

**REFERENCES: PLEASE LIST TWO CARE GIVING REFERENCES - NOT RELATED TO YOU
 IF YOU HAVE NOT BEEN A CAREGIVER PROVIDE WORK REFERENCES**

Full Name	Relationship
Company or Client	Phone
Address	
Full Name	Relationship
Company or Client	Phone
Address	

CURRENT POLICYOWNER SERVICES

Extent of Care You are Providing	ADL	Describe your experience providing these services
Bathing		
Bowel Management		
Bladder Management		
Continence Care		
Dressing		
Feeding		
Toileting		
Transferring		
Medication Management		
Other		

Average Number of Hours worked a day	Average Number of days worked a week
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If you are no longer able to provide the kind of care needed will you seek assistance from a licensed Health Care Provider?
 Yes No
 If so, when? _____

I certify that I do not live with the insured and am therefore eligible as a caregiver to be approved under the "Care by Family Member" benefit.

DISCLAIMER AND SIGNATURE

I Certify that my answers are true and complete to the best of my knowledge. **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. Equitable Life & Casualty Insurance Company may disclose the contents of your application to the Equitable policyowner, his or her representative(s), Insurance regulators or others as required by law. I acknowledge that Equitable will issued an IRS Form 1099-MISC for tax reporting purposes.**

Signature _____ Date _____