New Life Application

instruction guide

As the Financial Professional/Insurance Broker, you are responsible for completing the necessary forms required for processing and underwriting this application. Following the instructions below will help you complete and submit a new Application for Life Insurance, knowledgeably and efficiently.

Completing the Application:

The application comprises of four Sections:

Section A — Proposed Insured Information (their general information)

Section B — Product Information (includes premium and rider information)

Section C — Questionnaires, as applicable

Section D — Authorization/Agreement Signature(s)

- After completing **Sections A**, **B**, and **C**, as applicable, the Proposed Insured and Owner, if different, must check the appropriate boxes in **Section D** to indicate the supplemental forms or Questionnaires that have been completed, and date and sign the application.
- Make sure the appropriate issuing Company is elected on the application.
- If the Owner is different from the Proposed Insured, complete the Owner Questionnaire.
- If the transaction involves a replacement, ensure that the appropriate paperwork is completed.
- Best practice is to complete the Medical Information Questionnaire to enable the Underwriter to promptly begin the underwriting process. Unless required for specific programs or the updating of medical evidence, the completion of the Medical Information Questionnaire is optional if a paramedical or medical exam is required. Complete the Medical Information Questionnaire in all cases when the Proposed Insured is age 0–15.

Before Beginning the Application:

- Use the state-specific application for the state where the Owner will sign the application.
- Complete the application legibly in blue or black ink or use "e-Forms for Life" available on axa-equitable.com under "Tools and Marketing" or "Quick Links."
- **Do Not** use a pencil to complete the application.

- Make sure you complete the Financial Professional Certification and submit it with the application.

For Survivorship Policies:

- Section B — Product Information captures information about Proposed Insured 2 and must be completed by the Proposed Insured 2.
- Complete a separate Questionnaire(s), as required, for each Proposed Insured when submitting the application (for example: Medical Information Questionnaire, Substance Usage Questionnaire, and Foreign Residence and Travel Questionnaire).

For Children Policies:

- If the Proposed Insured is a child, issue age 0–14, a parent or legal guardian must sign.
  - If there is no parent or legal guardian, the Applicant must sign if the Applicant is responsible for the support of the child.

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For Trusts, Corporations and Partnerships Owned Policies:

- If the Owner is a Corporation or a Trust, an authorized Officer of the Corporation or a Trustee must sign.
  - If the Owner is a Corporation, print the firm's name and the title of the authorized officer.
  - If the Owner is a Trust, indicate "Trustee" after the signature.
  - If the Owner is a Trust and the Proposed Insured is age 70 or older, regardless of the Face Amount, please provide a copy of the executed Trust document for review.
- If the Owner is a partnership, a partner involved in the purchase must sign.

Changes/Corrections to Life Application:

- If a change is required to an answer on the application or questionnaire(s), place a line through the incorrect answer and insert the correct information.
  - The Owner must initial all changes.
  - The Proposed Insured must also initial all changes pertaining to personal information and insurability-related answers.
  - If the Proposed Insured is a minor, a parent or legal guardian must initial all changes on behalf of the minor (Proposed Insured).
  - **Do Not** use correction fluid or tape for any alterations.

Reviewing this Life Application Instructions before you meet with your client will assist you to be knowledgeable and prepared, as well as assist with the processing of the Life Application.

Payment with Life Application:

- If accepting payment, you must follow the instructions on the Temporary Insurance Agreement/Receipt.
  - A check or money order made payable to the issuing Company selected on page 1 above Section A must accompany the application.
  - Enter the amount paid in the section on the application titled "Complete if Money is Paid with Application."
  - **Do Not** accept payment if Face Amount exceeds $2 million for single life, $3 million for joint life, or $1 million if multiple applications submitted.
  - **Do Not** accept cash payments.

You Should Know

- Billing notices will be sent to the Owner at the address indicated on the Application/Questionnaire unless otherwise detailed in the "Remarks" section.
- In order to comply with the Patriot Act, federal law requires that all financial institutions obtain, verify, and record information that identifies each Owner of life insurance.
- Backdating to save age is permitted in accordance with our published guidelines, but in no event can the policy be backdated more than six months prior to the application date (three months in Ohio). If the case is backdated and the mode is bank draft, additional premiums may be drafted from the bank account at issue. Backdating to save age is not permitted if the Proposed Insured is beyond the maximum age on which we would issue the policy.

Call the Life Insurance Sales Desk or visit www.axa-equitable.com, if you have further questions.

1290 Avenue of the Americas, New York, NY 10104, (212) 554-1234

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1290 Avenue of the Americas, New York, NY 10104

(Select One)

☐ **AXA Equitable Life Insurance Company**

☐ **MONY Life Insurance Company of America**

Application for Individual Life Insurance - Part 1

"AXA Equitable" is the brand name of AXA Equitable Financial Services, LCC and its family of companies, including the AXA Equitable Life Insurance Company and MONY Life Insurance Company of America.

SECTION A-PROPOSED INSURED INFORMATION

PROPOSED INSURED

Plan Name _____ **Face Amount** _____

1. Name First _____ Middle _____ Last _____

2. SSN _____ 3. Sex Male Female

4. Is the Proposed Insured the Owner? ☐ Yes ☐ No (If "No," complete Owner Questionnaire or see Survivorship Product Questionnaire if applicable)

5. Primary residential address _____ Bldg/Apt/Suite _____

City/Municipality _____ County/Parish* _____ State _____ Zip _____

** County/Parish only required in AL, FL, GA, KY, LA, SC*

6. Are you a U.S. citizen? ☐ Yes ☐ No (If "No," complete Foreign Residence and Travel Questionnaire)

7a. Phone # _____ ☐ Daytime ☐ Cell ☐ Evening b. Best time to call _____ ☐ AM ☐ PM

8. Date of birth _____ (mm/dd/yyyy) 9. Place of birth _____ (Country/State)

10. Email address _____

11. Do you have a driver's license? ☐ Yes ☐ No If "Yes," provide license number, state and expiration date

Number _____ State _____ Expiration Date _____ (mm/dd/yyyy)

If no driver's license, do you have a government issued ID? ☐ Yes ☐ No

If "Yes" to government issued ID, type of ID _____ Government ID number _____

EMPLOYMENT

12. Currently employed? ☐ Yes ☐ No ☐ Retired ☐ Other _____

If "Yes," to question 12, complete questions 13-15

13. Current occupation(s) a. Title _____ b. Years at current job** _____

**If less than one year at current job, give previous occupation information in remarks section

c. Duties _____

14. Employer name _____

15. Work site address _____

City _____ State _____ Zip Code _____

FINANCIAL DETAILS

16. Income (If minor, complete for Parent/Guardian)

Gross Earned Annual Income (salary, commissions, bonuses)	Gross Unearned Annual Income (dividends, pensions, interest real estate income, etc)	Gross Annual Income (Household)	Total Net Worth (Household)
$	$	$	$

17. In the last 5 years, have you filed for bankruptcy? ☐ Yes ☐ No

If "Yes," Chapter _____ Date opened _____ (mm/dd/yyyy) Date Closed _____ (mm/dd/yyyy)

BENEFICIARY

18. If no contingent beneficiary is named, the contingent beneficiary will be: (1) the Proposed Insured's surviving children, if any, in equal shares; or (2) if the Proposed Insured has no surviving children, the contingent beneficiary will be the Proposed Insured's estate. Total percentage must equal 100% for each category of beneficiary. If percentage shares are left blank, the shares will be deemed equal. If beneficiary is a Trust other than Owner, include full name and date of Trust.

Full Name	Relationship to Insured	Beneficiary Type	(%) Percentage
		☐ Primary ☐ Contingent	
		☐ Primary ☐ Contingent	
		☐ Primary ☐ Contingent	
		☐ Primary ☐ Contingent	

PURPOSE OF INSURANCE

Complete questions 19 and 20 only if Proposed Insured and Owner are same. If Owner is different from Proposed Insured(s) and completing Owner's Questionnaire, do not complete this section.

19. Complete For Personal Insurance
☐ Income Replacement ☐ Mortgage/Debt Repayment ☐ Estate Planning ☐ Charitable/Gifting ☐ Other _____

20. Complete for Business Insurance
☐ Key Person ☐ Buy-Sell ☐ Deferred Comp ☐ Other (please specify) _____
☐ Loan indemnification (Security for Loan) Amount of loan $_____ Duration _____
Interest charged on loan _____ Collateral pledged to secure loan _____

a. Type ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Corp.

b. Name of business _____ Nature of business _____

c. How long has the business been in operation? _____ Years

d. % of business owned by Proposed Insured _____ %

e. Fair market value of the business: $_____

f. Are all members of the business being similarly insured? ☐ Yes ☐ No
If "Yes," provide details of business coverage issued or applied for on other members. (Use remarks section if additional space is needed)

Name and Title	% of Business Owned	Amount In Force or Applied For

g. Has the business filed for bankruptcy and/or reorganization in the past 5 years? ☐ Yes ☐ No
If "Yes," explain _____

h. Business/Corporation finances: (Complete chart below for the past 2 years)

Year	Assets	Liabilities	Gross Sales	Net Profit
	$	$	$	$
	$	$	$	$

OTHER INSURANCE

If questions 21a, b or c are answered "Yes," please provide details in charts below. (Use remarks section if additional space is needed)

21. Including any policies and riders with the Company checked on page 1 above section A of the Application its affiliates and any other life insurance company:

a. Do you have any life insurance/annuities currently in force, including any policy that has been sold, settled or assigned to or with a settlement or viatical company or any other person or entity? ☐ Yes ☐ No

b. Will the coverage applied for replace, change, or affect any existing policy(ies) or contract(s)? ☐ Yes ☐ No

c. Do you have any other formal life insurance applications pending? ☐ Yes ☐ No

d. Including this application, what is the total amount of life insurance coverage pending (base policy face amount plus amounts attributable to additional benefits and riders) that you plan to accept on the Proposed Insured? _____

Chart for questions 21a and b

Name of Company	Total Amount (Face Plus Riders)	Year Issued	Policy/ Contract #	P-Personal G-Group B-Business A-Annuity	To Be Replaced Changed or Affected	1035 Exchange
				☐P ☐B ☐G ☐A	☐ Yes ☐ No	☐ Yes ☐ No
				☐P ☐B ☐G ☐A	☐ Yes ☐ No	☐ Yes ☐ No
				☐P ☐B ☐G ☐A	☐ Yes ☐ No	☐ Yes ☐ No

Chart for question 21c

Name of Company	Total Amount (Face Plus Riders)	Competitive or Additional
	$	☐ Competitive ☐ Additional
	$	☐ Competitive ☐ Additional

PERSONAL HISTORY

22. Have you ever had a driver's license suspended, revoked or restricted? ☐ Yes ☐ No
23. Have you in the last 5 years, been convicted of, or pled guilty or no contest to reckless or negligent driving, any moving violations or driving under the influence of alcohol or drugs? ☐ Yes ☐ No
24. Have you in the last 2 years been disabled for 2 or more weeks? ☐ Yes ☐ No

Complete if any answer to question(s) 22 through 24 is "Yes." (Use remarks section if additional space is needed)

Question #	Date (mm/dd/yyyy)	Description of Event

25. Do you engage in regular exercise? (For example, running, walking, strength training, tennis) ☐ Yes ☐ No
If "Yes," give details of type, frequency and length of time _____

_____

26. Have you ever had an application for life or health insurance declined, postponed, required an extra premium, offered with a reduced face amount or other modification or had a life or health policy or contract that was cancelled, recalled or denied renewal?
(If "Yes," please state companies and provide full details.) ☐ Yes ☐ No
27. Have you in the last 10 years, been convicted of, or pled guilty or no contest to a felony, or are current felony charges pending? *(If "Yes," state offense and penalty, date of probation, duration of probation and end date in remarks section.)* ☐ Yes ☐ No
28. Do you expect to travel outside of the U.S. or Canada, or change your country of residence in the next 2 years? *(If "Yes," complete Foreign Residence and Travel Questionnaire)* ☐ Yes ☐ No
29. a. In the last 2 years have you flown other than as a passenger? *(if "Yes," complete Aviation Questionnaire)* ☐ Yes ☐ No
    b. In the next 2 years do you plan to fly as other than a passenger? *(If "Yes," complete Aviation Questionnaire)* ☐ Yes ☐ No
    c. In the last 2 years have you engaged in motor racing on land or water, underwater diving, skydiving, ballooning, hang gliding, parachuting or flying ultra-light aircraft or other hazardous sports or hobbies? *(If "Yes," complete Avocation Questionnaire)* ☐ Yes ☐ No
    d. In the next 2 years do you plan to engage in motor racing on land or water, underwater diving, skydiving, ballooning, hang gliding, parachuting or flying ultra-light aircraft or other hazardous sports or hobbies? *(If "Yes," complete Avocation Questionnaire)* ☐ Yes ☐ No
30. Are you a member of the armed forces, including the reserves? ☐ Yes ☐ No
(reserves includes active duty or full time training of 31 days or more per year)
(If "Yes," you must also submit a completed and signed Life Insurance/Annuity Disclosure to Active Duty Members of the Armed Forces)

ALCOHOL/DRUG/TOBACCO USE

31. Have you ever received medical treatment or counseling for, or been advised by a physician to reduce or discontinue, the use of alcohol or prescribed or non-prescribed drugs? *(If "Yes," complete Substance Usage Questionnaire)* ☐ Yes ☐ No

Do not complete if Proposed Insured is age 0–17

32. Do you currently use or have you ever used tobacco or nicotine products? ☐ Yes ☐ No
If "Yes," provide details in chart below.

Product Type(s)	Amount and Frequency Indicate amount and frequency of use	Indicate date last used (mm/yyyy)
☐ Cigarettes	# ____ per ☐ Day ☐ Month ☐ Year	
☐ Cigars ☐ Cigarillos	# ____ per ☐ Day ☐ Month ☐ Year	
☐ Pipe ☐ Chewing Tobacco ☐ Nicotine Patch or Gum	Not Applicable	
☐ Other (please specify)		

MEDICAL CERTIFICATION

Section to be completed only when submitting medical examinations of another insurance company
If "Yes" to questions 34 or 35, complete a Medical Information Questionnaire

33. Name of Insurance Company _____ Date of Exam _____ (mm/dd/yyyy)
34. To the best of your knowledge and belief, have there been any changes to the statements in the examination? ☐ Yes ☐ No
35. Have you consulted a medical doctor or other practitioner since the examination indicated in question 33 above? ☐ Yes ☐ No

SOURCE OF FUNDS

Questions 36 and 37a-c not required if completing Owner's Questionnaire

"Parties" refers to the following: the Proposed Insured, the Owner or Beneficiary, the Beneficiary of any Trust owning the policy; and/or the Owner of any legal entity owning the polices.

36. Do you intend to finance any of the premium required to pay for this policy through a financing or loan agreement? ☐ Yes ☐ No
(If "Yes," submit a copy of the financing or loan agreement)

37. a. Indicate the source of funds used to purchase this insurance.
☐ Income ☐ Investments/Savings ☐ Loans ☐ Gifts/Inheritance
☐ Settled Contracts (give details)_____ ☐ Other (please specify)_____

b. Have any of the Parties been offered or promised any incentive (financial or otherwise) as an inducement to apply for or purchase the proposed policy, such as (but not limited to), zero cost or no cost life insurance or cash payments? ☐ Yes ☐ No

c. Has any compensation or other inducement (including cash, offers or discussions of free insurance, any forgiveness or potential forgiveness of any debt, or other benefits) been discussed or offered directly or indirectly to any of the following in connection with the application for the purchase of this policy: the Proposed Insured, the Owner or Beneficiary, the Beneficiary of any Trust owning the policy, and/or the owner of any legal entity owning the policy, or is there any expectation of receiving any such compensation or inducement? ☐ Yes ☐ No

If "Yes," please state the compensation or inducement that will be received or could be received and by whom.

_____

_____

_____

JUVENILE INSURANCE

COMPLETE IF PROPOSED INSURED IS UNDER AGE 15
Medical Information Questionnaire is also required

38. a. Total amount of Insurance in force on the life of: Applicant $_____

Parent(s)/Legal Guardian if other than Applicant $_____

b. What is the relationship between the Applicant and the Proposed Insured if other than Parent/Legal Guardian?_____

c. Any other children in the family insured for a lesser amount? ☐ Yes ☐ No If "Yes," details _____

_____

d. Is Applicant different from the Owner? ☐ Yes ☐ No Applicant's Name _____

Applicant's SSN _____ Relationship to Proposed Insured _____

Applicant's Address _____
No. & Street Bldg./Apt./Suite City/Municipality State Zip Code

MONEY PAID WITH APPLICATION

COMPLETE IF MONEY IS PAID WITH APPLICATION

Insurability Questions for Limited Temporary Insurance Agreement

39. Is any Proposed Insured less than 15 days or over 70 years of age? ☐ Yes ☐ No
40. Within the past 24 months has any Proposed Insured been attended by a care provider or been seen at a medical facility for heart condition or disease, stroke or cancer? ☐ Yes ☐ No
41. Within the past 10 years has any Proposed Insured been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) by a member of the medical profession? ☐ Yes ☐ No
42. Within the past 12 months has any Proposed Insured: been admitted, or advised by a medical professional to be admitted, to a hospital or other licensed health care facility; had surgery performed or recommended; or been advised by a medical professional to have any diagnostic test (excluding AIDS-related test) that was not completed? ☐ Yes ☐ No
43. Other than planned routine check-ups, does the Proposed Insured have concerns or symptoms for which a medical professional has not yet been consulted? ☐ Yes ☐ No
44. Within the past 24 months has any Proposed Insured been declined for a life, health or Long-Term Care policy? ☐ Yes ☐ No

COMPLETE ONLY IF "NO" TO ALL QUESTIONS IN 39-44 IN SECTION A OF THIS APPLICATION AND QUESTIONS 36 TO 41 IN THE SURVIVORSHIP PRODUCT QUESTIONNAIRE, IF APPLICABLE. IF ANY OF QUESTIONS 39-44 in SECTION A OF THIS APPLICATION OR QUESTIONS 36-41 OF THE SURVIVORSHIP PRODUCT QUESTIONNAIRE, IF APPLICABLE, ARE ANSWERED "YES" or LEFT BLANK A PREMIUM MAY NOT BE PAID BEFORE THE POLICY IS DELIVERED AND **NO TEMPORARY INSURANCE WILL BE IN EFFECT.**

45. Is money paid with this Application? ☐ Yes ☐ No If "Yes," amount paid $ _____

If "Yes," and an amount paid is indicated above, complete and sign the Temporary Insurance Agreement.

REMARKS – When providing details to questions, please reference question number. If additional space is needed, attach additional sheet(s) of paper with your name and signature.

AXA Equitable Life Insurance Company MONY Life Insurance Company of America

(Referred to below as "the Company(ies)")

SECTION D – AUTHORIZATION/AGREEMENT SIGNATURE

THIS DOCUMENT MUST BE COMPLETED, SIGNED AND SUBMITTED WITH ENTIRE APPLICATION

ACKNOWLEDGEMENT OF OUR UNDERWRITING PROCESS	I (We) acknowledge that I (we) have reviewed the statement of the Underwriting Process of the Company(ies) (the "Statement") which describes from whom and why the Company(ies) obtains information about me (us), to whom such information may be reported and how I (we) may obtain a copy of it. The Statement contains the notice required by the Fair Credit Reporting Act. I (We) acknowledge that in the event the Company(ies) use lab results from another insurance company authorized by me (us) it does so with the belief that I (we) have satisfied all consent and disclosure procedures for the other insurance company.
AUTHORIZATION TO OBTAIN NON-HEALTH INFORMATION	I (We) authorize any employer, business associate, government unit, financial institution, consumer reporting agency, the Medical Information Bureau, my (our) insurance agency and my (our) financial professional to disclose to the Company(ies) and its authorized representatives any information they may have about my (our) occupation, avocations, insurance activities, finances, driving record, character and general reputation. I (We) authorize the Company(ies) to obtain investigative consumer reports, as appropriate.
PURPOSE OF AUTHORIZATIONS	I (We) understand that the information obtained will be used by the Company(ies) to determine my (our) eligibility for life insurance coverage and such other uses specified in accordance with the Statement attached to this application. In addition, information may be disclosed to the Medical Information Bureau (MIB).
COVERAGE CONDITIONS	I (We) understand that the Company(ies) may not issue coverage unless I (we) provide this authorization, and that, while I (we) may refuse to sign this authorization, my (our) refusal to do so could result in coverage not being issued.
ADDITIONAL AUTHORIZATIONS	I (We) understand that the Company(ies) may request additional authorizations in order to obtain the information the Company(ies) needs to complete its review of my (our) application and, if the policy is issued, in connection with any claim asserted under the policy, I (we) understand that I (we) am (are) not required to provide these authorizations but that, if I (we) choose not to provide them, this application and any claim made under the policy, if issued, may be rejected.
DURATION	Unless otherwise revoked, I (we) agree that this authorization will expire on the earlier of the date that the Company(ies) declines my application for coverage or, if a policy is issued, 24 months from the date of my (our) application. I (We) understand that I (we) may revoke my (our) authorizations at any time, except to the extent that the Company(ies) has (have) taken action in reliance on this authorization, and that this application and any claim made under the policy, if issued, may be rejected. My (Our) revocation must be submitted in writing to: Corporate Chief Underwriter, 1290 Avenue of the Americas, New York, New York 10104.

SECTION D – AUTHORIZATION/AGREEMENT SIGNATURE

AUTHORIZATION IF BANK DRAFT IS ELECTED	I (We) request and authorize my (our) Bank to charge monthly or quarterly my (our) checking account to pay premiums due under the policy(ies). It is understood that debits will be made automatically after the effective date determined by the Company checked on page 1 above section A of the Application and/or any other affiliated companies, and if charges are overlooked or inadvertently not made, the Company checked on page 1 above section A of the Application and/or any other affiliated companies may charge my (our) account at a later date provided the policy(ies) is (are) active. I (We) understand that the use of the Bank Draft Payment Plan does not change any policy provision. I (We) understand this authorization is to remain in full force and in effect, unless terminated. I (We) understand this Plan may be terminated by the depositor, the Owner or the Company checked on page 1 above section A of the Application and/or any other affiliated companies upon 30 days written notice to the other parties or if any charge due is not paid or is reversed by the Bank. I (We) understand this Plan may be terminated upon closing of my account. I (We) understand if this Plan is terminated, premiums for regular or scheduled premium policies will be payable directly to the Company checked on page 1 above Section A of the Application. I (We) agree that this Plan may be terminated if any debit is not honored by the Bank or Depository for any reason. I (We) further agree that if any such charge is dishonored, whether with or without cause and whether intentionally or inadvertently, the Company checked on page 1 above section A of the Application and/or any other affiliated companies shall be under no liability whatsoever, even if such dishonor results in the forfeiture of insurance.

AGREEMENT	Each signer of this Application agrees that: 1) Except when the required money is paid with this Application and as stated in the Temporary Insurance Agreement/Receipt, no insurance shall take effect on this Application: (a) until the date the policy and all amendments are delivered to the Owner(s) and all delivery requirements have been completed; (b) before any Register Date of the policy; and (c) unless the statements and answers in all parts of this Application and any applicable supplements continue to be true and complete to the best of my (our) knowledge and belief, without material change, as of the latest of the date: (i) the policy and all amendments are delivered to the Owner(s); (ii) all delivery requirements have been completed; and (iii) the full initial premium is paid while the person(s) proposed for insurance is (are) living. 2) If temporary insurance is to be provided, the full initial premium must accompany this Application; the Proposed Insured(s) and Owner(s) understand and agree to the terms of the Temporary Insurance Agreement/Receipt and have executed and the Owner(s) has received a copy of the Temporary Insurance Agreement/Receipt. 3) The Temporary Insurance Agreement/Receipt states the conditions that must be met before any insurance takes effect if the full initial premium is paid with this Application. Temporary insurance is not provided for a policy or benefit applied for under the terms of a guaranteed insurability option or a conversion privilege. 4) No financial professional or medical examiner has authority to modify this Application and/or its supplements or questionnaires, the Temporary Insurance Agreement/Receipt (if applicable), or to waive any of the Company's rights or requirements. 5) We shall not be bound by any information unless it is stated in Application Part 1, Application Part 2 or any of its supplements or questionnaires. 6) I (We) acknowledge receipt of the Living Benefits Brochure (Accelerated Death Benefit Rider Brochure), where applicable. 7) I (We) acknowledge that no representation is made that a particular rate or risk classification is being offered based on the information provided in response to the policy Application questions. 8) If applicable, the Trustee(s) represent(s) that the Trust named as Owner is allowed to purchase life insurance and securities under the trust document. I (We) further represent that beneficial interests in the Trust are at this time, and currently intend to be only for parties who are related closely by blood or law, and have a substantial interest in the Proposed Insured(s) engendered by love and affection, or those who have a lawful and substantial economic interest in the continued life of the Proposed Insured(s). 9) I (We) represent and certify to the Company checked on page 1 above section A of the Application and/or any other affiliated companies that none of the monies utilized to fund this policy derived directly or indirectly from illegal activities or sources and/or tax evasion.

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION	***Under the penalties of perjury, I (we) certify that (i) the number showing on this form is my (our) correct Taxpayer Identification Number (Social Security Number, Employer Identification Number or other Taxpayer Identification Number), and (ii) I (we) am (are) not subject to backup withholding because (A) I (we) am (are) exempt from backup withholding or (B) I (we) have not been notified by the Internal Revenue Service (IRS) that I (we) am (are) subject to backup withholding as a result of a failure to report all interest or dividends or (C) the IRS has notified me (us) that I (we) am (are) no longer subject to backup withholding and (iii) I (we) am (are) a U.S. person (including a U.S. resident alien). Certification Instructions: You must cross out item (ii) above if you have been notified by the Internal Revenue Service that you are currently subject to backup withholding because you have failed to report all interest or dividends on your tax return. The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.***

SECTION D – AUTHORIZATION/AGREEMENT SIGNATURE

STATE FRAUD DISCLOSURES

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 AN INTENTIONALLY FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

ACKNOWLEDGMENTS

I (We) have a right to ask for and receive copies of this Authorization/Agreement Signature Form and all other authorizations signed by me (us). I (We) agree that reproduced copies will be as valid as the original.

PLEASE INDICATE YOU HAVE REVIEWED THE APPLICATION AND QUESTIONNAIRES AS THEY HAVE BEEN COMPLETED BY CHECKING THE APPROPRIATE BOX(ES) BELOW. FAILURE TO CHECK THE APPROPRIATE BOX(ES) WILL REQUIRE YOU TO SIGN AN APPLICATION AMENDMENT.

☐ **Section A - Proposed Insured Information**

Section B - Product Information (Must select at least 1 product)

- ☐ Term Life
- ☐ Universal Life (Athena UL)
- ☐ Indexed Universal Life (Athena IUL)
- ☐ Variable Universal Life (IL Optimizer II)
- ☐ Variable Universal Life (IL Legacy II)
- ☐ Survivorship Universal Life (ASUL III)
- ☐ Survivorship Variable Universal Life (SIL Legacy)
- ☐ Interest Sensitive Whole Life (ISWL)
- ☐ Employer Sponsored Life Insurance (ESLI)
- ☐ Corporate Owned IL (COIL)

Section C - Additional Underwriting Requirements

- ☐ Owner Questionnaire
- ☐ Foreign Residence and Travel Information Questionnaire
- ☐ Medical Information Questionnaire
- ☐ Financial Information Questionnaire
- ☐ Children's Term Insurance Rider Questionnaire
- ☐ Substance Usage Questionnaire
- ☐ Aviation Questionnaire
- ☐ Avocation Questionnaire
- ☐ Term Policy/Rider Conversion or Purchase Option Questionnaire
- ☐ Long Term Care Services Rider Questionnaire (I have received the Outline of Coverage and Personal Worksheet)

SIGNATURES

I (We), the undersigned agree that the statements and answers in all parts of the Application and any application questionnaires checked above are true and complete to the best of my (our) knowledge and belief. Further, I (we) understand that I am (we are) agreeing to all the terms and conditions of this application, including, but not limited to, Authorization/Agreement Signature.

Notice for VUL Policies Only, Signature required FOR ALL POLICIES:

IMPORTANT NOTICE FOR PERSONS 60 YEARS OR OLDER

YOU MAY RETURN YOUR VARIABLE LIFE INSURANCE POLICY WITHIN 30 DAYS FROM THE DATE THAT YOU RECEIVE IT AND RECEIVE A REFUND AS DESCRIBED BELOW.

WHEN YOU ALLOCATE YOUR ENTIRE PREMIUM TO THE MONEY MARKET ACCOUNT AND/OR THE GUARANTEED INTEREST ACCOUNT AVAILABLE UNDER THE POLICY AS LISTED ON THIS APPLICATION, THEN THE AMOUNT OF YOUR REFUND WILL BE EQUAL TO A RETURN OF YOUR PREMIUM AND POLICY FEES, IF APPLICABLE, UNLESS YOU MAKE A TRANSFER, IN WHICH CASE THE AMOUNT OF YOUR REFUND WILL BE EQUAL TO THE POLICY'S ACCOUNT VALUE. FOR ALL OTHER INVESTMENT ALLOCATIONS, THE AMOUNT OF YOUR REFUND WILL BE EQUAL TO THE POLICY'S ACCOUNT VALUE ON THE DAY THE POLICY IS RECEIVED BY THE COMPANY OR THE FINANCIAL PROFESSIONAL WHO SOLD YOU THE POLICY. THIS AMOUNT COULD BE LESS THAN YOUR INITIAL PREMIUM.

YOU SHOULD NOTE THAT YOU WILL NOT RECEIVE A REFUND IF YOU CHOOSE TO CANCEL THE POLICY AND RETURN IT AFTER 30 DAYS FROM THE DATE THAT YOU RECEIVE IT. A REFUND OF THE POLICY AFTER 30 DAYS MAY RESULT IN A SUBSTANTIAL PENALTY KNOWN AS A SURRENDER CHARGE.

X_____ X_____

Signature of Proposed Insured 1 (Parent, Guardian, or Applicant if Proposed Insured is a Child, Issue Ages 0–14)

Signature of Proposed Insured 2

X_____ _____ _____

Signature of Owner or Applicant if not Proposed Insured(s) (If corporation, print firm's name, signature and title of authorized officer.) (If Trust, signature of trustee.)

Signed by Owner at City, State

Dated on (mm/dd/yyyy)

SECTION D – AUTHORIZATION/AGREEMENT SIGNATURE

FINANCIAL PROFESSIONAL TO COMPLETE THIS SECTION

Will any existing insurance be replaced, changed or affected (or has it been) assuming the insurance applied for will be issued? ☐ Yes ☐ No

If "Yes," is the information provided in question 21 on Part 1 of the Application for Proposed Insured 1, and question 21 of the Survivorship Product Questionnaire for Proposed Insured 2, if applicable, complete and accurate? ☐ Yes ☐ No

If "No," provide details _____

I certify that I have asked and recorded completely and accurately the answers to all questions on the fully completed Application Part 1, and know of nothing affecting the risk that has not been recorded herein.

☐ **I have** witnessed the signature required on the fully completed Part 1.

☐ **I have not** witnessed the signature required on the fully completed Part 1. (Explain below.)

_____

Certification for VUL Policies Only, Signature required FOR ALL POLICIES:

Based on the information furnished by the Proposed Insured(s) and Owner, if other than the Proposed Insured(s), in this and any other part of the application(s), I certify that I have reasonable grounds for believing the purchase of the policy applied for is suitable for the Applicant or the Owner. I further certify the current prospectuses were delivered and that no written sales materials other than those furnished by the Company were used.

X_____ _____

Signature of Licensed Professional/Insurance Broker — Dated on (mm/dd/yyyy)

Print Licensed Financial Professional's Name _____ License Number _____

☐ **AXA Equitable Life Insurance Company**, 1290 Avenue of the Americas, New York, NY 10104

☐ **AXA Equitable Life and Annuity Company,** Home Office: 370 17th Street, Suite 4950, Denver, CO 80202

☐ **MONY Life Insurance Company of America (MLOA),** 2999 North 44th Street, Suite 250, Phoenix, AZ 85018

Instructions: Proposed Insured must complete and sign the bottom portion of this form. The Agent should enter the Examiner's Name and Address, if known. This form must be submitted with the Application.

Name of Examiner _____

Examiner's Address _____

NOTICE AND CONSENT FOR URINE, ORAL FLUID, AND/OR BLOOD TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your urine, oral fluid, and/or blood for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes the Insurer to collect urine, oral fluid, and/or withdraw blood and order laboratory tests only in regard to your present application for insurance.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, immune disorders, nicotine, drugs and certain prescribed medications.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if your HIV test is normal, no report is made about it to the MIB, Inc. If the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MlB, Inc. a generic code which signifies only a non-specific urine, oral fluid, and/or blood test abnormality. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HlV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer asks that you name and authorize disclosure to a physician or other health care provider with whom you can discuss the test results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS Virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

CONSENT AND DISCLOSURE

I have read and I understand this Notice and Consent For Urine, Oral Fluid, and/or Blood Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the collection of urine and/or oral fluid and/or withdrawal of blood from me by needle, the testing of that urine, oral fluid, and/or blood, and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

In the event of positive test results, I authorize disclosure to the following physician or health care provider:

Name: _____

Address: _____

_____ _____

Print Name of Proposed Insured | Date of Birth

_____ _____ _____

Signature of Proposed Insured or Parent/Guardian | Date | State of Residence

_____

Witness

Life Insurance Buyer's Guide

This guide can help you when you shop for life insurance. It discusses how to:

- Find a Policy That Meets Your Needs and Fits Your Budget
- Decide How Much Insurance You Need
- Make Informed Decisions When You Buy a Policy

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers.

This guide does not endorse any company or policy.

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AXA Equitable Life Insurance Company and affiliates.

IMPORTANT THINGS TO CONSIDER

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.
2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?
3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.
4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.
5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance **may be costly**.
6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.
7. Review your **life insurance** program with your agent or company every few years to keep up with changes in your income and your needs.

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Buying Life Insurance

When you buy **life insurance**, you want coverage that fits your needs.

First, decide how much you need–and for how long–and what you can afford to pay. Keep in mind the major reason you buy **life insurance** is to cover the financial effects of unexpected or untimely death. **Life insurance** can also be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

What About the Policy You Have Now?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
- It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.
- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

How Much Do You Need?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?
- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

What Is the Right Kind of Life Insurance?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of **life insurance**: **term insurance** and **cash value insurance**. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a conversion period–even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and STUDY IT CAREFULLY. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

Life Insurance Illustrations

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what *could* happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

Finding a Good Value in Life Insurance

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Remember that no one company offers the lowest cost at **all** ages for **all** kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.

AXA Equitable Life Insurance Company MONY Life Insurance Company of America

SECTION B – TERM LIFE INSURANCE

Name of Proposed Insured _____ Date of Birth _____

PLAN INFORMATION

1. Product Name **(Check One)**

☐ **Level Term 10** ☐ **Annual Renewal Term**
☐ **Level Term 15** ☐ **One Year Term**
☐ **Level Term 20**

2. Amount of Insurance $_____

3. Backdate to save age ☐ Yes ☐ No
Max 6 months prior to application date (3 months in OH)
(Premiums for insurance coverage begin on the backdated Register Date)

PREMIUM INFORMATION

4. Premium Mode

a. Direct Billing (By Mail) ☐ Annually* ☐ Semi-annually ☐ Quarterly
Annually is the only payment mode available for the One Year Term product

b. Bank Draft** ☐ Monthly Draft Date is the same as the Register Date
(Voided Check Required)
If bank account holder is not the Owner or Proposed Insured, please complete Systematic Payment Enrollment Form.
☐ **In lieu of voided check, use first premium check to set up Systematic Payment Plan**

c. Salary Allotment ☐ Annually ☐ Semi-annually ☐ Quarterly ☐ Monthly

Unit name _____ Unit number _____ Register date _____ (mm/dd/yyyy)

If Allotter is not Proposed Insured, provide Name _____ SSN/EIN/TIN _____

OPTIONAL BENEFITS/RIDERS

5.

☐ Disability Premium Waiver Rider

☐ Children's Term Insurance Rider *(complete Children's Term Insurance Rider Questionnaire)*

Amount $_____

☐ Other (as allowed or available with product) _____

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AXA Equitable Life Insurance Company
MONY Life Insurance Company of America

LIVING BENEFITS: FINANCIAL SECURITY AT A TIME OF GREAT NEED

ACCELERATED DEATH BENEFITS

We all like to think that we will lead long and healthy lives. Yet if a terminal illness strikes, the emotional and financial hardship can be devastating. The Living Benefits rider (Accelerated Death Benefits rider) can help ease the financial burden often associated with such hardship. The rider allows you to receive a portion of the death benefit from your life insurance policy while the insured person (or in the case of a Survivorship last-to-die policy, the last surviving insured person) is alive, but is medically diagnosed with a terminal illness.

What are Living Benefits?
Living Benefits are offered as a rider to your insurance policy. This rider allows you to receive a portion of the death benefit from your policy if the insured person is medically diagnosed with a condition limiting his or her life expectancy to 12 months or less.

Why are Living Benefits important?
Terminal illness can mean tremendous financial hardship. Living Benefits provide added flexibility and financial security by making funds available to you at a time of great need.

How do I include Living Benefits in my policy?
Generally speaking, if you apply for a life insurance policy with a face amount of at least $50,000, the Living Benefits rider is automatically included — unless you specifically ask to have it excluded. There is no charge if the rider is included at issue. If, however, you initially exclude the Living Benefits rider and wish to add it after the policy has been issued, you may be charged an administrative fee of $100. In addition, we may require that the insured undergo blood testing and provide evidence of insurability to add the rider at a later date.

Does it cost anything to keep this benefit?
There is no charge to you for having the Living Benefits rider on your policy. However, we do accrue interest on the amount of the Living Benefits payment we make to you as well as on any unpaid premium we advance after we make a Living Benefits payment. You may be charged up to $250 (or state variation) per policy to process a claim. The charge is deducted from the available proceeds.

How much money can I receive as a Living Benefit?
Generally, you can receive any amount between $5,000 and 75% of the proceeds that would be payable at death, up to a maximum of $500,000 (or state variation). If you own more than one policy, the combined maximum you may receive for all policies issued by the insurer or its affiliated companies is $500,000 (or state variation).

Do I have to use the money to pay for medical costs or nursing home expenses?
No. You may use the funds for whatever purpose you wish. Living Benefits are not a substitute for either a health insurance policy or a long-term care insurance policy.

If I receive a Living Benefits payment, does it affect how much is left to my beneficiaries?

Yes. A Living Benefits payment acts as a lien (similar to a loan) against your policy. It reduces the death benefit payable to your beneficiaries. It also reduces the amount of policy value available for loans, as well as the cash value of your policy. The lien equals the amount of the Living Benefits payment you receive, plus interest we charge on the lien plus any premiums we advance after the payment is made to keep the policy in force. (Refer to the example on pages 2–3.)

If I receive a payment, does it affect the premiums on my policy?

No. Policy premiums, and their due dates, remain unchanged. If a premium is due on your term, whole life, or any other fixed premium policy after you have received a Living Benefits payment, we will pay the premium and add the unpaid premium amount to the lien. If your policy is a flexible premium variable, universal or adjustable life policy and there is not sufficient value in the policy to keep it from lapsing after a Living Benefits payment is made, we will advance a premium sufficient to keep the policy in force. Any premiums we advance will be added to the lien.

What happens to my policy if I receive a payment and the insured person lives longer than expected?

Nothing, unless the amount of the lien including interest, plus premiums advanced by the insurer, if any, reaches a point where it equals the total death benefit payable under the policy. In this case, you may repay the total amount of the lien or let the policy terminate.

Can my policy lapse after I receive a Living Benefits payment?
Yes. If at any time the amount of the lien equals the total death benefit, we will notify you by mail that the policy and rider will terminate in 31 days, unless the full amount of the lien is repaid.

I bought my policy to provide for my beneficiaries. If I receive money from my policy before I die, will their needs still be met?
You may want to consult with your financial professional to find out if your insurance coverage will still be adequate to help meet other needs. This is especially important if you bought your policy to provide for estate liquidity or for the financial security of others after your death.

Do I have other options if I need money from my policy?
Depending on the type of policy you own, you may be able to borrow or withdraw money from your policy instead of receiving a Living Benefits payment. As with a Living Benefits payment, loans or withdrawals will reduce a policy's cash value and the death benefit payable to your beneficiary. However, a Living Benefits payment will usually provide you with more money than a policy loan or withdrawal.

Is a Living Benefits payment taxable to me?
Generally not, but you should consult with your personal tax advisor on this issue.

Will a payment affect whether the insured is eligible for public assistance programs like Medicaid and Supplemental Social Security (SSI)?
It may. We suggest that you contact the appropriate government agencies to inquire about limits on eligibility.

How do I collect Living Benefits?
You must submit a claim to the insurer. To do so, either call the Customer Service toll-free number at 1-800-777-6510 or write to the National Operations Center, P.O. Box 1047, Charlotte, NC 28201, to request a Living Benefits Claim Kit. The Claim Kit provides detailed information and instructions as well as the necessary forms for filing a claim.

How is payment made?
It is paid to you in a lump sum by check.

May I submit more than one claim?
Only one Living Benefits payment will be approved for each policy that you own.

A HYPOTHETICAL EXAMPLE

Joe is 55 years old and has been diagnosed with cancer. He is not expected to live longer than 12 months. He decides to submit a claim for Living Benefits under his $200,000 universal or adjustable life policy. The cash surrender value of the policy is currently $50,000, and he has no policy loans outstanding on the policy.

Joe contacts his financial professional and finds that the maximum Living Benefits available to him is the lesser of $500,000 and 75% of $200,000 = $150,000. He requests half of this amount, or $75,000, on his claim and receives a lump sum payment of $74,750 (claim processing fee of $250 assessed).

Joe dies 10 months after filing his claim for Living Benefits. His wife as the beneficiary on his policy receives $120,032. This death claim payment and other policy values are calculated as follows.

Before Payment of Living Benefits:	
Policy Death Benefit	$200,000
Cash Surrender Value	$50,000
Living Benefits Payment Requested	$75,000
Net Amount Minus $250 Processing Fee	$74,750

Immediately after Payment of Living Benefits:	
Death Benefit	$200,000
Lien Outstanding	$75,000
Death Benefit Net of the Lien	$125,000
Cash Surrender Value	$50,000
Initial Lien against Cash Value [75,000 x (50,000/200,000)][1]	$18,750
Cash Surrender Value Net of Lien	$31,250

1 *The lien resulting from the Living Benefit payment is equal to the amount of Living Benefit plus accrued interest plus additional amounts, if any, that are advanced to keep the policy in force. A portion of the lien is allocated against the cash/loan value generally in proportion to the relationship between the cash values and the death benefit.*

TEN MONTHS LATER:

Lien	$75,000
Interest on Lien[2]	$4,968
Lien Plus Interest	$79,968
Death Benefit Net of the Lien [200,000 – $79,968]	$120,032

2 *Assumes a hypothetical 8% annual rate. The actual interest rate will not exceed the greater of the 90-Day Treasury Bill and the maximum adjustable policy loan rate permitted at the time the Living Benefits payment is made. The interest rate accrued on the portion of the lien that is allocated to the policy cash value will not be more than the policy loan interest rate.*

This brochure provides general information about Living Benefits. It is not a policy or a contract of insurance. More detailed information is available from your financial professional. Unlike proceeds payable at death, money received as Living Benefits may be taxable. Review the Living Benefits information with your personal tax advisor before you choose to make use of this benefit. There may be variations in the features and disclosures regarding the Living Benefits in order to comply with individual state insurance laws. Living Benefits may not be available in all states.

Notes:

Please be advised that this brochure is not intended as legal or tax advice. Accordingly, any tax information provided in this brochure is not intended or written to be used, and cannot be used, by any taxpayer for the purpose of avoiding penalties that may be imposed on the taxpayer. The tax information was written to support the promotion or marketing of the transaction(s) or matter(s) addressed, and you should seek advice based on your particular circumstances from an independent tax advisor.

For all life insurance products other than Incentive Life® Legacy℠, the Living Benefits rider is issued by AXA Equitable Life Insurance Company (AXA Equitable), New York, NY 10104.

For Incentive Life® Legacy℠, the Living Benefits rider is issued by MONY Life Insurance Company of America (MONY America) in all states and jurisdictions other than New York, Puerto Rico and the Virgin Islands, where it is issued by AXA Equitable. MONY America is an Arizona Stock Corporation, with the main administrative office at 1290 Avenue of the Americas, New York, NY 10104.

Variable life insurance is co-distributed by affiliates AXA Advisors, LLC and AXA Distributors, LLC, both located at 1290 Avenue of the Americas, New York, NY 10104.

AXA Equitable Life Insurance Company, MONY Life Insurance Company of America, AXA Advisors and AXA Distributors are affiliated and directly or indirectly owned by AXA Equitable Financial Services, LLC. and do not provide tax or legal advice. You should consult with your own attorney and/or tax advisor before making final Investment or planning decisions.

Incentive Life® is a registered service mark and Incentive Life® Legacy℠ is a service mark of AXA Equitable.

1290 Avenue of the Americas, New York, NY 10104, (212) 554-1234

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FINANCIAL PROFESSIONAL/BROKER CERTIFICATION FOR PRODUCTS OTHER THAN VARIABLE LIFE AND INDEXED UNIVERSAL LIFE

Name of Proposed Insured _____ Date of Birth _____ (mm/dd/yyyy)

PROPOSED INSURED INFORMATION

Brokerage Name/Agency Code _____

1. Rate Class/Tobacco Class quoted Proposed Insured 1 _____
   Proposed Insured 2 _____
2. Are you aware of any other information that would adversely affect Proposed Insured's eligibility, acceptability, or insurability?
   Proposed Insured 1 ☐ Yes ☐ No Proposed Insured 2 ☐ Yes ☐ No
   If "Yes," please provide details _____
   If "Yes," do not accept money and/or execute a Temporary Insurance Agreement/Receipt.

3a. Does (do) the Proposed Insured(s) speak and understand English?
   Proposed Insured 1 ☐ Yes ☐ No Proposed Insured 2 ☐ Yes ☐ No

b. Does the Owner speak and understand English? ☐ Yes ☐ No

4. Did you:
   a. Verify the identity of the Proposed Insured(s) and Owner by reviewing the driver's license, passport or other Government Issued ID?
      Proposed Insured 1: ☐ Yes ☐ No Proposed Insured 2: ☐ Yes ☐ No Owner: ☐ Yes ☐ No
   b. Inquire about the source of the customer's assets and income?
      Proposed Insured 1: ☐ Yes ☐ No Proposed Insured 2: ☐ Yes ☐ No Owner: ☐ Yes ☐ No
   c. Confirm that the Proposed Insured(s), Owner or Applicant is not (nor is a family member of or associated with) a foreign military, government or political official?
      Proposed Insured 1: ☐ Yes ☐ No Proposed Insured 2: ☐ Yes ☐ No Owner: ☐ Yes ☐ No
      (If "No," to 4.a, b, or c, money may not be taken without Company home office approval.)
5. How long have you known Proposed Insured 1 _____ Proposed Insured 2 _____
6. Your relationship, if any, to Proposed Insured 1 _____ Proposed Insured 2 _____
7. If Proposed Insured is a child (issue age 0–14), when did you last see child? _____(mm/dd/yyyy)

FINANCIAL PROFESSIONAL INFORMATION

8.

Financial Professional Name(s)	**Financial Professional Number**	**%**	**Contact by ☐ Phone ☐ E-mail ☐ Fax Contact or E-mail Address**	**Annualize Commission Retail Only**
				☐ Do not prepay (4) ☐ Prepay (5)
				☐ Do not prepay (4) ☐ Prepay (5)
				☐ Do not prepay (4) ☐ Prepay (5)

CERTIFICATION/AGREEMENT

MUST BE COMPLETED AND SIGNED BY FINANCIAL PROFESSIONAL OR BROKER

I certify that I have successfully communicated to the Proposed Insured(s) and Owner(s) AXA Equitable's position against stranger originated life insurance (STOLI). I have not promoted or facilitated the promotion of a planned sale or assignment of this proposed policy to a life settlement, viatical, or other secondary market provider or other investor, nor am I aware that the issuance of this proposed policy is being procured by any such entity. I have not been involved in any sale or potential sale of a beneficial interest in this proposed policy or interest in an entity owning this proposed policy, nor am I aware of any terms in any Trust documents connected with this proposed policy providing for subsequent transfers of beneficial interests therein. Further, I am not aware of any discussion with a third party, relative to a potential transfer of an interest in this proposed policy outside of the sales process.

I certify that I have truly and accurately recorded all information supplied by Proposed Insured(s), Owner(s) and any Applicant(s) onto this Application. I know of nothing affecting the insurability of the Proposed Insured(s) which is not fully recorded in this application.

I agree to notify AXA Equitable or the Company checked on page 1 of section A of the Application if I am aware there is any material change* to any of the answers or representations made in this application or its supplements or questionnaires before the full initial premium is paid, the proposed policy is delivered, and all other delivery requirements are completed. I further certify that all sales materials used during the sales process including buyer's guides and disclosure notices were appropriate and in accordance with regulatory and compliance guidelines.

**A change that may affect the rating or insurability of the Proposed Insured(s) or the overall approval of this Application.*

Signature of Licensed Financial Professional/Insurance Broker _____ Date _____

Print Licensed Financial Professional/Insurance Broker's Name _____

License Number _____

COMPANY COPY

(Check One) ☐ **AXA Equitable Life Insurance Company** ☐ **MONY Life Insurance Company of America**

LIMITED TEMPORARY INSURANCE AGREEMENT/RECEIPT

Name of Proposed Insured _____ Date of Birth _____ (mm/dd/yyyy)

INSTRUCTIONS

If the full initial premium is paid with the Application, and all the questions 39 to 44 in section A of the Application and questions 36 to 41 in the Survivorship Product Questionnaire, if applicable, are answered "no," one original, signed Temporary Insurance Agreement/Receipt must be returned with the application. The other original, signed Temporary Insurance Agreement/Receipt must be left with the Owner(s). If the policy applied for is a survivorship policy, both Proposed Insured(s) and the Owner must sign.

In this Agreement, "we," "our," and "us" mean the insurance company checked above. We will pay an insurance benefit, upon receipt of all claim documents that we may require at that time, to the beneficiary named in the Application if a person proposed for insurance dies while temporary insurance is in effect. For joint survivorship life insurance policies, the insurance benefit is payable upon the death of the second of the Proposed Insureds to die. Any coverage provided under this Agreement is subject to the conditions stated below. The temporary insurance will be in the amount described below and in accordance with the terms of the policy we would issue.

CONDITIONS

Conditions Precluding Temporary Insurance Coverage: **If any of the following applies, no financial professional is authorized to accept payment, and NO INSURANCE WILL TAKE EFFECT UNDER THIS AGREEMENT.**

(1) Any of the questions 39 to 44 in Section A of the Application or **questions 36 to 41 in the Survivorship Product Questionnaire, if applicable,** is answered YES or LEFT BLANK.
(2) Any material misstatement made in any part of the Application, any application supplement, questionnaire or in this Agreement.
(3) The amount paid with this Agreement is less than the full initial premium required for the policy, or a properly signed approved payment authorization is not submitted.
(4) The check or withdrawal authorization submitted with this Agreement is dishonored when first presented for payment.

DATE TIA STARTS

Date Temporary Insurance Coverage Starts: Temporary insurance under this Agreement shall not take effect until: (i) we receive the full initial premium, and (ii) a signed Application, and (iii) the later of (a) and (b) has occurred.

a. The date that the Medical Information Questionnaire is completed, if initially required as to any Proposed Insured(s) by our published underwriting rules (see below).

To be completed by Financial Professional/Insurance Broker: A Medical Information Questionnaire

☐ **Is** required for Proposed Insured 1 ☐ **Is not** required for Proposed Insured 1 and
☐ **Is** required for Proposed Insured 2 ☐ **Is not** required for Proposed Insured 2

OR

b. The date that Part 2 (Paramedical or Medical exam) is completed, if initially required as to the Proposed Insured(s) by our published underwriting rules (see below).

To be completed by a Financial Professional/Insurance Broker: An Application Part 2 (Paramedical or Medical Exam)

☐ **Is** required for Proposed Insured 1 ☐ **Is not** required for Proposed Insured 1 and
☐ **Is** required for Proposed Insured 2 ☐ **Is not** required for Proposed Insured 2

If any Proposed Insured dies as a result of accidental bodily injury, directly and independently of all other causes, before a required Medical Information Questionnaire or Application Part 2 (Paramedical or Medical Exam) for that person is completed, then the temporary insurance will be in effect subject to the conditions contained in this Agreement, unless it terminated earlier.

LIMITED AMOUNT

The amount of temporary insurance is the amount of insurance applied for on the life of any Proposed Insured and in effect under all Temporary Insurance Agreements/Receipts issued by the company checked above, and its subsidiaries or affiliates, not to exceed $1,000,000 in total.

DATE TIA COVERAGE ENDS

Date Temporary Insurance Coverage Ends—90-Day Maximum Coverage Period: Temporary insurance under this Agreement will end upon the earliest of:

(1) The date we offer insurance other than as applied for on any Proposed Insured; and
(2) The date the policy takes effect, which is the date the policy and all amendments are delivered to the Owner(s) and all delivery requirements have been completed; and
(3) The date any policy issued under the Application is refused by the Owner(s); and
(4) Five days after we mail a notice declining the Application and enclosing a refund on any premium paid; and
(5) The 90th day after the date Part 1 of the Application is signed by the Proposed Insured(s) and Owner(s).

COVERAGE NOT PROVIDED

(1) No coverage is provided under this Agreement for a policy or benefit applied for under the terms of a guaranteed insurability option or a conversion privilege.
(2) No coverage is provided under this Agreement if Section 1035 paperwork is received without the full initial premium with the Application for the Exchange Contract.
(3) There is no coverage under this Agreement for any death resulting from suicide (while sane or insane). Our liability is limited to return of premium paid.

PREMIUM CHECKS

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY CHECKED ON PAGE ONE. DO NOT MAKE CHECK PAYABLE TO THE FINANCIAL PROFESSIONAL OR LEAVE THE PAYEE BLANK.

Receipt: Received from **X**_____

$_____ , which is at least the full initial premium required for the policy.
The payment indicated above will be refunded (without interest) if any temporary insurance under this Agreement ends, other than because of death or because the policy has taken effect.

AFFIRMATIONS

In signing below, I (we) agree that I (we) have reviewed all parts of the Application and, as of date below, I (we) affirm that the statement and answers made in all parts of that Application continue to be true and complete to the best of my (our) knowledge and belief. I (We) understand that if the conditions listed in the Agreement are not met, no temporary insurance will take effect. I (We) also understand the provisions contained in this Agreement regarding: (1) the limitation on the amount of temporary coverage provided; (2) when temporary coverage will begin and end; and (3) the coverage that is **not** provided under this Agreement. I (We) explicitly agree to all of the terms and conditions contained in this Agreement as written and understand **that no financial professional, insurance broker or agent has the authority to modify the Application, its supplements or questionnaires or this Agreement, or to bind the company by making any promise or representation contrary to the terms and conditions contained in the Application or this Agreement.**

SIGNATURES

I (We), the undersigned, by my (our) signature(s) below agree to all the terms and conditions of the Application, including, but not limited to, the Acknowledgment and Authorization.

X_____ **X**_____
Signature of Proposed Insured 1 Signature of Proposed Insured 2
(Parent, Guardian, or Applicant if Proposed Insured is a Child, Issue Ages 0–14)

X_____ _____ _____
Signature of Owner or Applicant if not Proposed Insured(s) Signed by Owner at City, State Dated on (mm/dd/yyyy)
(If corporation, print firm's name, signature and title of authorized officer.)
(If Trust, signature of trustee.)

I am not aware of any other information that would adversely affect Proposed Insured's eligibility for insurance coverage.
On the date of this Agreement, I received the premium amount indicated above. This Agreement bears the same date as the Application Part 1. I have explained the terms of this Agreement to the Proposed Insured(s) and Owner(s) who has (have) stated to me that she/he (they) understand and accept them.

Signature of Licensed Financial Professional/Insurance Broker **X**_____

OWNER COPY

(Check One) ☐ **AXA Equitable Life Insurance Company** ☐ **MONY Life Insurance Company of America**

LIMITED TEMPORARY INSURANCE AGREEMENT/RECEIPT

Name of Proposed Insured _____ Date of Birth _____ (mm/dd/yyyy)

INSTRUCTIONS

If the full initial premium is paid with the Application, and all the questions 39 to 44 in section A of the Application and questions 36 to 41 in the Survivorship Product Questionnaire, if applicable, are answered "no," one original, signed Temporary Insurance Agreement/Receipt must be returned with the application. The other original, signed Temporary Insurance Agreement/Receipt must be left with the Owner(s). If the policy applied for is a survivorship policy, both Proposed Insured(s) and the Owner must sign.

In this Agreement, "we," "our," and "us" mean the insurance company checked above. We will pay an insurance benefit, upon receipt of all claim documents that we may require at that time, to the beneficiary named in the Application if a person proposed for insurance dies while temporary insurance is in effect. For joint survivorship life insurance policies, the insurance benefit is payable upon the death of the second of the Proposed Insureds to die. Any coverage provided under this Agreement is subject to the conditions stated below. The temporary insurance will be in the amount described below and in accordance with the terms of the policy we would issue.

CONDITIONS

Conditions Precluding Temporary Insurance Coverage: **If any of the following applies, no financial professional is authorized to accept payment, and NO INSURANCE WILL TAKE EFFECT UNDER THIS AGREEMENT.**

(1) Any of the questions 39 to 44 in Section A of the Application or **questions 36 to 41 in the Survivorship Product Questionnaire, if applicable,** is answered YES or LEFT BLANK.
(2) Any material misstatement made in any part of the Application, any application supplement, questionnaire or in this Agreement.
(3) The amount paid with this Agreement is less than the full initial premium required for the policy, or a properly signed approved payment authorization is not submitted.
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a. The date that the Medical Information Questionnaire is completed, if initially required as to any Proposed Insured(s) by our published underwriting rules (see below).

To be completed by Financial Professional/Insurance Broker: A Medical Information Questionnaire

☐ **Is** required for Proposed Insured 1 ☐ **Is not** required for Proposed Insured 1 and
☐ **Is** required for Proposed Insured 2 ☐ **Is not** required for Proposed Insured 2

OR

b. The date that Part 2 (Paramedical or Medical exam) is completed, if initially required as to the Proposed Insured(s) by our published underwriting rules (see below).

To be completed by a Financial Professional/Insurance Broker: An Application Part 2 (Paramedical or Medical Exam)

☐ **Is** required for Proposed Insured 1 ☐ **Is not** required for Proposed Insured 1 and
☐ **Is** required for Proposed Insured 2 ☐ **Is not** required for Proposed Insured 2

If any Proposed Insured dies as a result of accidental bodily injury, directly and independently of all other causes, before a required Medical Information Questionnaire or Application Part 2 (Paramedical or Medical Exam) for that person is completed, then the temporary insurance will be in effect subject to the conditions contained in this Agreement, unless it terminated earlier.

LIMITED AMOUNT

The amount of temporary insurance is the amount of insurance applied for on the life of any Proposed Insured and in effect under all Temporary Insurance Agreements/Receipts issued by the company checked above, and its subsidiaries or affiliates, not to exceed $1,000,000 in total.

DATE TIA COVERAGE ENDS

Date Temporary Insurance Coverage Ends—90-Day Maximum Coverage Period: Temporary insurance under this Agreement will end upon the earliest of:

(1) The date we offer insurance other than as applied for on any Proposed Insured; and
(2) The date the policy takes effect, which is the date the policy and all amendments are delivered to the Owner(s) and all delivery requirements have been completed; and
(3) The date any policy issued under the Application is refused by the Owner(s); and
(4) Five days after we mail a notice declining the Application and enclosing a refund on any premium paid; and
(5) The 90th day after the date Part 1 of the Application is signed by the Proposed Insured(s) and Owner(s).

COVERAGE NOT PROVIDED

(1) No coverage is provided under this Agreement for a policy or benefit applied for under the terms of a guaranteed insurability option or a conversion privilege.
(2) No coverage is provided under this Agreement if Section 1035 paperwork is received without the full initial premium with the Application for the Exchange Contract.
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ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY CHECKED ON PAGE ONE. DO NOT MAKE CHECK PAYABLE TO THE FINANCIAL PROFESSIONAL OR LEAVE THE PAYEE BLANK.

Receipt: Received from **X**_____

$_____ , which is at least the full initial premium required for the policy.

The payment indicated above will be refunded (without interest) if any temporary insurance under this Agreement ends, other than because of death or because the policy has taken effect.

AFFIRMATIONS

In signing below, I (we) agree that I (we) have reviewed all parts of the Application and, as of date below, I (we) affirm that the statement and answers made in all parts of that Application continue to be true and complete to the best of my (our) knowledge and belief. I (We) understand that if the conditions listed in the Agreement are not met, no temporary insurance will take effect. I (We) also understand the provisions contained in this Agreement regarding: (1) the limitation on the amount of temporary coverage provided; (2) when temporary coverage will begin and end; and (3) the coverage that is **not** provided under this Agreement. I (We) explicitly agree to all of the terms and conditions contained in this Agreement as written and understand **that no financial professional, insurance broker or agent has the authority to modify the Application, its supplements or questionnaires or this Agreement, or to bind the company by making any promise or representation contrary to the terms and conditions contained in the Application or this Agreement.**

SIGNATURES

I (We), the undersigned, by my (our) signature(s) below agree to all the terms and conditions of the Application, including, but not limited to, the Acknowledgment and Authorization.

X_____ **X**_____

Signature of Proposed Insured 1 Signature of Proposed Insured 2

(Parent, Guardian, or Applicant if Proposed Insured is a Child, Issue Ages 0–14)

X_____ _____ _____

Signature of Owner or Applicant if not Proposed Insured(s) Signed by Owner at City, State Dated on (mm/dd/yyyy)

(If corporation, print firm's name, signature and title of authorized officer.)

(If Trust, signature of trustee.)

I am not aware of any other information that would adversely affect Proposed Insured's eligibility for insurance coverage.

On the date of this Agreement, I received the premium amount indicated above. This Agreement bears the same date as the Application Part 1. I have explained the terms of this Agreement to the Proposed Insured(s) and Owner(s) who has (have) stated to me that she/he (they) understand and accept them.

Signature of Licensed Financial Professional/Insurance Broker **X**_____

THIS PAGE MUST BE LEFT WITH THE PROPOSED INSURED/APPLICANT

UNDERWRITING PROCESS INFORMATION

YOUR INSURANCE APPLICATION

YOUR INSURANCE APPLICATION & HOW IT IS HANDLED

Thank you for applying for life insurance with us. This form provides important information about the underwriting of your Application and our practice respecting your personal and medical record information as required by those states that have adopted the NAIC Model Insurance Information and Privacy Protection Act and other states that may have similar requirements.

OUR UNDERWRITING PROCESS

Underwriting. Our evaluation of your Application begins with the medical history you furnish. Since we rely on the accuracy and completeness of your answers, we may verify them both before and after a policy is issued. This description is not intended to limit or alter the authorization provided in conjunction herewith. In the event of any inconsistencies, the terms of the actual Authorization will control.

Source of Information. We may request additional information from physicians, hospitals, clinics, medical practitioners, medical testing laboratories, pharmacies, pharmaceutical benefits managers, life settlement companies, life settlement brokers/providers, other health care providers, health plans, the Medical Information Bureau, other insurers to which you have applied, your employer, business associates, financial institutions, governmental units, consumer reporting agencies and your financial professional. Your signature of the Acknowledgment and Authorization Form and any additional authorizations we may request permit us to make these inquiries. They may be made by personal interview, by telephone or in writing. We do not use another insurer's underwriting decision as a basis for our decision on your Application. You have the right to know (usually through a physician you name) what information we have concerning you, and if it is incorrect, to have it corrected. If you want more information about this, contact your financial professional. If we request information about you from an insurance support organization, they may also furnish this information to others authorized by you. In this connection, the federal and various state Fair Credit Reporting Acts require that you be given this notice.

To help establish eligibility for insurance, an investigative consumer report (including information on finances, character and general reputation) may be requested. It would be based on interviews with your employer, business associates, financial institutions, governmental units, and references you name. You may also be interviewed yourself. You may write to us for more complete details on consumer reports. You also have the right to know whether a consumer report was made, the name and address of the agency which made it, and to obtain a copy of the report from them. You can obtain a summary of all your rights under the Fair Credit Reporting Act from the Consumer Reporting Agency.

MEDICAL INFORMATION BUREAU (MIB)

The MIB is a non-profit organization of life insurance companies. Its members exchange information in order to protect the majority of applicants from the few who might not disclose significant facts in applying for coverage. Member companies report to it information of underwriting significance as authorized by applicants and policy holders. This information is, in turn, available only to other member companies when appropriately authorized to secure it. While the MIB may help us identify areas about which we need additional information for our underwriting evaluation, we do not use MIB reports as the basis for our underwriting decisions. Upon request, the MIB will arrange for disclosure to you of any information it may have concerning you. If you question the accuracy of this information, you may request a correction according to the federal Fair Credit Reporting Act. You may contact MIB, Inc at 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone: (866) 692-6901.

REPORT OF ADVERSE DECISION

If an adverse underwriting decision is made on your Application, you will be notified and given the reason for this as well as instructions for obtaining further details. If you believe this decision was based on erroneous information, you should contact your financial professional.

WHERE TO WRITE TO US

Where to Write to Us. Your financial professional/insurance broker will be pleased to give you the address of our office to which you can write concerning any of the matters discussed above.

AXA EQUITABLE

AXA EQUITABLE LIFE INSURANCE COMPANY
AXA EQUITABLE LIFE AND ANNUITY COMPANY
MONY LIFE INSURANCE COMPANY OF AMERICA
MONY LIFE INSURANCE COMPANY

SUPPLEMENTAL FORM FOR NEW BUSINESS APPLICATIONS

"AXA Equitable" is the brand name of AXA Equitable Financial Services, LCC and its family of companies, including the above companies.

This supplemental form must be completed for all new business applications submitted to our processing center. Please make sure to provide all information for the applicable beneficiaries listed below. This supplemental form will become part of the application for the coverage you applied for and will amend the "Beneficiary" section of the application.

BENEFICIARY INFORMATION: If no contingent beneficiary is named, the contingent beneficiary will be (1) the Proposed Insured's surviving children, if any, in equal shares; or (2) if the Proposed Insured has no surviving children, the contingent beneficiary will be the Proposed Insured's estate. Total percentage must equal 100% for each category of beneficiary. If percentage shares are left blank, the shares will be deemed equal. If beneficiary is a Trust other than Owner, include full name and date of Trust.

(Please use additional sheets if you have more than three beneficiaries in either category.)

(a) PRIMARY BENEFICIARY(IES)

Full Name:_____ _____ _____
Primary Beneficiary #1 (%) Percentage ☐SSN ☐ITIN ☐EIN

Address_____ City _____State _____Zip_____

_____ _____ _____
Email Address Phone Number Relationship to Proposed Insured

Full Name:_____ _____ _____
Primary Beneficiary #2 (%) Percentage ☐SSN ☐ITIN ☐EIN

Address_____ City _____State _____Zip_____

_____ _____ _____
Email Address Phone Number Relationship to Proposed Insured

Full Name:_____ _____ _____
Primary Beneficiary #3 (%) Percentage ☐SSN ☐ITIN ☐EIN

Address_____ City _____State _____Zip_____

_____ _____ _____
Email Address Phone Number Relationship to Proposed Insured

(b) CONTINGENT BENEFICIARY(IES)

Full Name:_____ _____ _____
Contingent Beneficiary #1 (%) Percentage ☐SSN ☐ITIN ☐EIN

Address_____ City _____State _____Zip_____

_____ _____ _____
Email Address Phone Number Relationship to Proposed Insured

Full Name:_____ _____ _____
Contingent Beneficiary #2 (%) Percentage ☐SSN ☐ITIN ☐EIN

Address_____ City _____State _____Zip_____

_____ _____ _____
Email Address Phone Number Relationship to Proposed Insured

(b) CONTINGENT BENEFICIARY(IES) - Continued

Full Name:_____ _____ _____
Contingent Beneficiary #3 (%) Percentage ☐SSN ☐ITIN ☐EIN

Address_____ City _____State _____Zip_____

_____ _____ _____
Email Address Phone Number Relationship to Proposed Insured

I (we), the undersigned, agree that the information in this supplemental form is true and complete to the best of my (our) knowledge and belief.

X_____ _____
Signature of Owner Dated on (mm/dd/yyyy)
(If corporation, print firm's name, signature and title of authorized officer.)
(If Trust, signature of trustee.)

X_____ _____
Signature of Joint Owner Dated on (mm/dd/yyyy)

AXA EQUITABLE

AXA EQUITABLE LIFE INSURANCE COMPANY
AXA EQUITABLE LIFE AND ANNUITY COMPANY
MONY LIFE INSURANCE COMPANY OF AMERICA
MONY LIFE INSURANCE COMPANY

SECONDARY ADDRESSEE SUPPLEMENTAL FORM FOR CALIFORNIA NEW BUSINESS APPLICATIONS

"AXA Equitable" is the brand name of AXA Equitable Financial Services, LCC and its family of companies, including the above companies.

Name of Proposed Insured(s) _____ Policy Number (If known) _____

This supplemental form must be submitted to our processing center for all new business applications signed in the state of **California.** If you choose to elect a secondary addressee please provide the applicable information below. This supplemental form will become part of the application for the coverage you applied.

PROTECTION AGAINST UNINTENDED TERMINATION: I, the Owner, understand that I have the right to designate at least one person other than myself to receive written notice of lapse or termination of the policy for which I applied. I understand that such notice will not be sent until 30 days after the premium or charge is due and unpaid.

☐ I elect to designate a person to receive such notice (complete information below)
☐ **I DO NOT** elect to designate a person to receive such notice

Name _____

Home Address No. and Street _____ Bldg/Apt/Ste _____

City _____ State _____ Zip Code _____

I (we), the undersigned, agree that the information in this supplemental form is true and complete to the best of my (our) knowledge and belief.

X _____ _____
Signature of Owner — Dated on (mm/dd/yyyy)
(If corporation, print firm's name, signature and title of authorized officer.)
(If Trust, signature of trustee.)

X _____ _____
Signature of Joint Owner — Dated on (mm/dd/yyyy)

(Select One) ☐ **AXA Equitable Life Insurance Company**
☐ **MONY Life Insurance Company of America**

Proposed Insured's Name _____ Date of Birth _____

AUTHORIZATION TO RELEASE INFORMATION PROTECTED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA")

TO OBTAIN HEALTH INFORMATION In this authorization, "I" "we" "our" "me" and "us" means the Proposed Insured/Patient or Authorized Representative. I (We) authorize any physician, hospital, clinic, medical practitioner, medical testing laboratory, pharmacy, pharmacy benefit manager, medically related facility or other health care provider, health plan or insurance company (including the Company selected above, with respect to other coverages) and the Medical Information Bureau to disclose to the Company checked above and its authorized representatives (collectively hereinafter "the Company checked above") any and all information, including medical reports, pharmaceutical records or prescription history, whether fact or opinion, they may have about any diagnosis, treatment, medication or drug history, and prognosis regarding my past, present or future physical or mental condition.

RE-DISCLOSURE OF HEALTH INFORMATION I (We) understand that any disclosure of information to the Company selected above for the purpose of determining my (our) eligibility for coverage carries with it the potential for re-disclosure, meaning the information may no longer be protected by HIPAA. However, please note that such information may be protected by other state and federal privacy laws such as the Gramm-Leach-Bliley Act.

PURPOSE OF AUTHORIZATIONS I understand the following parties may need to collect information on me in regard to the proposed coverage: The Company checked above and its reinsurers; any insurance support organization; any consumer reporting agency; and all persons authorized to represent these organizations for this purpose. I (We) understand that the information obtained will be used by the Company checked above to determine my (our) eligibility for life insurance coverage and any associated risk rating classification, and to obtain reinsurance. If a policy is issued to me (us), this information may also be used in the future to administer my (our) policy and process claims made under the policy. In addition, information may be disclosed to the Medical Information Bureau (MIB) who, upon request, may disclose such information about me (us) in its file to another member company with whom I (we) apply for life or health insurance or to whom a claim for benefits may be submitted; when requested by a government agency; in connection with a legal or arbitration proceeding; or for other purposes as required or permitted by applicable law.

COVERAGE CONDITIONS I (We) understand that the Company checked above is conditioning the issuance of coverage on the provision of this authorization, and that, while I (we) may refuse to sign this authorization, my (our) refusal to do so could result in coverage not being issued.

ADDITIONAL AUTHORIZATIONS You have advised me (us) that the Company checked above may request additional authorizations in order to obtain the information the Company checked above needs to complete its review of my (our) application and, if the policy is issued, in connection with any claim asserted under the policy. I (we) understand that I (we) am not obligated to provide these additional authorizations but that, if I (we) choose not to provide them, this application and any claim made under the policy, if issued, may be rejected.

DURATION Unless otherwise revoked, I (we) agree that this authorization will expire on the earlier of the date that the Company checked above declines my application for coverage or, if a policy is issued, 24 months from the date of my application. I (We) understand that I (we) may revoke my (our) authorization at any time. No termination or revocation shall affect (1) any action that the Company checked above has taken in reliance on this authorization or (2) any right granted the Company checked above by law to contest a claim under the policy or the policy items. If I (we) choose to revoke any authorization, the application and any claim made under the policy, if issued, may be rejected. My revocation must be submitted in writing to: Chief Underwriter, AXA Equitable Life Insurance Company, or MONY Life Insurance Company of America, 1290 Avenue of the Americas, New York, New York 10104.

COPY OF AUTHORIZATIONS I (We) have a right to ask for and receive true copies of this Authorization Form and all other authorizations signed by me (us). I (We) agree that reproduced copies will be as valid as the original.

X_____
Signature of Proposed Insured/Patient or Authorized Representative

_____
Print Name of Proposed Insured/Patient or Authorized Representative

_____
Description of Personal Representative's Authority or Relationship to Proposed Insured/Patient

Dated at City, State _____ on _____
(mm/dd/yyyy)

AXA Equitable Life Insurance Company MONY Life Insurance Company of America

SECTION C – OWNER QUESTIONNAIRE FORMING PART OF THE APPLICATION FOR LIFE INSURANCE – Complete if other than Proposed Insured

Name of Proposed Insured _____ Date of Birth _____ (mm/dd/yyyy)

COMPLETE FOR ALL OWNER TYPES

For Joint Owners provide name, residential address, Social Security #, date of birth, driver's license #, state of issue and expiration date, occupation and employer's name in Remarks Section on the Application.

1. Owner Type ☐ Individually Owned ☐ Partnership ☐ Corporation ☐ Trust ☐ LLC ☐ Sole Proprietorship
2. Owner's name _____
3. Relationship to Proposed Insured _____
4. ☐ SSN ☐ EIN ☐ ITIN _____ 5. Email address _____
6. Address _____

City _____ State _____ Zip Code _____

If P.O. Box, put residential address in Remarks Section.

Complete if Owner Type is Partnership, Corporation, Trust, LLC, Sole Proprietorship

7. Person(s) authorized to act on behalf of Owner Name _____ Title _____

Name _____ Title _____

COMPLETE IF INDIVIDUALLY OWNED

8. Do you have a driver's license? ☐ Yes ☐ No If "Yes," provide license #, state and expiration date

Number _____ State _____ Expiration Date _____ (mm/dd/yyyy)

If no driver's license, do you have a government issued ID? ☐ Yes ☐ No

If "Yes," to government issued ID, type of ID _____ Government ID # _____

9. Date of birth _____ (mm/dd/yyyy) 10. Currently employed? ☐ Yes ☐ No ☐ Retired *(If "Yes," complete question 11)*
11. Occupation _____ Employer name _____
12. Income

Gross Earned Annual Income (salary, commissions, bonuses)	Gross Unearned Annual Income (dividends, pensions, interest, real estate income, etc.)	Gross Annual Income (Household)	Total Net Worth (Household)
$	$	$	$

13. Are you a member of the armed forces, including the reserves? ☐ Yes ☐ No

(reserves includes active duty or full-time training of 31 days or more per year)

(If "Yes," you must also submit a completed and signed Life Insurance/Annuity Disclosure to Active Duty Members of the Armed Forces.)

14. Are you a U.S. citizen? ☐ Yes ☐ No (If "No," please complete "a" and "b" or "c," where applicable.)
    a. Country of Citizenship _____ Date of Entry into the U.S. _____ (mm/dd/yyyy)
    b. Residents with legal permanent status (Resident) in U.S. only

    Green Card/Visa Type _____ Expiration Date _____ (mm/dd/yyyy)
    c. Residents residing in the U.S. temporarily (Non-Resident) with valid Visa only

    Visa # _____ Visa Type _____ Expiration Date _____ (mm/dd/yyyy)

    Form I-94 Expiration Date _____ (mm/dd/yyyy) Passport # _____

Complete Question 15 for all non-resident (foreign) Owners. If the Owner is not a U.S. Person (U.S. Citizen or U.S. Corporation, Partnership or Trust established or organized under the laws of a state of the United States), then he, she or it may have to provide additional documentation, including IRS form W-8 BEN. Any foreign Owner (Individual, Trust, Corporation, Partnership, Other Entity) must have a US bank account.

15. U.S. bank name _____ Account # _____

OTHER INSURANCE

16. Including any policies and riders with AXA Equitable, its affiliates and any other life insurance company:
    a. Do you have any life insurance/annuities currently in force, including any policy that has been sold, settled or assigned to or with a settlement or viatical company or any other person or entity? ☐ Yes ☐ No
    b. Will the coverage applied for replace, change, or affect any existing policy(ies) or contract(s)? ☐ Yes ☐ No

Complete as appropriate if any of questions 16a and b is "Yes"

Name of Company	Total Amount (Face Plus Riders)	Year Issued	Policy/ Contract #	P-Personal G-Group B-Business A-Annuity	To Be Replaced Changed or Affected	1035 Exchange
				☐ P ☐ B ☐ G ☐ A	☐ Yes ☐ No	☐ Yes ☐ No
				☐ P ☐ B ☐ G ☐ A	☐ Yes ☐ No	☐ Yes ☐ No

COMPLETE IF TRUST OWNED

17a. Situs of Trust: The Trust is subject to the laws of the state of _____ b. Date of Trust _____ (mm/dd/yyyy)

18. Name(s) of Grantor(s) _____

19. Name(s) and title(s) of current Trustee(s) _____

20a. How long has the Trustee known the Proposed Insured? _____

b. What is the nature of the relationship between the Proposed Insured and the Trustee? _____

c. Is the Trust? ☐ Revocable ☐ Irrevocable (Check appropriate box)

d. Can interests in the Trust be sold without changing the terms of the Trust? ☐ Yes ☐ No

21. Did the Proposed Insured and/or the Owner retain an attorney to prepare the Trust documents? ☐ Yes ☐ No
If "Yes," provide name and address of attorney. If "No," provide the name and address of the person or entity that did prepare the Trust documents.
Please provide the relationship of the preparer of the Trust to the Proposed Insured

Name _____ Relationship to the Proposed Insured _____

Address _____

22. Name(s) of current Beneficiary(ies) of the Trust _____

23. What is the nature of the relationship between the Grantor(s) and Beneficiary(ies)? _____

24. Is there a Trust Protector? ☐ Yes ☐ No (If "Yes," answer 25a and 25b.)
A Trust Protector is a third party appointed by the Grantor to provide direction and guidance to the Trustee.

25a. How long has the Trustee known the Trust Protector? _____

b. What is the nature of the relationship between the Proposed Insured and the Trust Protector? _____

PURPOSE OF INSURANCE

26. Complete For Personal Insurance
☐ Income Replacement ☐ Mortgage/Debt Repayment ☐ Estate Planning ☐ Charitable/Gifting ☐ Other _____

27. Complete for Business Insurance
☐ Key Person ☐ Buy-Sell ☐ Deferred Comp ☐ Other (please explain) _____

☐ Loan indemnification/Amount of loan $ _____ Duration _____

Interest charged on loan _____ Collateral pledged to secure loan _____

a. Type: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Corporation

b. Name of Business _____ Nature of Business _____

c. How long has the business been in operation? _____ Years d. Fair market value of the business $ _____

e. % of business owned by Proposed Owner, if other than the Proposed Insured _____ %

f. Are all members of the business being similarly insured? ☐ Yes ☐ No
If "Yes," provide details of business coverage issued or applied for on other members (use separate sheet if necessary)

Name and Title	% of Business Owned	Amount In Force or Applied For

g. Has the business filed for bankruptcy and/or reorganization in the past 5 years? ☐ Yes ☐ No

If "Yes," explain _____

h. Business/Corporation finances: (Complete chart below for the past 2 years)

Year	**Assets**	**Liabilities**	**Gross Sales**	**Net Profit**
	$	$	$	$
	$	$	$	$

For employer owned life insurance there are notice and consent requirements, established in the Tax Code, that must be met before issuance of the contract, as well as tax limitations on those who can be insured. When purchasing insurance on employees or directors, you should consult your tax advisor to avoid adverse tax consequences.

SOURCE OF FUNDS

"Parties" refers to the following: the Proposed Insured, the Owner or Beneficiary, the Beneficiary of any Trust owning the policy, and/or the Owner of any legal entity owning the policy.

28. Do you intend to finance any of the premium required to pay for this policy through a financing or loan agreement? ☐ Yes ☐ No
    If "Yes," with whom are you financing _____

29. Indicate the source of funds used to purchase this insurance.
    ☐ Income ☐ Investments/Savings ☐ Loans ☐ Gifts / Inheritance
    ☐ Settled Contracts-give details _____ ☐ Other (specify) _____

30. Have any of the Parties been offered or promised any incentive (financial or otherwise) as an inducement to apply for or purchase the proposed policy, such as (but not limited to), zero cost or no cost life insurance or cash payments? ☐ Yes ☐ No

31. Has any compensation or other inducement (including cash, offers or discussions of free insurance, any forgiveness or potential forgiveness of any debt, or other benefits) been discussed or offered directly or indirectly to any of the following in connection with the application for the purchase of this policy: the Proposed Insured, the Owner or Beneficiary, the Beneficiary of any Trust owning the policy, and/or the owner of any legal entity owning the policy, or is there any expectation of receiving any such compensation or inducement?
    ☐ Yes ☐ No

If "Yes," please state the compensation or inducement that will be received or could be received and by whom.

_____

_____

_____

important information regarding

Employer-Owned Life Insurance*

(Non-New York and Non-Washington Employers)

Federal tax legislation has created notice and consent requirements for employer-owned life insurance ("EOLI"). **Failure to satisfy these requirements can result in loss of income tax-free treatment of the policy's death benefit**. The following generally describes these requirements, as well as a reporting requirement contained in the federal legislation. All clients need to consult their legal counsel to ensure that they comply with all legal requirements related to life insurance they purchase on employees.

Definition of EOLI

Internal Revenue Code ("Code") Section 101(j) defines EOLI as a life insurance contract which:

- Is owned by a person engaged in a trade or business (an "employer") and under which the employer or a related person (collectively, the "applicable policyholder") is directly or indirectly a beneficiary under the contract and
- Covers the life of an insured who is an employee with respect to the applicable policyholder on the date the contract is issued.

Please note the following about this definition:

- First, although it does not clarify when an employer is deemed to "own" a policy, it appears that the employer must be formally designated as the policy owner. That is, it appears that just having an economic interest in the policy would not be considered ownership (otherwise, the second requirement requiring that the employer or a related person be a beneficiary under the contract would be unnecessary).
- Under this definition, for a contract to be considered an EOLI contract, the applicable policyholder must have an interest in the policy. Accordingly, contracts where the entire death benefit will be paid directly to heirs of the employee should not be considered EOLI contracts.

Notice and Consent Requirements (Required before the policy is issued)

Generally, Code Section 101(j) provides that, in the case of an EOLI contract, the applicable policyholder's portion of the death benefit (less premiums paid by the applicable policyholder) is taxable unless notice and consent requirements are met *and* one of the following exceptions applies:

- **Recent Employees**

The insured was an employee of the applicable policyholder at any time during the 12-month period before death.

- **Directors and Highly Compensated Employees**

At the time the contract was issued, the insured was:

- ☐ A director of the applicable policyholder, or
- ☐ A highly compensated employee of the applicable policyholder. For this purpose, a "highly compensated employee" for any year generally includes an employee who:
  - At any time during the year or preceding year was a 5% owner;
  - Had compensation for the preceding year in excess of the dollar limit in Internal Revenue Code Section 414(q) (For example, this amount is $110,000 for 2010. This amount is subject to change on an annual basis); or
  - Is among the highest paid 35% of employees

- **Amounts Paid to Heirs**

The applicable policyholder's portion of the death benefit is:

- ☐ Paid to a family member of the insured,
- ☐ Paid to an individual who is a designated beneficiary of the insured (other than the employer or a related entity),
- ☐ Paid to a trust for the benefit of any such family member or designated beneficiary,
- ☐ Paid to the estate of the insured or
- ☐ Used to purchase an equity (or partnership capital or profits) interest in the applicable policyholder from such a family member, beneficiary, trust or estate.

**For the purpose of this form, the term employer refers to the actual employer or a "related person" as described in IRC Section 101(j)(3)(B)(ii)*

Note that, although Code Section 101(j) does not specify when the applicable policyholder's portion of the death benefit must be paid or used as above, the legislative history indicates that it should be paid or used by the due date of the tax return for the taxable year of the applicable policyholder in which the death benefit is received.

Thus, unless the notice and consent requirements are met in a timely fashion, and the contract meets one of the above exceptions, the portion of the death benefit received by the applicable policyholder will only be excludable from gross income to the extent of premiums and other amounts paid. Under the notice and consent requirements, **before the issuance of the contract**, the employee must:

- Be notified in writing of the applicable policyholder's intent to insure his/her life and the maximum face amount for which the employee could be insured at the time the contract is issued,
- Provide written consent to being insured under the contract and to such coverage continuing after he/she terminates employment and
- Be informed in writing that the applicable policyholder will be a beneficiary of any proceeds payable upon the death of the employee.

Reporting Requirements

Code Section 6039I imposes certain reporting requirements on every applicable policyholder who owns EOLI contracts. Effective for tax years ending November 13, 2007, policyholders are required to file IRS Form 8925 with their return to the IRS for each year the contracts are owned.

The form requires:

- The number of their employees at the end of the tax year,
- The number of such employees that are insured under EOLI contracts at the end of the tax year by policies issued after August 17, 2006,
- The total amount of insurance in force at the end of the tax year under such contracts,
- The name, address and taxpayer identification number of the applicable policyholder and the applicable policyholder's type of business and
- That the applicable policyholder has a valid consent for each insured employee (or, if such consents are not obtained, the number of insured employees for whom such consent was not obtained). Consent generally expires one year after execution by the employee or earlier on termination of employment. The policy must be issued before consent expires.

Effective Date

The above rules generally apply to life insurance contracts issued after August 17, 2006, with a possible exception for certain contracts issued pursuant to an Internal Revenue Code Section 1035 exchange. Note, however, that material increases in the death benefit or other material changes will generally cause an existing contract to be treated as a new contract that may be subject to the above rules. Such changes will also cause an insured's status to be re-determined and notice and consent generally renewed.

Cat. #137310 (8/10)

□ **AXA Equitable Life Insurance Company**
1290 Avenue of the Americas
New York, New York 10104
(212) 554-1234

□ **AXA Life and Annuity Company**
1675 Broadway, Suite 1700
Denver, Colorado 80202
(212) 554-1234

□ **MONY Life Insurance Company**
1290 Avenue of the Americas
New York, New York 10104
(212) 554-1234

□ **MONY Life Insurance Company of America**
1290 Avenue of the Americas
New York, New York 10104
(212) 554-1234

CALIFORNIA

NOTICE REGARDING REPLACEMENT
REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one--or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

_____ _____
(Applicant's Signature) (Date)

_____ _____
(Agent's Signature) (Date)

ACKNOWLEDGEMENT AND DISCLOSURE FOR EMPLOYER-OWNED LIFE INSURANCE POLICIES*

In connection with the purchase of life insurance policies from AXA Equitable Life Insurance Company and/or one of its affiliates on the following insured(s) *(attach extra pages if necessary)*:

Name of Insured	*Policy No. (if existing policy)*
_____	_____
_____	_____
_____	_____
_____	_____

On behalf of the Policy Owner, the undersigned authorized representative acknowledges that the Policy Owner named below has received the document entitled **"Important Information Regarding Employer-Owned Life Insurance Policies"** and it is understood that the Policy Owner is solely responsible for ensuring that it complies with all legal requirements of IRC 101(j) related to life insurance it purchases on its employees. In addition, the representative confirms either

☐ The Policy Owner has provided notice to the employee and obtained the employee's signed consent to purchase life insurance on their life; or

☐ The Policy Owner has determined, whether individually or with the advice of their counsel, that the provisions of IRC 101(j) do not apply to this situation and does not intend to obtain the employee's signed consent.

(Check the box that applies)

_____
Policy Owner

_____
Signature of Authorized Business Representative of the Policy Owner

_____
Name and Title of Authorized Business Representative of the Policy Owner (Please Print)

_____
Date

**For the purpose of this form, the term employer refers to the actual employer or a "related person" as described in IRC Section 101(j)(3)(B)(ii)]*

Producers: This form must be filed with the life insurance application for Employer Owned Life Insurance in all states but Washington state.

Catalog # 141825. (9/10)

AXA Equitable Life Insurance Company MONY Life Insurance Company of America

SECTION C – FINANCIAL QUESTIONNAIRE FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

Complete SECTION I only if the Proposed Insured is **under age 65** and the sum of the Face Amount(s) of *all* concurrent and/or pending applications with the Company checked on page 1 above Section A of the Application and/or any other affiliated companies equals **$2 million or more.**

Complete SECTIONS I *and* II if the Proposed Insured is **age 65 or older** and the sum of the Face Amount(s) of *all* concurrent and/or pending applications with the Company checked on page 1 above section A of the Application and/or any other affiliated companies equals **$2 million or more.**

Provide responses for each Proposed Insured and each Owner(s), as well as each Beneficiary, where applicable. (If additional space is needed, attach additional sheet(s) of paper, which must be signed and dated by the Proposed Insured, Owner, and Financial Professional(s)).

Name of Proposed Insured _____ Policy # (if known) _____ Date of Birth _____ (mm/dd/yyyy)

SECTION I PERSONAL FINANCIAL STATEMENT OF THE PROPOSED INSURED(S)

1. Balance Sheet

Assets		Liabilities	
Description	Amount	Description	Amount
Cash	$	Mortgages	$
Stocks, Bonds, Securities	$	Loans	$
Real Estate (including primary residence)	$	Notes	$
Retirement Plans	$	Other (please specify)	$
Business Equity	$	Other (please specify)	$
Other (please specify)	$	Other (please specify)	$
Other (please specify)	$	Other (please specify)	$
Total	$	Total	$
		Net Worth (total assets – total liabilities)	$

2. Income

	Earned Income	Unearned Income				
	Income	Dividends/Interest	Rental Income	Pension/Social Sec.	Other (please specify):	Total
Current Year	$	$	$	$	$	$
Last Year	$	$	$	$	$	$

3. How was the proposed face amount determined for this Application?
State what formula was used (e.g., estate tax calculation, survivor needs, estimated fair market value or book value of the business, capitalization of earnings, etc.); if none, state "None" _____

4. Do you expect any changes greater than 15% in income or net worth in the next 12 months? ☐ Yes ☐ No
If "Yes," please explain _____

SECTION II (CONT'D ON NEXT TWO PAGES) OTHER INFORMATION

"Parties" refers to the following: the Proposed Insured, the Owner or Beneficiary, the Beneficiary of any Trust owning the policy, and/or the Owner of any legal entity owning the policy.

5. Do any of the Parties intend to use or transfer the policy for any type of pre-death financial settlement, such as a viatical settlement, senior settlement, life settlement, or for any other settlement in the secondary market? ☐ Yes ☐ No

6. Will any other person or entity (i.e., a person or entity different than the Owner or Beneficiary initially named in the policy) provide any funding, financing, or guarantees for any premium payment on the policy, or are any potential or alternate sources of funding, financing, or guarantees under consideration? ☐ Yes ☐ No
If "Yes," please submit a copy of all actual or potential funding, financing, or guarantee documents, and a detailed, third party prepared Personal Financial Statement signed by the preparer. The above documents are not required if funding is part of a split-dollar arrangement (1) between the employer and the employee or a corporation and its shareholders, provided that the employment and/or shareholder relationship was not entered into to establish a premium funding arrangement; or (2) between the Proposed Insured and another family member (i.e., in either case, there is no third party unaffiliated entity or non-related individual involved). Please also answer the following questions:

a. State why the premiums will or may be funded or financed, or why other guarantees will or may be provided.

_____

_____

_____

SECTION II (CONT'D FROM PREVIOUS PAGE)
OTHER INFORMATION

b. State the name of the other person or entity providing the actual or potential funding, financing, or guarantees and role (i.e., lender, guarantor, etc).

c. State how the actual or potential funding, financing, or guarantees will be repaid, what collateral will be used, and whether the lender's or guarantor's ability to recover is limited to the value of the policy.

d. Will a letter of credit or personal guarantee be posted? ☐ Yes ☐ No
If "Yes," please state the details, including details relating to the assets backing the letter of credit.

7. Will any of the Parties have the right or option to transfer any direct or indirect interest in the policy to another person or entity at a predetermined price or other terms? ☐ Yes ☐ No
If "Yes," please identify the right or the option and submit a copy of all documents providing for that right or option.

8. a. Will a trust, partnership, or other entity receive or potentially receive any direct or indirect ownership, death benefits, or other interests or benefits in the policy? ☐ Yes ☐ No
If "Yes," please submit a copy of all documents that create the trust, partnership or other entity. The above documents are not required if funding is part of a split-dollar arrangement (1) between the employer and the employee or a corporation and its shareholders, provided that the employment and/or shareholder relationship was not entered into to establish a premium funding arrangement; or (2) between the Proposed Insured and another family member (i.e., in either case, there is no third party unaffiliated entity or non-related individual involved).

b. If an employer sponsored split dollar arrangement, please indicate the amount of time the employee or shareholder has been affiliated with the entity: _____ years

9. Has there been any consideration or any written information provided regarding the sale or transfer or potential sale or transfer to another person, partnership, or other entity of (1) any interest in this policy; or (2) any interest in a trust or other entity that has an interest in this policy? ☐ Yes ☐ No
If "Yes," please state what has been considered or provided, what action has or may be taken in the future as a result, and attach the written information provided.

10. Have any of the Parties sold or transferred any life insurance policy or an interest therein, within the last five years? ☐ Yes ☐ No
If "Yes," please state the details of the transaction including name of each company and the number of years the policy was in effect.

SECTION II (CONT'D FROM PREVIOUS PAGE)

11. Has any entity, other than the Company checked on page 1 above section A of the Application, medically evaluated the Proposed Insured to determine life expectancy or will such an evaluation occur? ☐ Yes ☐ No

If "Yes," please state who has conducted or will conduct the examination, and when the examination occurred or will occur.

_____

_____

_____

REFERENCES

Please complete this References section if:
the Proposed Insured is **under age 70** and the sum of the Face Amount(s) of *all* concurrent and/or pending applications with the Company checked on page 1 above section A of the Application and/or any other affiliated companies equals **$10 million or more;**
or
the Proposed Insured is **age 70 or older** and the sum of the Face Amount(s) of *all* concurrent and/or pending applications with the Company checked on page 1 above section A of the Application and/or any other affiliated companies equals **$5 million or more.**

☐ Attorney ☐ Accountant

_____

Name, Title Business Address Telephone No.

Has the above-named reference been authorized to release information? ☐ Yes ☐ No

If "No," please explain _____

_____

_____

If you did not provide a reference, please explain _____

_____

_____

CERTIFICATIONS

State laws prohibit intentional misstatements in connection with any application for insurance. If you make any misstatement in response to the questions in this Financial Questionnaire (including any intentional misstatement regarding the actual or potential funding of premiums, or transfer or sale of this policy), you will be subject to those laws and any penalties that may result.

I (We), as Proposed Insured and Owner, represent that if I (we) enter into any transaction at any time to assign, sell, or otherwise transfer any interest in the policy or any interest in a trust or other entity owning the policy:

(1) I (we) have not relied on any representations by the Company checked on page 1 above section A of the Application and/or any other affiliated companies, or its Agents/Insurance Brokers, regarding the benefits and risks of such a transaction; and

(2) there are no guarantees that I (we) will be successful, and I (we) may incur costs or other disadvantages and risks of such a transaction. The disadvantages and risks of such a transaction include, but are not limited to, the risk of tax consequences, the loss of death benefits, the loss of insurability, or the loss of other rights or interests that I (we) are not aware of.

If additional sheets of paper are attached to this Financial Questionnaire, please indicate the number of additional pages: _____ pages