EQUITABLE

1290 Avenue of the Americas, New York, NY 10104

(Select One)

☐ **Equitable Financial Life Insurance Company**
☐ **Equitable Financial Life and Annuity Company**
☐ **Equitable Financial Life Insurance Company of America**

APPLICATION PART 2: PARAMEDICAL QUESTIONS INDIVIDUAL LIFE INSURANCE

Reason for submission of this form: ☐ **New Policy** ☐ **Policy Change** ☐ **Reinstatement**

This form is to be completed by the Proposed/Existing Insured regarding his/her health for underwriting purposes.

PROPOSED/ EXISTING INSURED

Policy # (if known) _____

1. Name First _____ Middle _____ Last _____

2a. Date of Birth _____ (mm/dd/yyyy) 2b. ☐ Male ☐ Female

PERSONAL PHYSICIAN

3. Do you have a personal physician? ☐ Yes ☐ No

4. If "Yes," Physician Name or Name of Practice or Clinic _____

5. Street Address _____ City _____ State _____ Zip _____

6. Phone # _____

7. Date and reason last consulted if within the last 5 years
   a. Date (mm/dd/yyyy) _____
   b. Reason _____

8. What treatment was given or recommended? _____ ☐ None

FAMILY HISTORY

9 a. Did both your birth parents live to age 70? ☐ Yes ☐ No ☐ I don't know

b. Do you have a birth parent or birth sibling who has died of a heart attack, stroke or cancer before age 60? ☐ Yes ☐ No ☐ I don't know

If "Yes," provide the following:

Relationship (mother, father, sister, brother)	**Age at Death**	**Cause of Death**

MEDICAL HISTORY

If you check "Yes" to any of the conditions on questions 10-21, please give details in the chart on page 3.
On questions 10 and 11 "check all that apply" and provide details.

10. Have you ever consulted a medical professional, been diagnosed or treated for any of the following? ☐ Yes ☐ No

a. ☐ Cancer
☐ Benign Cyst/Tumor/Polyp
☐ Other Tumor or Growth

b. ☐ Chest Pain
☐ Heart Attack
☐ Heart Murmur/Valvular Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Irregular Heart Beat/Arrhythmia
☐ Stroke/TIA
☐ Other Heart or Blood Vessel Disorder

11. In the last 10 years, have you consulted a medical professional, been diagnosed or treated for any of the following, other than already indicated? ☐ Yes ☐ No

a. ☐ Diabetes/ High Blood Sugar
☐ Gestational Diabetes
☐ Glucose Intolerance / Pre-Diabetes
☐ Thyroid Disorder
☐ Lymph Node or Other Gland Disorder

b. ☐ Bladder Disorder
☐ Breast Disorder
☐ Kidney Disorder
☐ Prostate Disorder
☐ Reproductive Disorder (other than infertility)
☐ Urine abnormalities – blood, protein or sugar in the urine
☐ Other Kidney or Urinary System Disorder

c. ☐ Asthma
☐ Bronchitis
☐ Emphysema/COPD
☐ Sleep Apnea
☐ Tuberculosis
☐ Other Respiratory/Lung Disorder

d. ☐ Anxiety
☐ Depression
☐ Eating Disorder
☐ Other Emotional or Psychological Condition

e. ☐ Cirrhosis of the Liver
☐ Crohn's / Ulcerative Colitis
☐ Hepatitis
☐ Ulcer
☐ Other Esophagus, Gallbladder, Bowel/ Intestine, Liver, Pancreas or Stomach Disorder

f. ☐ Arthritis
☐ Chronic Pain
☐ Gout
☐ Lupus
☐ Other Bone, Joint, Muscle or Connective Tissue Disorder

g. ☐ Alzheimer's Disease/Dementia
☐ Memory Loss/Cognitive Impairment
☐ Multiple Sclerosis
☐ Neuritis
☐ Paralysis
☐ Parkinson's Disease
☐ Seizures/Epilepsy
☐ Other Brain, Nervous System or Neurological Disorder

h. ☐ Anemia
☐ Blood Disorder
☐ Immune System Disorder

12. Are you now under medical observation or treatment for any reason not stated above? ☐ Yes ☐ No

13. Has your weight changed by more than 10 pounds in the last 6 months? ☐ Yes ☐ No
If "Yes," _____ Pounds _____ Provide Details _____

14. Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

15. Other than stated in questions 10 to 14, in the last 5 years have you:

a. Consulted or been treated by a medical professional, or treated at a hospital, clinic, or other facility for any reason, including any illness, injury or surgery? (Do not include colds or minor injuries.) ☐ Yes ☐ No

b. Had electrocardiogram, x–ray, or other diagnostic test (including lab tests, but excluding any test related to HIV/AIDS)? (Do not include routine screening test with normal results.) ☐ Yes ☐ No

c. Been advised by a member of the medical profession to have any diagnostic test, treatment or surgery (except as related to HIV/AIDS) which has not been completed? (Do not include routine screening test.) ☐ Yes ☐ No

16. Are you taking any medications other than as stated in answers to Questions 10-15? (Include prescription and non-prescription medications. Do not include vitamins or supplements.) ☐ Yes ☐ No

17. a. Do you currently consume alcoholic beverages? ☐ Yes ☐ No

When you consume alcohol, what is the usual number of drinks? _____

What best describes your frequency of consumption?

☐ Every Day ☐ 5 to 6 times per week ☐ 3 to 4 times per week ☐ Once or twice a week ☐ 2 to 3 times a month ☐ Once a month ☐ 4 to 11 times per year ☐ 1 to 3 times per year

b. (i) If "No," have you ever consumed alcoholic beverages? ☐ Yes ☐ No

(ii) If "Yes," please provide: Date Last Used _____(mm/dd/yyyy)
Reason stopped _____

MEDICAL HISTORY (CONTINUED)

18. Describe your tobacco/ nicotine product usage history, including but not limited to:

    e-cigarettes, cigarettes, cigars, pipe, chewing tobacco, snuff, hookah, nicotine patch, nicotine gum.

    ☐ Daily* ☐ Weekly* ☐ Monthly* ☐ Yearly* ☐ I quit less than a year ago* ☐ I quit over a year ago* ☐ I have never used
    *provide details in chart

Product Type(s) If cigars, provide number used per year	**Indicate date last used (mm/yyyy)**

19. Describe your marijuana use in the past 5 years. ☐ Recreational / Social* ☐ Medicinal* ☐ I have never used
    *Provide details including frequency (daily, weekly, monthly, yearly), and date of last use on page 4.

20. In the last 10 years, have you used, except as legally prescribed by a medical professional: opiates, morphine, tranquilizers, sedatives, amphetamines, barbiturates, methadone, benzodiazepine, hallucinogens, methamphetamines, heroin, cocaine, crack, ecstasy, PCP or LSD? ☐ Yes ☐ No

21. Have you ever been advised by a medical professional to limit or discontinue the use of alcohol or drugs (prescribed or non-prescribed), or received treatment or counseling, or been a member in any self-help group because of your alcohol or drug use? ☐ Yes ☐ No

DETAILS

List details of all "Yes" answers on pages 1 through 3. When providing details, please reference Question No./Letter. Also include the following: (1) Name, Address and Phone Number of Medical Professional or facility consulted or seen (Include City & State); (2) Date of Diagnosis (mm/dd/yyyy) and Duration of Illness; and (3) Diagnosis/Treatment/Medication.

Question No./ Letter	

STATE FRAUD DISCLOSURE

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

SIGNATURES

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers will be part of the application for insurance or request for policy change or reinstatement, as applicable. The Insurer may rely on them in acting on the application or making the policy change or reinstatement.

Dated at _____ on _____ **X** _____
City State Mo. Day Yr. Signature of Proposed/Existing Insured

Signature of Examiner as Witness _____

DETAILS

PARAMEDICAL REPORT

Equitable Financial Life Insurance Company
Equitable Financial Life and Annuity Company
Equitable Financial Life Insurance Company of America (EFLOA)

Policy # (if known) _____

Proposed/Existing Insured:

1. Name First _____ Middle _____ Last _____

2. Date of Birth _____ (mm/dd/yyyy)

3a. Height (Without shoes) _____ft. _____in.

3b. Weight (Clothed) _____lbs.

3c. Chest ___ Full Inspiration _____ in.

3d. Chest ___ Forced Expiration _____ in.

3e. Abdomen at Umbilicus _____ in.

3f. Did you weigh? ☐ Yes ☐ No **3g.** Did you measure? ☐ Yes ☐ No

4. Blood Pressure—Record 1st Reading. If Reading exceeds 140 systolic and/or 90 diastolic, obtain and record 2nd and 3rd Readings at 5 min. intervals.

	1st Reading	2nd Reading	3rd Reading
Systolic			
Diastolic—(5th phase)			

5. Pulse Rate _____ per min.

Is it regular? ☐ Yes ☐ No

If "No," describe _____

6. Did you observe any physical defects (including scars, deformities, amputation, paralysis, sight or hearing impairment, etc.)?

☐ Yes ☐ No

If "Yes," describe _____

7. Urinalysis

	Neg.	Pos.	Amt.
Protein	☐	☐	_____
Sugar	☐	☐	_____
Blood	☐	☐	_____

In all cases, *send specimen to the laboratory with completed identification slip.*

8. Is blood being sent to the laboratory? ☐ Yes ☐ No

I made the examination reported above at _____ A.M./P.M. (circle one)

on _____ (Month) (Day) (Year)

at _____ (No.) (Street) (City or Town) (State)

What proof (photo-proof preferred) of Applicant's identity did you review? ☐ Driver's License ☐ Other (Specify: _____)

Did this proof include a photograph? ☐ Yes ☐ No

Are you related to the Applicant or Financial Professional? ☐ Yes ☐ No

Name of Financial Professional _____

X _____ **(Examiner's Signature)**

_____

Name of Facility (STAMP or PRINT)

_____

No. Street

_____

City State Zip Code

PARAMEDICAL FEE AUTHORIZATIONS

(To be detached only by Equitable)

Name of Examination Facility (Print or Stamp)

Name of Person Examined (Print)

Street Address

Date of Birth

Date of Examination

City or Town State Zip Code

☐☐☐ - ☐☐ - ☐☐☐☐ SSN ☐☐ - ☐☐☐☐☐☐☐ EIN

Examiner's Social Security No. or Employer's Tax Identification No., whichever is applicable. *(The fee cannot be paid without your Social Security Number or Employer Identification Number, whichever is applicable. Your S.S.N. or E.I.N. is required for tax reporting purposes under the Internal Revenue Code. If you do not furnish this number, you may be subject to a fine imposed by the IRS.)*

Insurance Examination (20) Fee $

If other tests were done, which were requested and authorized by Equitable, list below:

Fee $

Fee $

Fee $

EQUITABLE WILL PAY UP TO ITS CUSTOMARY FEE FOR THIS EXAM AS AGREED UPON BY THE APPROVED VENDOR.

Equitable Use Only		Account	X	Code
LIC at		Individual Life		01
ASU at				
		Individual Health		03
APP #		Individual Annuity		05
	or	Medical		07
Pol. #				
		EFLAC		20
		EFLOA		
		EFLIC		