

# Equitable Reserve Association

A Not-For-Profit Fraternal Life Insurance Association, est. 1897

---

## **Instructions for Application for Disability Insurance Benefits & Authorization/Notice to Obtain Information**

Please complete Forms 156, 155 and 820A in order for us to obtain additional medical information in the consideration of your claim.

Mail completed form to:  
Equitable Reserve Association  
Attn: Claims Department  
P.O. Box 448  
Neenah, WI 54957-0448

***Keep a copy of the completed form for your records.***

Call the Claims Department at 1-800-722-1574 if you have any questions or concerns.



# EQUITABLE RESERVE ASSOCIATION

116 S. Commercial Street • Neenah, Wisconsin 54956

## NOTICE OF INFORMATION PRACTICES REQUIRED BY THE INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

To properly underwrite and administer your life and health coverage, Equitable Reserve Association must collect certain information. In general, it includes age, occupation, physical condition, health history, mode of living and avocations.

The primary source of information is your application and any supporting amendments, questionnaires, etc. However, it may be necessary to obtain more information from sources such as medical professionals and institutions which have provided care to you or members of your family proposed for coverage, your employers and business associates, friends and neighbors, public records and other insurance companies to which you may have applied. Information from these sources may be obtained by correspondence, phone, or personal contact.

In some cases we may ask an insurance support organization to complete an investigative consumer report for us. That organization may retain a copy of the report and may disclose its contents to others for whom it performs such services.

### **DISCLOSURES**

By law, Equitable Reserve Association, either directly or through an agent, may disclose information about you to others without your specific authorization. When asked to do so, we provide only that which is reasonably necessary to accomplish the intended purpose. The following summary describes disclosures which may be made, although Equitable Reserve Association may not always choose to make such disclosures:

1. To other persons or organizations who perform business, professional or insurance services for us, and whose proper performance for us requires that we disclose certain information to them.
2. To another insurance company to which you have applied for coverage or benefits.
3. To your Equitable Reserve Association agent to assist in providing proper service to you.
4. To insurance support organizations formed to prevent or detect fraud in insurance transactions.
5. To our reinsurers if we ask them to accept a portion of the risk under your policy.
6. To a medical care institution or medical professional to verify that you have coverage with us. Also, if a medical examination for insurance purposes reveals a condition or problem unknown to the individual, we may inform the individual's personal medical professional.
7. To state regulatory authorities who conduct examinations and audits of Equitable Reserve Association operation.
8. To group policyholders who are entitled to audit our records and receive reports of claim experience.
9. To law enforcement agencies to assist in the prevention or prosecution of fraud, or to alert them to the possibilities of illegal conduct.

### **YOUR RIGHTS OF ACCESS TO INFORMATION ABOUT YOU**

You have certain rights concerning access to information about you that we have collected and retained in our files. To maintain security of that information, access will be permitted only after proper identification has been submitted to us.

If you would like access to this information you must send a signed, written request to the Underwriting Department, Equitable Reserve Association, P.O. Box 448, Neenah, WI 54957-0448. The request must include full name, address, telephone number and policy number. Within 30 business days after receiving your request we will tell you the nature and substance of the information in our files. If you wish to see and copy the record in person, we will advise you of the location of the records. There may be a charge for each copy made.

Also, we will tell you to whom we have disclosed information about you within the last two years or to whom such information normally would have been disclosed.

There are limitations of access. We will identify sources of information which comes from institutions such as hospitals, clinics, doctors or insurance support organizations, but we will not identify sources of information which was obtained from individuals such as friends or neighbors. Also, we are not obligated to provide access to information obtained in connection with or in anticipation of a claim for policy benefits or a civil or criminal proceeding.

Medical information will be provided only through a doctor or some other medical professional, designated by you, who is licensed to provide medical care relevant to the nature of the information.

### **CORRECTION OR DELETION OF INFORMATION**

If you believe after reviewing information in our files that it is incorrect, you may request, in writing that we correct, amend or delete any item of information. Requests should be directed to the Underwriting Department, Equitable Reserve Association, P.O. Box 448, Neenah, WI 54957-0448. We will respond within thirty business days of receipt of your written request.

If we agree that certain changes should be made, we will notify any person to whom we may have disclosed the original information during the preceding two years. We will also notify any insurance support organization to whom we have disclosed the information or who may have furnished the original information.

If we do not agree to change our records you may file with us a brief written statement setting forth what you believe to be the correct, relevant or fair information and why you disagree with our decision not to change the original information. Your statement will become a permanent part of our file and will be disclosed in the future with the original information. Also, copies of your statement will be sent to any person or insurance support organization to whom the original information was furnished.

### **INVESTIGATIVE CONSUMER REPORT NOTICE**

As part of our procedure for processing your initial insurance application, an investigative consumer report may be prepared, in which information is obtained from public records and through personal interviews with your neighbors, friends, employers, business associates or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request to be personally interviewed during completion of the report, and you also have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation. Either of these written requests should be directed to the Underwriting Department, Equitable Reserve Association, P.O. Box 448, Neenah, WI 54957-0448.

### **MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE**

Information about your insurability will be treated as confidential. Equitable Reserve Association may, however, make a brief report to the Medical Information Bureau, a nonprofit membership organization of life insurance companies which operates an information exchange for its members. If you apply to another Bureau member company of life or health insurance coverage or submit a claim for benefits, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file you may contact them and seek a correction by the procedures in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, MA, 02112, telephone number (617) 426-3660.

Equitable Reserve Association 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.



# EQUITABLE RESERVE ASSOCIATION

116 S. Commercial Street • Neenah, Wisconsin 54956

## FINANCIAL AND MEDICAL RECORDS 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, insurance company, insurance support organization (such as MIB) or health care provider that has provided payment, treatment or services to me ("My Providers") to disclose the entire medical record and any other protected health information concerning me to Equitable Reserve Association and their agents, employees and representatives. This includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I understand that the information obtained by use of this Authorization will be used by Equitable Reserve Association to determine eligibility for insurance coverage or benefits. By my signature below, I acknowledge that any agreements I have made to restrict my protected health do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this Authorization at my request, as permitted by #164.508(c)(1)(iv) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

This authorization shall remain in force for 24 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 Reserve Association, 116 S. Commercial Street, Neenah, WI 54956, Attention: New Business Department. Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers. 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 Reserve Association has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, Equitable Reserve Association will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and to persons or organizations as set forth in the accompanying Notice of Information Practices.

I **KNOW** that I may request a personal interview by the Consumer Reporting Agency by writing the Underwriting Department, Equitable Reserve Association, P.O. Box 448, Neenah, WI 54957-0448.

I **KNOW** that I may request a copy of any investigative consumer report by writing the Underwriting Department, Equitable Reserve Association, P.O. Box 448, Neenah, WI 54957-0448.

I **ACKNOWLEDGE** receipt of the Notice of Information Practices, the Investigative Consumer Report Notice and the Medical Information Bureau Disclosure Notice.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Equitable Reserve Association may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

DATED \_\_\_\_\_  
(Month) (Day) (Year)

\_\_\_\_\_  
Signature of Proposed Insured or Parent,  
if Proposed Insured is a minor

\_\_\_\_\_  
Proposed Insured's Spouse

\_\_\_\_\_  
Name of Minor Proposed Insured

\_\_\_\_\_  
Date of Birth of Proposed Insured

\_\_\_\_\_  
Social Security No. of Proposed Insured

\_\_\_\_\_  
Address of Proposed Insured

**APPLICATION FOR  
DISABILITY BENEFITS**

**Equitable Reserve Association  
A Fraternal Benefit Society**

**116 S. Commercial Street  
Neenah, Wisconsin 54956**

**NOTE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.**

---

---

**IMPORTANT:** For your disability coverage submit this form within 20 days after the start of your disability. It is your responsibility to have this form completed in full without cost to the Association. All questions must be answered in full and properly signed by you.

---

---

**PART 1 STATEMENT OF THE INSURED**

Name of Insured \_\_\_\_\_ Policy No. \_\_\_\_\_  
Insured's Address \_\_\_\_\_ Assembly No. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Phone \_\_\_\_\_ Right or Left Handed \_\_\_\_\_ Height & Weight \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Date Employed \_\_\_\_\_

- 
- 1 a. Name of sickness \_\_\_\_\_  
b. Describe symptoms. \_\_\_\_\_  
c. Date first symptoms noticed? Date \_\_\_\_\_, \_\_\_\_\_.  
d. Have you ever had this or similar sickness before? If yes, when?  Yes  No Date \_\_\_\_\_, \_\_\_\_\_.  
e. State what you believe caused your sickness. \_\_\_\_\_

- 
- 2 a. Date and hour of accident? Date \_\_\_\_\_, \_\_\_\_\_ Hour \_\_\_\_\_  AM  PM  
b. What injuries were received? \_\_\_\_\_  
c. Where were you when injured? \_\_\_\_\_  
d. What were you doing? \_\_\_\_\_  
e. What caused your injury? \_\_\_\_\_

- 
- 3 a. Date and name of first doctor consulted. Date \_\_\_\_\_, \_\_\_\_\_ Name \_\_\_\_\_  
b. Name and address of all other doctors consulted. \_\_\_\_\_  
c. Between what dates have you been confined to a hospital? From \_\_\_\_\_, \_\_\_\_\_ Hour \_\_\_\_\_  AM  PM  
To \_\_\_\_\_, \_\_\_\_\_ Hour \_\_\_\_\_  AM  PM  
Name and address of hospital. \_\_\_\_\_

---

4. List all sicknesses and injuries for which you have been treated during the past five years. Give dates, names, and addresses of doctors. \_\_\_\_\_

- 
5. a. Date Sickness/Injury cause you to quit work entirely. Date \_\_\_\_\_, \_\_\_\_\_ Hour \_\_\_\_\_  AM  PM  
b. Date you were first able to do any part of your work supervisory or otherwise?  
Date \_\_\_\_\_, \_\_\_\_\_ Hour \_\_\_\_\_  AM  PM  
c. Date you were able to resume your regular work. Date \_\_\_\_\_, \_\_\_\_\_ Hour \_\_\_\_\_  AM  PM  
d. State any part of your work you could not perform during any period you were partially disabled. \_\_\_\_\_

---

6. Name all other organizations (including Workman's Compensation) in which you are insured for this disability. Please give dates of policies and benefits paid. \_\_\_\_\_

---

I certify that the foregoing statements and answers are true and complete to the best of our knowledge and belief.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Policyowner

## PART 2 STATEMENT OF THE EMPLOYER

This statement must be signed by the employer or an authorized delegate of the employer. If the insured is self-employed, the insured will complete the following statements giving all the details.

1. Occupation of the insured at the time of disability?

\_\_\_\_\_

2. Employed how many days per week?

\_\_\_\_\_

6. Occupation in which the insured returned?

\_\_\_\_\_

3. Average monthly earnings?

\_\_\_\_\_

7. Has employee requested unemployment benefits? \_\_\_\_\_  
Does employee have group income protection? \_\_\_\_\_

4. Date employee last worked?  AM  
\_\_\_\_\_ Hour \_\_\_\_\_  PM

Date \_\_\_\_\_  
\_\_\_\_\_ (Company Name)

5. Date employee returned to work?  AM  
\_\_\_\_\_ Hour \_\_\_\_\_  PM

Address \_\_\_\_\_  
\_\_\_\_\_  
(Signature) (Official Position)

**PART 3 ATTENDING PHYSICIAN'S STATEMENT**

It is the responsibility of the policyholder to have this claim form completed in full without cost to the Association. All questions on this form relate directly to the insuring provisions of the contract and therefore must be completed in full. Payment of approved benefits will not exceed the date this report is completed. Please return this form direct to Equitable Reserve Association.

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Mo. Day Year  
 Is Patient Retired? Yes  No  Patient's Sex Male  Female   
 Employer Name \_\_\_\_\_

**1. History**

- a. Is this condition the result of: Accidental Injury? \_\_\_\_\_ or Sickness? \_\_\_\_\_
- b. When did symptoms first appear or accident happen? Date \_\_\_\_\_, 20\_\_\_\_
- c. Date patient ceased work because of disability. Date \_\_\_\_\_, 20\_\_\_\_
- d. Has patient ever had same or similar condition? Yes  No  If "Yes", state when and describe. \_\_\_\_\_
- e. Is condition due to injury or sickness arising out of patient's employment? Yes  No  Unknown
- f. Names and addresses of other treating physicians or facilities who may have rendered treatment. \_\_\_\_\_

**2. Diagnosis (including any complications)**

- a. Date of last examination. Date \_\_\_\_\_, 20\_\_\_\_
- b. Diagnosis (including any complications) \_\_\_\_\_
- c. Subjective symptoms \_\_\_\_\_
- d. Objective findings (including current X-rays, EKG's, Laboratory Data, and any clinical findings) \_\_\_\_\_

**3. Dates of Treatment**

- a. Is patient still under your care for this condition? Yes  No
- b. Date of first visit. Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
- c. Date of last visit. Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
- d. Frequency. Weekly  Monthly  Other (Specify)

**4. Nature of Treatment (Including surgery and medications prescribed, if any)****5. Prognosis**

- a. Is patient now totally disabled? Patient's Job Any Other Work  
 Yes  No  Yes  No

b. What duties of patient's job is he/she incapable of performing?

	<b>Patient's Job</b>	<b>Any Other Work</b>
Do you expect a fundamental or marked change in the future?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
How long was or will patient be continuously totally disabled (unable to work)?		
From _____ 20____ To _____ 20____		
How long was or will patient be partially disabled?		
From _____ 20____ To _____ 20____		

---

**6.** Is Patient requesting benefits for loss of income from:  
Social Security, and other government unit, or other insurance organization? Yes  No

---

I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.

\_\_\_\_\_  
(Signature of Physician)

\_\_\_\_\_  
(Date)