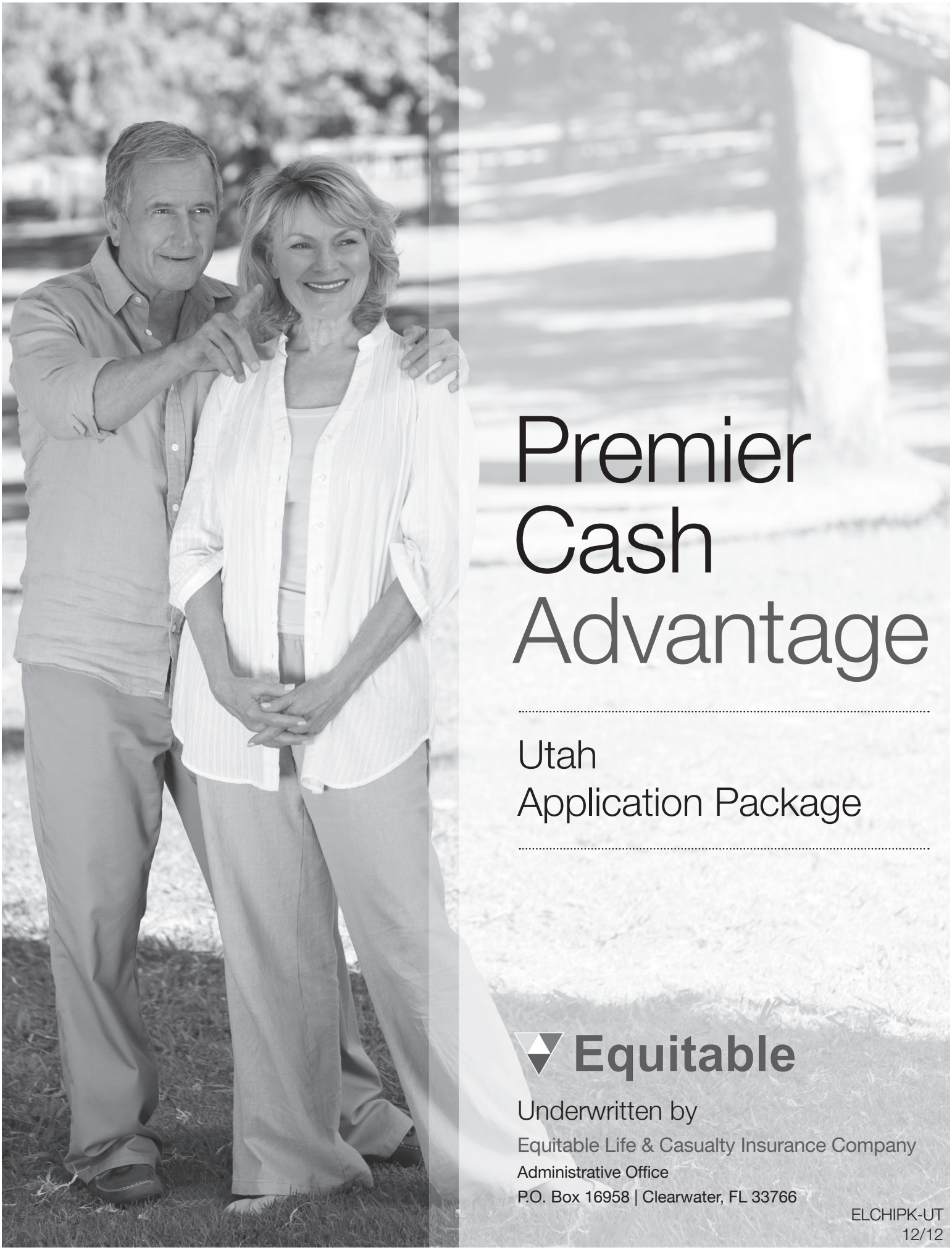

Premier Cash Advantage

Utah Application Package

Equitable

Underwritten by

Equitable Life & Casualty Insurance Company

Administrative Office

P.O. Box 16958 | Clearwater, FL 33766

ELCHIPK-UT
12/12

Important Reminders

Equitable Life & Casualty Premium Cash Advantage plans use the age at policy application date for determining the age of the proposed insured for insurance purposes. **Premium quote calculations should be based upon the proposed insured's age (i.e. actual age) on the application date.**

How to Avoid Delays

- Ask each question exactly as written (do not paraphrase).
- Record each answer exactly as given.
- Complete the application legibly and in black ink.
- Please include the best time to contact the applicant in Section 1, in case a telephone interview is required.
- Never use "white-out" or similar substances for corrections or mistakes; **Cross out errors and have each applicant initial and date any corrections or mistakes.**
- Use an additional sheet to record any pertinent information you feel would be helpful in evaluating the risk.
- Ensure that all sections of the application are signed as required:
  - Part C MONTHLY PRE-AUTHORIZATION PAYMENT PLAN – Electronic Funds Transfer Authorization **must be** signed by the payor.
  - Part E ACKNOWLEDGEMENTS & AUTHORIZATION **must be** signed by the proposed insured.
  - Part F AGENT'S STATEMENT **must be** signed by the agent.
  - Page 9 – Conditional Coverage Receipt **must be** signed by the agent.
- Distribute the detachable sections of the Application as required:
  - Page 9 – Investigative Consumer Report Notice to Applicant **must be** left with the proposed insured.
  - Page 9 – Conditional Coverage Receipt **must be** left with the account owner, if first month's premium is submitted with application.
- If replacing existing insurance, ensure that the REPLACEMENT NOTICE is completed.

Payment of Premiums

- Cash is not permitted for the payment of premium(s).
- Payments by check must be made payable to Equitable Life & Casualty Insurance Company.
- If the first premium payment is being made by check or money order it must be dated no later than the date the Application was signed by the account owner.
- If the first premium payment is being made by EFT, make sure the payor is aware that the EFT authorization is effective immediately. **The initial premium will be drafted upon approval.**
- Agent cannot make premium payments (unless the proposed insured is the agent or a dependent of the agent).

Faxing and Shipping Instructions

- Mail to: Equitable Life & Casualty Insurance Company Attn: New Business, PO Box 16958, Clearwater, FL 33766-6958.
- Overnight/Courier to: Equitable Life & Casualty Insurance Company Attn: New Business, 2650 McCormick Dr, Clearwater, FL 33759
- Fax to: Equitable Life & Casualty Insurance Company Attn: New Business, fax number 855-367-0114.
- Fax a copy of the application, copy of the voided check and all applicable forms.
- Do not mail the original items; destroy once an underwriting decision has been made.

APPLICATION

Limited Benefit Health Coverage Providing Hospital Confinement and Related Benefits

Equitable Life & Casualty Insurance Company

Administrative Office: P.O. Box 16958, Clearwater, FL 33766-6958
Phone: (855) 775-4663 • Fax: (855) 367-0114

APPLICATION FOR: ☐ New Coverage ☐ Reinstatement ☐ Change of Benefits

If reinstatement or change of benefits requested, please print policy number affected: _____

MAIL POLICY TO: ☐ Agent ☐ Insured

PART A. APPLICANT INFORMATION

_____ ☐ Male ☐ Female
Last Name First Name MI

_____
Soc. Sec. # Birth Date (mm/dd/yyyy) Age

_____
Street Address City State Zip

_____
Daytime Phone *(please include area code)* Best Time to Call E-Mail Address

QUALIFYING INFORMATION

*(If any answer to questions 1 thru 5 is "YES" you are **not** eligible for coverage. DO NOT SUBMIT APPLICATION.)*

1. In the past 12 months have you: been confined as an inpatient to a hospital or a nursing home or have you received home health care? ☐ YES ☐ NO
2. In the past 24 months have you: had a heart attack, stroke, congestive heart failure, heart surgery/bypass, malignant melanoma or cancer (other than skin cancer)? ☐ YES ☐ NO
3. In the past 12 months have you: been treated for chronic obstructive lung disease, insulin dependent diabetes, dementia, Alzheimer's disease, cirrhosis, diabetes with complications or chronic liver or kidney disease; been prescribed to use oxygen? ☐ YES ☐ NO
4. In the past 12 months have you: had surgery which required an inpatient hospital stay or been advised to have surgery which will require an inpatient stay but have not yet done so? ☐ YES ☐ NO
5. Have you ever: been treated for or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or HIV infection, aneurysm, cardiomyopathy, or peripheral vascular disease; been treated for drug or alcohol abuse; received an organ transplant, had an amputation due to disease, or used a defibrillator? ☐ YES ☐ NO

Plan Selection ☐ A ☐ B ☐ C

Will this policy replace any existing insurance with any company? ☐ YES ☐ NO
If yes, please complete the Replacement Notice.

PART B. PREMIUM

Hospital Confinement Indemnity Annual Premium for Applicant ..... $_____

Premium Payment Mode ☐ Annual ☐ Semi-Annual (.520)
☐ Quarterly (.265) ☐ Monthly EFT (1/12)

Total Mode Premium for Applicant ..... $_____

Total Initial Premium + one-time $25 Application Fee ..... $_____

Requested Effective Date _____ /_____ / _____

Requested Effective Date cannot be prior to the Application Date.
If no Effective Date is requested, the Effective Date will be the date of the underwriting decision to approve issuance of coverage.

PART C. MONTHLY PRE-AUTHORIZED PREMIUM PAYMENT PLAN

Authorization to Honor Withdrawals to be drawn by Equitable Life & Casualty Insurance Company.

TO _____
Name of my Bank My Bank's Address City State Zip Code

As a convenience to me, I request and authorize you to charge the account shown below for premiums drawn by and payable to the order of Equitable Life & Casualty Insurance Company, Administrative Office, Clearwater, Florida, provided there are sufficient funds in my account to pay the same upon presentation.

_____
Account # Bank Routing #

Account Type: ❒ Checking Account ❒ Savings Account Bank Draft Day *(days 1-28)* _____
(Attach a Voided "Sample" check if applicable, or a Deposit slip)

I agree that my rights in respect to each payment shall be the same as if it were drawn by me and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you receive notice for which you agree you will be fully protected in honoring such requests. I further agree that if any such payment is not honored, whether with or without cause and whether intentionally, or inadvertently, you shall be under no liability at all although such action could result in the forfeiture of insurance.

X _____
Premium Payer's Signature *(as it appears on bank records)* Printed Name of Insured *(if different from premium payer)*

PART D. NOTICE OF LAPSE

I understand that a third party designee is a person other than myself who will receive notice of lapse or termination of my insurance policy for nonpayment of premium. My third party designee will not be notified until thirty (30) days after a premium is due and unpaid.

☐ I elect NOT to designate a third party designee. ☐ I elect to designate a third party designee, named below.

_____
Last Name First Name MI Phone *(please include area code)*

_____
Street Address City State Zip

PART E. ACKNOWLEDGEMENTS & AUTHORIZATION

ALL STATEMENTS MADE IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE, TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT THE STATEMENTS FORM THE BASIS UPON WHICH INSURANCE WILL BE MADE EFFECTIVE. I UNDERSTAND THAT OMISSIONS, MISREPRESENTATIONS OR MISSTATEMENTS COULD RESULT IN DENIAL OF AN OTHERWISE VALID CLAIM AND/OR THE RESCISSION, VOIDING, OR REFORMATION OF MY INSURANCE.

I understand that insurance applied for will not become effective until: a) approved and issued; b) I have been furnished written notice of the effective date; and c) I have paid the premium in full. I understand that any changes in my health conditions, if applicable, from the date of this application until insurance becomes effective, may result in the declination of my coverage. No agent or other representative has required, permitted, or encouraged me to answer any question inaccurately or has waived any conditions of this application.

☐ I have received an Outline of Coverage.
☐ If this application is completed electronically or over the phone, I understand the Outline of Coverage will be delivered with the policy.

AUTHORIZATION: I authorize Equitable Life & Casualty Insurance Company (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my physical condition, other coverage and any other information needed to underwrite my application for insurance such as criminal or motor vehicle records. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company, pharmacy benefit manager or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. This Authorization includes all information about drugs, alcoholism, and mental illness. I understand and agree that the Company or its representatives may conduct a phone interview or face-to-face assessment as part of the underwriting process. I agree that this Authorization will be valid for 24 months from the date signed, and know that I or my authorized representative may have a photocopy of it.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or, so long as the Company has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my agent or to the attention of the Underwriting Manager.

I understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by the Company in accordance with federal or state law. 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 also understand that my application for insurance can be declined if I choose not to sign this Authorization.

CAUTION: Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

This policy provides limited benefits. Review your policy carefully. Pre-existing conditions are not covered unless the loss begins more than six (6) months after your effective date of coverage.

Signed at _____

City and State Date

X _____

Applicant Signature

PART F. AGENT'S STATEMENT

I am not aware of any additional information which may have a bearing on the insurability of the applicant for insurance on this application and any supplement to it. I have advised the applicant not to withhold any information relative to this application and its questions. I have advised the applicant to review the application for completeness and accuracy and that no coverage is in effect until the applicant is notified in writing by Equitable Life & Casualty Insurance Company. I certify that I asked all the questions and truthfully and accurately recorded the answers contained herein (except if application is completed electronically or over the phone). To the best of my knowledge and belief, the insurance applied for: ☐ is or is likely ☐ is not or is not likely to replace or change any existing policy(ies) or contract(s).

X _____

Agent's Signature Agent's Name (Printed)

_____

Agent Number Agent's E-mail Address Date

Equitable Life & Casualty Insurance Company

Administrative Office • PO Box 16958, Clearwater, FL 33766-6958

HOSPITAL CONFINEMENT INDEMNITY INSURANCE
INITIAL PREMIUM RECEIPT ACKNOWLEDGEMENT

☐ I, agree that I have submitted my initial premium plus application fee in the amount of $_____ via check, money order, or cashier's check, to my agent acting on behalf of Equitable Life & Casualty Insurance Company.

☐ I, authorize Equitable Life & Casualty Insurance Company to deduct my initial premium payment plus application fee from my account when the policy is issued.

_____ _____
Applicant's Signature Date

_____ _____
Agent's Signature Date

LEAVE WITH APPLICANT

Equitable

Underwritten by
Equitable Life & Casualty Insurance Company
Administrative Office
P.O. Box 16958 | Clearwater, FL 33766

Duplication Notice

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.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. 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
- 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).

MDN-10A

Leave with applicant

Equitable Life & Casualty Insurance Company

Administrative Office • PO Box 16958, Clearwater, FL 33766-6958

Initial Payment Acknowledgement

I understand that if I select to have my initial premium, plus the application fee automatically deducted from my account (EFT), the amount will be deducted on the date that the policy is issued by Equitable Life & Casualty Insurance Company.

_____ _____

Applicant's Signature Date

RETURN TO COMPANY

Equitable Life & Casualty Insurance Company

Administrative Office: P.O. Box 16958, Clearwater, FL 33766-6958

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

Equitable Life & Casualty Insurance Company

Administrative Office: P.O. Box 16958, Clearwater, FL 33766-6958

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

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

Premier Cash Advantage Administrative Office

Equitable Life & Casualty Insurance Company
Premier Cash Advantage
Administrative Office
PO Box 16958
Clearwater, FL 33766-6958
(855) 755-7663

FAX TRANSMITTAL

FOR USE WITH EFT MONTHLY PREMIUM APPLICATIONS ONLY

855-367-0114

Use this fax number only for applications and new business documents. Applications faxed to any other number can cause delays in processing your business.

Please complete the following information:

Total number of pages being faxed including this cover sheet _____

Agent Name_____

Agent Number or Agency Name _____

Agent Phone Number _____

Agent Fax Number_____

Comments _____

_____

_____

_____

_____

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_____