ABS ALLIED BENEFIT SUITE

Dental • Vision • Life & Disability • Personal Protection

New Group Submission Guide

What is ABS?

Allied Benefit Suite offers market-leading dental, vision, life and disability insurance and a personal protection plan. ABS makes offering these benefits to employees easy with a single point of contact for administration, billing and payment, rather than managing multiple relationships. If a group purchases a Delta Dental Small Business Plan they have access to any or all of the additional benefits offered in the Allied Benefit Suite (ABS).

How are ABS plans quoted?

Contact a participating General Agent for assistance in quoting all Allied Benefit Suite products. Requests for all Equitable LTD quotes along with any life quote for a group of less than 10 must be submitted directly to Allied Administrators at abs@alliedadministrators.com. Custom life quotes may also be requested for any group over 10 enrollees.

Are the monthly enrollment cutoff dates the same for ABS as they are for the SBP products?

Yes. The cutoff date for ABS products is the same as Delta Dental SBP Plans, which is the 5th of the month. Please note: the Equitable group app must be signed prior to the effective date of coverage.

Where can I submit new business?

New business would be submitted directly to your General Agent the same as you would a new Delta Dental Small Business Plan group.

Still have questions? Please contact:

Paul Wensloff
Director of Client Services at Allied Administrators
pwensloff@alliedadministrators.com
(415) 989-7443 ext. 241

Allied ADMINISTRATORS

DELTA DENTAL®

SMALL BUSINESS PROGRAM GROUP DENTAL APPLICATION

Delta Dental of California
560 Mission Street, Suite 1300
San Francisco, CA 94105
415-972-8300

APPLICANT INFORMATION

Name of Applicant:	Fed. ID/TIN:		Public Entity: ☐ Yes ☐ No
Contact:	Phone:		
Email:	Fax:		
Address:			
City:	State: CA	ZIP Code:	County:
Industry Type:	SIC:		
Billing Address, if different:			
Billing Contact:	Phone:		Fax:
Billing Email:			
Situs State: California	Group Type: Employer	Contract Type: Non Retention	Length of Contract: 2 Years
Proposed Effective Date:			
Recipient of Electronic Documents and Notices: ☐ Applicant ☐ Other (provide name and email, address or fax number):			
Dual Choice (choice of a Dental Dental PPO plan and a DeltaCare® USA plan) ☐ Yes ☐ No			
Name of prior carrier:			

DELTA DENTAL PPO℠ BENEFIT DESIGNS – Underwritten by Delta Dental of California

	Classic		Options	Voluntary
Plan Reimbursement	PPO	PPO Plus Premier	PPO Plus Premier	PPO
Select Plan	☐ Value ☐ Enhanced	☐ Value ☐ Enhanced	☐ PPO 1 ☐ PPO 2 ☐ PPO 3	☐ PPO Vol
Select Plan Variables				
Endodontic/Periodontic			☐ Basic ☐ Major	
Calendar Year Deductible (Per Enrollee/Family)			PPO 1 and 2: ☐ $50/$150 ☐ $25/$75 PPO 3: ☐ $40/$120-$50/$150 ☐ $0-$25/$75	
D&P Maximum Waiver®	☐ Yes ☐ No			
Calendar Year Maximum (Per Enrollee)	☐ $1,000 ☐ $1,500	☐ $2,000 ☐ $2,500		☐ $1,000 ☐ $1,500
Orthodontic Services (Optional)	☐ Yes ☐ No		☐ No ☐ Child Only ☐ Adult & Child	☐ Yes ☐ No
Orthodontic Lifetime Maximum (Per Enrollee)	☐ $1,000 ☐ $1,500			$1,000

DELTACARE USA BENEFIT DESIGNS – Underwritten by Delta Dental of California

Select Plan: ☐ 10A ☐ 11A ☐ 12A ☐ 15B ☐ 48N

RATES AND FUNDING

PPO Employer Contribution and Participation Requirement (check one):

☐ 100%
All eligible employees

☐ 75%-99.9%
75% of eligible employees

☐ 0%-74.9%
(Voluntary Plan Only)

For groups with 5 or more eligible employees: Enrollment may not be less than the greater of the percentage listed above or 5 primary enrollees. For groups with 2-4 primary enrollees: Enrollment may not be less than the greater of the percentage listed above or 2 primary enrollees.

Note: Refer to Small Business Program brochure for specific plan information and underwriting guidelines.

DeltaCare USA Employer Contribution Requirement (check one):

☐ At least 75% for employees and dependents ☐ At least 75% for employees

☐ Less than 75% for employees

Enrollment may not be less than 2 primary enrollees.

PPO Monthly Rates					DeltaCare USA Monthly Rates				
	Rates		#Primary Enrollees	Total		Rates		#Primary Enrollees	Total
3 Tier									
EE Only	$	x		= $	EE Only	$	x		= $
EE+1	$	x		= $	EE+1	$	x		= $
EE+2 or more	$	x		= $	EE+2 or more	$	x		= $
4 Tier									
EE Only	$	x		= $	EE Only	$	x		= $
EE+Spouse	$	x		= $	EE+Spouse	$	x		= $
EE+Child(ren)	$	x		= $	EE+Child(ren)	$	x		= $
EE+Family	$	x		= $	EE+Family	$	x		= $
			TOTAL	$				**TOTAL**	$

ELIGIBILITY INFORMATION

Census Data (fill in the total # of primary employees for each of the applicable boxes, listed below):

# of Eligible Employees:	# of PPO Enrolled Employees:	# of DeltaCare USA Enrolled Employees:

Eligible Individuals (check applicable boxes): ☒ Eligible Employees ☐ Retired Employees

Eligible Dependents (check applicable boxes): ☒ Spouse ☒ Children ☐ Domestic Partner ☐ Other

Eligible Requirement (check one): ☐ Date of hire ☐ First of the month following date of hire
☐ First of the month following days of employment

Application is herewith made for a dental insurance contract from Delta Dental of California (Delta Dental). It is understood that any variance to the underwriting criteria for this contract must be approved by Delta Dental prior to acceptance of the plan. Applicant understands that, regardless of the effective date above, unless and until 1) this Application is executed by a duly authorized officer of Applicant and returned to Delta Dental's designated administrator and accepted by the administrator on behalf for Delta Dental, 2) the premium is paid, and 3) enrollment procedures are completed, no claims will be paid for Enrollees under the contract. It is understood that this Application is offered as an inducement for issuance of a dental insurance contract by Delta Dental. Such contract will be based exclusively on the information given to or acquired by Delta Dental from this Application and the terms of said contract will be issued separately. The contract will be deemed accepted and approved based on the Applicant's payment of premium after delivery of the contract. To that end, the signer of the Application declares that he/she has read the statements and answers above and that to the best of his/her knowledge that the answers are true. No waiver or modification of the Application shall be accepted unless in writing and signed by an authorized officer of Applicant.

This plan shall become effective only upon issuance of a written agreement executed by a duly authorized officer of Delta Dental. In the absence of fraud or intentional misrepresentation of material fact, the statements in this application are deemed to be representations and not warranties. Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to Delta Dental we would not in good faith have issued the contract at the same premium rate. ***Applicant agrees that premiums and current eligibility list will be submitted to Delta Dental's designated administrator by the 25th of the month prior to the coverage month.***

Except as otherwise limited by the Health Insurance Portability Accountability Act and its administrative simplification regulations ("HIPAA"), Applicant shall provide Delta Dental's designated administrator with Protected Health Information ("PHI") for the proper implementation, administration and management of the group dental contract for which the Applicant is applying. Delta Dental agrees that the PHI will be held confidential and used or further disclosed only to administer the group dental plan as described in the group dental insurance contract or as permitted or required by law. Delta Dental and Applicant shall comply with all applicable federal and state laws and regulations relating to administrative simplification, security, and privacy of PHI, including the terms of any business associate agreement/addendum that may be required as part of the group dental insurance contract to be executed between the Applicant and Delta Dental.

Executed this day, _____, for the Applicant at:_____
(City and State)

By:_____ Signature:_____
(Print Name and Title)

Delta Dental Authorized Signature:_____
(Michael G. Hankinson, Esq., EVP, Chief Legal Officer)

BROKER/AGENT INFORMATION

Broker/Agent Name:	State License:		
Contact Email:	Phone:	Fax:	
Company Name:	SSN/TIN:	Is Company Inc.? ☐ Yes ☐ No	
Commission Mailing Address:	City:	State:	Zip Code:
Commission(s):	Payable to:		
Broker/Agent Signature:_____		Date:	

GENERAL AGENT INFORMATION

General Agent Name:	State License:		
Contact Email:	Phone:	Fax:	
Company Name:	SSN/TIN:	Is Company Inc.? ☐ Yes ☐ No	
Commission Mailing Address:	City:	State:	Zip Code:
Commission(s):	Payable to:		
General Agent Signature:_____		Date:	

ELECTRONIC DELIVERY OF DOCUMENTS TERMS AND CONDITIONS

Delta Dental strives to be a green enterprise. As part of Delta Dental's green initiatives, we offer you the opportunity to have your Dental contract-related documents made available to you electronically. If you choose to have your contract-related documents made available to you electronically, the terms & conditions below apply.

1. Communication Methods: All communications that we provide to you in electronic form will be provided either (1) by accessing the Delta Dental or Delta Dental's designated administrator website with your user name and password or (2) via email. Documents sent to you through one of these two electronic methods will be considered delivered and received, unless there is an indication that the email address provided is invalid. All written documents delivered to you electronically will be considered "in writing." You should print or download for your records a copy of all electronic communications, this electronic documents disclosure and any other document that is important to you.
2. Types of Documents that Will Be Electronically Communicated: Documents available electronically include, but are not limited to: your contract, the Evidence of Coverage (Certificate/EOC) for your enrollees and your notifications.
3. How to Withdraw Consent: You may withdraw your consent to transact business electronically by contacting Delta Dental's designated administrator. We may treat your provision of an invalid email address or the subsequent malfunction of a previously valid address as a withdrawal of your consent to receive electronic Communications. A withdrawal of your consent to transact business electronically will be effective only after we have had a reasonable period of time to process your request.
4. How to Update Your Records: It is your responsibility to provide us with true, accurate and complete email address, and to maintain and update promptly any changes in this information. You can update your information by contacting Delta Dental's designated administrator.
5. Hardware and Software Requirements: In order to access, view, sign and retain electronic documents that we make available to you, you must:
    - Have a device that will connect to the Internet, access to an email account and access to an internet browser.
    - Access to Adobe products will not be required to electronically sign forms but may be necessary to view, download or print documents.
    - Be able to view the disclosures on your device.
    - Have sufficient storage capacity on your computer's hard drive or other data storage unit.

We will update you if there are any changes to the hardware or software requirements that could impact receiving or signing electronic documents.

☐ **Applicant has reviewed the Electronic Delivery Terms and Conditions above and consents to have contract-related documents provided electronically.**

Delta Dental Administrator's Use ONLY Application accepted on:_____

TPA Employer #: Delta Dental Group#: DeltaCare USA Group#:

APPLICATION FOR VISION CARE PLAN

3333 Quality Drive
Rancho Cordova, CA 95670

Complete all applicable questions accurately and in detail.

CLIENT INFORMATION

1 Full legal name of client as it is to appear on the policy:

Address:

City: County: State: CA ZIP:

Phone: Fax:

2 Key Contact: Title:

Phone: Fax: E-mail:

Client is headquartered in state of (if different state from section 1, provide physical address for client in this state)

Address:

City: County: State: ZIP:

3 What is the nature of your business?

4 In conjunction with health plan industry practices when providing electronic eligibility, VSP requests clients to send dependent eligibility information to VSP. This would include providing the covered dependent's full name, date of birth, and relationship to the employee/member. Dependents will be reported as a dependent under the employee's ID number.

Will dependent information be sent to VSP for eligibility purposes? ☒yes

5 Number of employees eligible for benefits:

6 Dependents: Eligible dependents are the covered employee's spouse and dependent children until they reach their 26th birthday (includes an unmarried child if incapable of self-support because of physical or mental incapacity that commenced prior to reaching the above age).

POLICY DETAILS

The rates listed must support the plan design and benefit selected and must meet all eligibility requirements. Any discrepancies may preclude acceptance by VSP.

7 Benefit Year (select one):

☒ Service Year (from last date of service)

8 Plan Type:

☒ Choice Plan

9 Plan Details:

☒ Frequency (12/12/12)
☒ Co-payment: $10 exam / $25 eyewear
☒ Standard Progressive Lenses Covered after Copay
☒ $130 Elective Contact Lens Allowance
☒ $150 Retail Frame Allowance

10 Requested effective date *(The effective date should not precede the date VSP receives this application.)*
This policy will become effective on the first day of

11 **Rates (Select One):**

☐ **3-tier Rate Structure**: (EE Only / EE + 1 / EE + 2 or more)
Rates: $8.12 / $15.42 / $22.74

☐ **4-tier Rate Structure**: (EE Only / EE + Spouse / EE + Child(ren) / EE + Family)
Rates: $8.12 / $16.64 / $17.28 / $29.95

*VSP rate tier chosen must match Delta Dental's Small Business Program rate tier.

AGREEMENT

The undersigned client hereby applies for vision care coverage through VSP. It is understood that:

A. All future employees will be covered when they become eligible; or offered VSP coverage if voluntary.
B. Coverage will terminate for an employee on the last day of the month in which employment terminates.
C. Member past service for clients previously covered by VSP will carry over and remain in force.
D. Any non-VSP-created information outlining coverage or plan details must be reviewed by VSP prior to distribution to members.
E. This agreement will continue in force 24 months from the effective date.

This application signed this

Client Name:

Name: Title:

Signature:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

BROKER / CONSULTANT

☐ The broker/consultant indicated below is hereby designated Broker of Record by the above signed employer.

Legal Firm Name:

Address:

City: County: State: ZIP:

Licensed Producer's Name: Title:

Phone: Fax: E-mail:

Broker Assistant Name: Phone: E-mail:

Taxpayer ID: Corporation ☐ Independent ☐

Commission Checks Payable to:

☐ Firm Name

☐ Contact Name

Name:

Address:

City: County: State: ZIP:

This application signed this [

Print Name: Title:

Signature of state-licensed agent:

Please send a copy of agent/broker license, if not currently on file with VSP.

GENERAL AGENT

Please send a copy of agent/broker license, if not currently on file with VSP.

Legal Firm Name:

Address:

City: County: State: ZIP:

Licensed Producer's Name: Title:

Phone: Fax: E-mail:

Broker Assistant Name: Phone: E-mail:

Taxpayer ID: Corporation ☐ Independent ☐

Commission Checks Payable to:

☐ Firm Name

☐ Contact Name

Name:

Address:

City: County: State: ZIP:

This application signed this [

Print Name: Title:

Signature of state-licensed agent:

FRAUD WARNINGS

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas, Louisiana, New Mexico, Rhode Island, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance Company for the purpose of defrauding or attempting to defraud the Company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance Company or agent of an insurance Company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Maine, Tennessee, Virginia and Washington: WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance Company for the purpose of defrauding the Company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Florida: Any person who knowingly and with an intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance Company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance Company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud or knowing that he/she 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.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement that is material to the interests of an insurer may be guilty of insurance fraud.

Pennsylvania: Any person who knowingly and with the intent to defraud any insurance Company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

All Other States: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

*"AXA" is the brand name of AXA Equitable Financial Services, LLC and its family of companies, including AXA Equitable Life Insurance Company (AXA Equitable) located at 1290 Avenue of the Americas, New York, NY 10104 and MONY Life Insurance Company of America (MONY America) located at 2999 North 44th Street, Suite 250, Phoenix, Arizona 85018.

**References herein to the "Company" refer to either AXA Equitable or MONY America as the applicable issuing company.

Group Employee Benefits
Application for Insurance

Regular Mail:
Equitable Employee Bene its Group
PO Box 1507
Secaucus, NJ 07096

Express Mail:
Equitable Employee Benefits Group
500 Plaza Drive, 6th Floor
Secaucus, NJ 07094

EQUITABLE

For Assistance Call (866) 274-9887

Equitable Financial Life Insurance Company of America

Full Legal Business Name of Group: _____

Headquarters' Address: _____ City _____ State _____ Zip _____

Contact Name: _____ Contact Title: _____

Contact Phone: _____ Contact E-Mail: _____

Application is hereby made to the Company indicated above on the basis of the information contained in this application, the Employer Verification Information, the enrollment data and available experience. The application in its entirety, and any other required information, is subject to Home Office approval before insurance can become effective.
If this application is approved by Home Office, it will be attached to and made part of the Group Policy(ies). Insurance will become effective on the effective date shown below, unless the Company sends written notice of a different effective date.

Coverage Election

☐ Basic Life	☐ Supplemental Life	☐ Voluntary Life	☐ Dental	☐ Accident
☐ Basic AD&D	☐ Supplemental AD&D	☐ Voluntary AD&D	☐ Vision	☐ Critical Illness
☐ Basic Dependent Life	☐ Supplemental Dependent Life	☐ Voluntary Dependent Life	☐ Short-Term Disability	
☐ Basic Dependent AD&D	☐ Supplemental Dependent AD&D	☐ Voluntary Dependent AD&D	☐ Long-Term Disability	

Effective Date Requested: _____ Policy Situs State _____

Agreements and Authorization

The undersigned declares that, to the best of his/her knowledge and belief, the statements and answers to the questions in this application are complete and true. No one except the Chief Executive Officer or the Secretary of the Company may make or modify any contract on behalf of such Company, and no waiver is valid unless it is in writing and signed by one of these officers and the policyholder. The policyholder agrees to accept the terms and provisions of the group policy, including its exhibits, riders, endorsements or amendments, if any.

I have read and acknowledge the applicable fraud warning attached.

Signed by the Group's Authorized Representative

Signature _____

Print Name _____

Title _____

City and State where signed _____

Date _____
(must be signed prior to Effective Date)

Writing Agent or Broker

Signature _____

Print Name _____

License Number _____ State _____

Date _____
(must be signed prior to Effective Date)

The final application placed on file with the Company must be signed.

E15872

FRAUD WARNINGS

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas, Louisiana, New Mexico, Rhode Island, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance Company for the purpose of defrauding or attempting to defraud the Company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance Company or agent of an insurance Company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Maine, Tennessee, Virginia and Washington: WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance Company for the purpose of defrauding the Company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Florida: Any person who knowingly and with an intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance Company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance Company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud or knowing that he/she 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.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement that is material to the interests of an insurer may be guilty of insurance fraud.

Pennsylvania: Any person who knowingly and with the intent to defraud any insurance Company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

All Other States: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

*"Equitable is the brand name of Equitable Holdings, Inc. and its family of companies, including Equitable Financial Life Insurance Company (Equitable Financial) (NY, NY), Equitable Financial Life Insurance Company of America (AZ stock corp., admin. office: Jersey City, NJ), and Equitable Distributors, LLC.

**References herein to the "Company" refer to either Equitable Financial Life Insurance Company or Equitable Financial Life Insurance Company of America as the applicable issuing company. E15872

PERSONAL
PROTECTION
PLAN

Personal Protection Plan Application Form

Employer-paid or voluntary option now available

By signing below, you are indicating that you are enrolling all employees in the Personal Protection Plan and agree to pay $9.00 per employee on a monthly basis. All spouses/domestic partners and dependents automatically receive benefits for employees you enroll and there is no additional charge. The effective date of the coverage will match the effective dates of the other benefits Allied administers for you.

_____

Group Name

_____ _____ _____

Signature Print Name Date

IMPORTANT: Please follow the steps below to make sure your employees and their families are enrolled and receive access to plan benefits:

1. Provide your broker a census of all employees, spouses/domestic partners, and dependents or complete an enrollment form for each employee.
2. Your broker will send the census or forms to Allied Administrators for processing.
3. You will receive a welcome kit with materials for your employees to learn about the Personal Protection Plan and to activate their coverage.
4. Each employee will need to activate their coverage online before accessing their benefits.