _____

RN-10 Return to Company

Replacement Notice

NOTICE TO APPLICANTS REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

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!

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage coverage and replace it with a policy to be issued by Equitable Life & Casualty Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your policy or Medicare Advantage coverage only if after due consideration and acceptance by the replacing insurer, you find that purchase of this Medicare Supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

STATEMENT TO APPLICANT BY AGENT: I have reviewed your current medical or health insurance coverage. To the best of my knowledge this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- ❒ Additional benefits.
- ❒ Same benefits, but lower premium.
- ❒ Fewer benefits and lower premiums.
- ❒ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ❒ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

- ❒ Other (please specify). _____

I call to your attention the following item for your consideration: If 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 and health history. Failure to include all material medical information on an application may provide a basis for the issuer 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, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____	_____
Producer's Signature	Producers PRINTED name and address
_____	_____
Applicant's Signature	Date

Producer: If this replacement notice is necessary, have the insured complete and sign this form and leave it with the Applicant

Replaced Company Name: _____

Replaced Company Address: _____

RN-10

Leave with Applicant

Premium Calculation

Medicare Supplement Plan _____

	Steps	**Example** – *Information displayed is for illustrational purposes only*	**Enrollee**
#1	**Enrollee Age** **Enrollee Zip Code**	65 12345	
#2	**Premium** Premium shown in Outline of Coverage	$150.00	
#3	**Household Premium Discount** If another Equitable Life & Casualty Medicare Supplement policyowner resides with the enrollee, multiply premium by .93	$150.00 x .93 = $139.50	
#4	**Payment Options** Modal Premiums – To determine other pay schedules, multiply the monthly premium by: Annual - MBD x 12 Semi-Annual - (MBD x 12) x .520 Quarterly - (MBD x 12) x .265	$139.50 Monthly Bank Draft Payment $443.61 Quarterly Payment $870.48 Semi-Annual Payment $1,674.00 Annual Payment	

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

Important Notice Before You Buy
Health Insurance

Dear Consumer:

Insurance is a very important, sometimes confusing and generally expensive consumer purchase. Health Insurance is one of the most significant coverages seniors consider buying. Many seniors feel they need extra information before making a decision.

Free Help is Available

Across Iowa there is a network of trained volunteers who can help you compare and analyze health policies you are considering. These volunteers have been trained by people from the State of Iowa Division of Insurance. This free service is available though the **Senior Health Insurance Information Program (SHIIP)**.

This Is Objective Information

SHIIP volunteers do not sell insurance. They work, with the help of the Iowa Insurance Division, to provide objective information about the policies you are considering.

The Decision Is Yours

SHIIP volunteers will not recommend companies, policies or agents. They cannot tell you which policy to buy. They can help you understand the *"fine print"* and what the policy does and does not cover.

Where To Call

For the SHIIP volunteer nearest you call **1-800-351-4664.** We hope you will use this valuable service as you consider the purchase of health insurance.

SENIOR HEALTH INSURANCE

SHIIP

INFORMATION PROGRAM

IA-SHIP

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.

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


Equitable