

Policyowner Name: _____

Policy Number: _____

PRIVATE CAREGIVER APPLICATION 1

Use Black INK

APPLICANT INFORMATION				
Last Name	First Name	M.I.	Date	
Street Address			Apartment/Unit #	
City	State	Zip		
Phone	E-Mail Address			
Social Security Number	License or Certification Number			
Are you related to the policyowner by blood or marriage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how? _____ Are You a Citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, are you authorized to work in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No Have You ever been discharged from a Position for abuse, neglect, or theft? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, When _____ Have you ever been convicted of a crime other than a minor traffic violation? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Explain _____				
EDUCATION				
High School			Address	
From	To	Did you Graduate? <input type="checkbox"/> Yes <input type="checkbox"/> No	Degree:	
College			Address	
From	To	Did you Graduate? <input type="checkbox"/> Yes <input type="checkbox"/> No	Degree:	
Caregiver Training			Address	
From	To	Were You Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Certification #	State
REFERENCES - Please list two care giving references (do not include friends or family)				
Full Name			Relationship	
Company or Client			Phone	
Address				
Full Name			Relationship	
Company or Client			Phone	
Address				

PREVIOUS EXPERIENCE

Company or Client		Phone		
Address		Supervisor		
Job Title	Starting Salary \$	Ending Salary \$	From	To
Responsibilities		Reason for Leaving		
Company or Client		Phone		
Address		Supervisor		
Job Title	Starting Salary \$	Ending Salary \$	From	To
Responsibilities		Reason for Leaving		

CURRENT POLICYOWNER SERVICES

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

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 issue an IRS Form 1099-MISC for tax reporting purposes.**

Signature _____ Date _____