



AXA Brokerage New Business Transmittal Form

Date Submitted:
 Proposed Insured 1:
 Proposed Insured 2:
 Cover Letter Attached : Yes No

Product Name:
 Agent Name & Code:
 BGA Name & Code:
 Total Pages Submitted:

Applications

- New Application Part A & D
- Section B – Product Questionnaire
- W-9 (Required if Trust or Corporate Owned)
- Trust Document

Questionnaires (Section C)

- Medical Questionnaire (required if exam done for company other than AXA)
- Aviation Questionnaire
- Avocation Questionnaire
- Foreign Travel Questionnaire
- Substance Usage (Drug / Alcohol) Questionnaire
- Owner Questionnaire (Required if Insured and Owner are different)

Additional Items

- Financial Professional Certification (Product Specific)
- Beneficiary Supplement Form
- Illustration (Signed / Unsigned)
- Illustration Certification

Medical Information / Requirements Ordered

- Paramed Exam
- Lab Slip
- HIV Consent
- HIPAA
- EKG / Treadmill
- Inspection Report / Vendor
- APS Ordered: Dr. / Facility
- APS Ordered: Dr. / Facility

Checks / Temporary Insurance*

Check Amount \$:
 Check # :
 Conditional Receipt (TIA) if Binding Coverage

EFT Form
 Void Check
 *Money only allowed at submission or after approval

Replacement Forms

- Replacement Forms
- 1035 Exchange Form

Agent Contracting Paperwork

- Submitted to AXA Licensing

Companion Case if Applicable

Name(s):

Informal / Trial App

- Informal Case Previously Submitted
- Informal Case Number

Other (Please Specify)

BGA Contact Information

BGA Case Manager:
 Phone:
 Email:
 Fax:
 Preferred Method of Contact: Phone Email Fax

Policy Mailing Information

Name:
 Address:
 Address:
 City, State, Zip:
 Phone:

AXA Submission Information

Overnight Mail

AXA New Business
 8501 IBM Drive, Suite 150
 Charlotte, NC 28262-4333
 855-266-6819
axaformal@axa.us.com

Fax
 Formal Applications

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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.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.



If the Owner is a Partnership, Corporation, LLC, Sole Proprietorship or Charity/Non-Profit an authorized Officer must complete and sign Supplemental Entity Ownership Form.

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, an authorized trustee of the named trust must sign and 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.com, if you have further questions.



Life Insurance products are issued by either AXA Equitable Life Insurance Company (AXA Equitable), New York, NY or by MONY Life Insurance Company of America (MLOA), an Arizona stock corporation with its main administrative office in Jersey City, NJ, 07310. MLOA is not licensed to conduct business in New York. Variable products are co-distributed by affiliates AXA Advisors, LLC and AXA Distributors, LLC. Universal and Term life products are co-distributed by AXA Network, LLC and AXA Distributors, LLC.

All guarantees are based on the claims-paying ability of the issuing company, either AXA Equitable Life Insurance Company or MONY Life Insurance Company of America.

"AXA" is a brand name of AXA Equitable Financial Services, LLC and its family of companies, including AXA Equitable Life Insurance Company (NY, NY), MONY Life Insurance Company of America (AZ stock company, administrative office: Jersey City, NJ), AXA Advisors, LLC, and AXA Distributors, LLC. AXA S.A. is a French holding company for a group of international insurance and financial services companies, including AXA Equitable Financial Services, LLC. This brand name change does not change the legal name of any of the AXA Equitable Financial Services, LLC companies. The obligations of AXA Equitable Life Insurance Company and MONY Life Insurance Company of America are backed solely by their claims-paying ability.

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

IU-133950 (2/18) (Exp 2/20)

G172981
Cat. #148509 (2/18)





(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, LLC 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
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
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
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 Gross Unearned Annual Income Gross Annual Income Total Net Worth
(salary, commissions, bonuses) (dividends, pensions, interest real estate income, etc) (Household) (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
				<input type="checkbox"/> P <input type="checkbox"/> B <input type="checkbox"/> G <input type="checkbox"/> A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> P <input type="checkbox"/> B <input type="checkbox"/> G <input type="checkbox"/> A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> P <input type="checkbox"/> B <input type="checkbox"/> G <input type="checkbox"/> A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Chart for question 21c

Name of Company	Total Amount (Face Plus Riders)	Competitive or Additional
	\$	<input type="checkbox"/> Competitive <input type="checkbox"/> Additional
	\$	<input type="checkbox"/> Competitive <input type="checkbox"/> 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)
<input type="checkbox"/> Cigarettes	# ____ per <input type="checkbox"/> Day <input type="checkbox"/> Month <input type="checkbox"/> Year	
<input type="checkbox"/> Cigars <input type="checkbox"/> Cigarillos	# ____ per <input type="checkbox"/> Day <input type="checkbox"/> Month <input type="checkbox"/> Year	
<input type="checkbox"/> Pipe <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Nicotine Patch or Gum	Not Applicable	
<input type="checkbox"/> 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 policies.

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.

SECTION D – AUTHORIZATION/AGREEMENT SIGNATURE

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

ACKNOWLEDGEMENT OF OUR UNDERWRITING PROCESS	<p>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.</p> <p>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.</p>
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AUTHORIZATION TO OBTAIN NON-HEALTH INFORMATION	<p>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.</p>
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PURPOSE OF AUTHORIZATIONS	<p>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).</p>
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COVERAGE CONDITIONS	<p>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.</p>
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ADDITIONAL AUTHORIZATIONS	<p>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.</p>
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DURATION	<p>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.</p>
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SECTION D – AUTHORIZATION/AGREEMENT SIGNATURE

AUTHORIZATION IF BANK DRAFT IS ELECTED	<p>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.</p> <p>I (We) understand that the use of the Bank Draft Payment Plan does not change any policy provision.</p> <p>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.</p> <p>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.</p> <p>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.</p>
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AGREEMENT	<p>Each signer of this Application agrees that:</p> <ol style="list-style-type: none"> 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.
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TAXPAYER IDENTIFICATION NUMBER CERTIFICATION	<p><i>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.</i></p>
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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 _____ Dated on (mm/dd/yyyy)
Signature of Licensed Professional/Insurance Broker

Print Licensed Financial Professional's Name _____ License Number _____

SECTION B – TERM LIFE INSURANCE

Name of Proposed Insured _____ Date of Birth _____

PLAN INFORMATION	<p>1. Product Name (Check One)</p> <p><input type="checkbox"/> Level Term 10 <input type="checkbox"/> Annual Renewal Term</p> <p><input type="checkbox"/> Level Term 15 <input type="checkbox"/> One Year Term</p> <p><input type="checkbox"/> Level Term 20</p> <p>2. Amount of Insurance \$ _____</p> <p>3. Backdate to save age <input type="checkbox"/> Yes <input type="checkbox"/> No Max 6 months prior to application date (3 months in OH) (Premiums for insurance coverage begin on the backdated Register Date)</p>
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PREMIUM INFORMATION	<p>4. Premium Mode</p> <p>a. Direct Billing (By Mail) <input type="checkbox"/> Annually* <input type="checkbox"/> Semi-annually <input type="checkbox"/> Quarterly <i>*Annually is the only payment mode available for the One Year Term product</i></p> <p>b. Bank Draft** <input type="checkbox"/> Monthly Draft Date is the same as the Register Date (Voided Check Required) <i>**If bank account holder is not the Owner or Proposed Insured, please complete Systematic Payment Enrollment Form.</i> <input type="checkbox"/> In lieu of voided check, use first premium check to set up Systematic Payment Plan</p> <p>c. Salary Allotment <input type="checkbox"/> Annually <input type="checkbox"/> Semi-annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly</p> <p>Unit name _____ Unit number _____ Register date _____ (mm/dd/yyyy)</p> <p>If Allotter is not Proposed Insured, provide Name _____ SSN/EIN/TIN _____</p>
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OPTIONAL BENEFITS/RIDERS	<p>5.</p> <p><input type="checkbox"/> Disability Premium Waiver Rider</p> <p><input type="checkbox"/> Children's Term Insurance Rider (complete Children's Term Insurance Rider Questionnaire) Amount \$ _____</p> <p><input type="checkbox"/> Other (as allowed or available with product) _____</p>
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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.

3. a. 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
(If "No," to 4.a, b, money may not be taken without Company home office approval.)
c. Is the *policy/contract* for the benefit of a Politically Exposed Person (PEP)*? Yes No
If Yes, define PEP position and Country: _____
** A Politically Exposed Person (PEP) is defined as: 1. A current or former senior foreign (non-U.S.) political figure; 2. His/her immediate family members (e.g., parents, spouse, sibling, children, in-laws); 3. Close associates - People who are widely and publicly known to maintain a close relationship with the PEP, including people who are in a position to conduct substantial financial transactions on behalf of the PEP; 4. Any corporation, business or other entity that has been formed by, or for the benefit of, the PEP.*

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. **Source of Funds for this purchase:** (Check box **and** circle sub-item(s)). If more than one box is checked, provide % breakdown. (Must add up to 100%)

Cash: Death Claim, Gift, Inheritance, Checking, Savings, Money Market, Payroll Deduction, CDs: _____ %

Borrowing: Mortgage (including Reverse Mortgage), Personal Loan, Credit: _____ %

NQ Annuity or Life Insurance: (Replacement, Surrender/Exchange, Policy Loan, Dividend, Withdrawal): _____ %

Qualified Annuity: (Replacement, Surrender/Exchange, Policy Loan, Dividend, Withdrawal): _____ %

401K, Pension Plans, Other Group Retirement Plans: _____ %

NQ: Brokerage, Investment Advisory Assets, Mutual Fund Shares, UIT Shares, Stocks or Bonds: _____ %

Qualified: Brokerage, ERISA Plan, Investment Advisory Assets, Mutual Funds Shares, UIT Shares, Stocks or Bonds: _____ %

Employer Contribution: _____ %

Other: Sale of Car, Home, Business, or Other Asset (specify: _____),
Legal Settlement, Lottery/Gaming Proceeds, Other: _____ : _____ %

9.

Financial Professional Name(s)	Financial Professional Number	%	Contact by <input type="checkbox"/> Phone <input type="checkbox"/> E-mail <input type="checkbox"/> Fax Contact or E-mail Address	Annualize Commission Retail Only
				<input type="checkbox"/> Do not prepay (4) <input type="checkbox"/> Prepay (5)
				<input type="checkbox"/> Do not prepay (4) <input type="checkbox"/> Prepay (5)
				<input type="checkbox"/> Do not prepay (4) <input type="checkbox"/> 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.

I, the agent, have confirmed the account holder name provided is the actual account holder of the bank information provided.

**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 _____

- 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 MIB, 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 HIV 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
Witness	State of Residence

**This authorization is valid for the AXA Equitable Life Insurance Company and
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 those listed above, with respect to their coverages) and the Medical Information Bureau to disclose to the Companies listed above and their authorized representatives (collectively hereinafter "the Companies named 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 Companies named 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 Companies named above and their 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 Companies named 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 Companies named above are 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 Companies named above may request additional authorizations in order to obtain the information the Companies named above need to complete its/their 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 revoked, I (we) agree that this authorization will expire on the earlier of the dates that the Companies named above decline 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 the Companies named above has/have taken in reliance on this authorization or (2) any right granted the Companies named 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)

(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	<p>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.</p> <p>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.</p>
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CONDITIONS	<p>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.</p> <p>(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.</p> <p>(2) Any material misstatement knowingly made in any part of the Application, any application supplement, questionnaire or in this Agreement.</p> <p>(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.</p> <p>(4) The check, withdrawal authorization, electronic or other commercially accepted debit transaction made or submitted with this Agreement is dishonored when first presented for payment.</p>
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DATE TIA STARTS	<p>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.</p> <p>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).</p> <p>To be completed by Financial Professional/Insurance Broker: A Medical Information Questionnaire</p> <p><input type="checkbox"/> Is required for Proposed Insured 1 <input type="checkbox"/> Is not required for Proposed Insured 1 and <input type="checkbox"/> Is required for Proposed Insured 2 <input type="checkbox"/> Is not required for Proposed Insured 2</p> <p>OR</p> <p>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).</p> <p>To be completed by a Financial Professional/Insurance Broker: An Application Part 2 (Paramedical or Medical Exam)</p> <p><input type="checkbox"/> Is required for Proposed Insured 1 <input type="checkbox"/> Is not required for Proposed Insured 1 and <input type="checkbox"/> Is required for Proposed Insured 2 <input type="checkbox"/> Is not required for Proposed Insured 2</p> <p>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.</p>
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LIMITED AMOUNT	<p>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 \$2,000,000 in total.</p>
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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	<p>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.</p> <p>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.</p>
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CONDITIONS	<p>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.</p> <p>(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.</p> <p>(2) Any material misstatement knowingly made in any part of the Application, any application supplement, questionnaire or in this Agreement.</p> <p>(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.</p> <p>(4) The check, withdrawal authorization, electronic or other commercially accepted debit transaction made or submitted with this Agreement is dishonored when first presented for payment.</p>
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DATE TIA STARTS	<p>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.</p> <p>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).</p> <p>To be completed by Financial Professional/Insurance Broker: A Medical Information Questionnaire</p> <p><input type="checkbox"/> Is required for Proposed Insured 1 <input type="checkbox"/> Is not required for Proposed Insured 1 and <input type="checkbox"/> Is required for Proposed Insured 2 <input type="checkbox"/> Is not required for Proposed Insured 2</p> <p>OR</p> <p>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).</p> <p>To be completed by a Financial Professional/Insurance Broker: An Application Part 2 (Paramedical or Medical Exam)</p> <p><input type="checkbox"/> Is required for Proposed Insured 1 <input type="checkbox"/> Is not required for Proposed Insured 1 and <input type="checkbox"/> Is required for Proposed Insured 2 <input type="checkbox"/> Is not required for Proposed Insured 2</p> <p>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.</p>
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LIMITED AMOUNT	<p>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 \$2,000,000 in total.</p>
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UNDERWRITING PROCESS INFORMATION

<p>YOUR INSURANCE APPLICATION</p>	<p>YOUR INSURANCE APPLICATION & HOW IT IS HANDLED</p> <p>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.</p>
<p>OUR UNDERWRITING PROCESS</p>	<p>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.</p> <p>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 MIB INC, 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.</p> <p>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.</p>
<p>MIB INC</p>	<p>The MIB INC is a not-for-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 INC may help us identify areas about which we need additional information for our underwriting evaluation, we do not use MIB INC reports as the basis for our underwriting decisions. Upon request, the MIB INC 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.</p>
<p>REPORT OF ADVERSE DECISION</p>	<p>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.</p>
<p>WHERE TO WRITE TO US</p>	<p>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.</p>

“AXA Equitable” is the brand name of AXA Equitable Financial Services, LLC and its family of companies, including the above companies.

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

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: _____ Date of Birth _____
Primary Beneficiary #1 (%) Percentage (mm/dd/yyyy) SSN ITIN EIN
 Address _____ City _____ State _____ Zip _____

Email Address _____ Phone Number _____ Relationship to Proposed Insured _____

Full Name: _____ Date of Birth _____
Primary Beneficiary #2 (%) Percentage (mm/dd/yyyy) SSN ITIN EIN
 Address _____ City _____ State _____ Zip _____

Email Address _____ Phone Number _____ Relationship to Proposed Insured _____

Full Name: _____ Date of Birth _____
Primary Beneficiary #3 (%) Percentage (mm/dd/yyyy) SSN ITIN EIN
 Address _____ City _____ State _____ Zip _____

Email Address _____ Phone Number _____ Relationship to Proposed Insured _____

(b) CONTINGENT BENEFICIARY(IES)

Full Name: _____ Date of Birth _____
Contingent Beneficiary #1 (%) Percentage (mm/dd/yyyy) SSN ITIN EIN
 Address _____ City _____ State _____ Zip _____

Email Address _____ Phone Number _____ Relationship to Proposed Insured _____

Full Name: _____ Date of Birth _____
Contingent Beneficiary #2 (%) Percentage (mm/dd/yyyy) SSN ITIN EIN
 Address _____ City _____ State _____ Zip _____

Email Address _____ Phone Number _____ Relationship to Proposed Insured _____

(b) CONTINGENT BENEFICIARY(IES) - Continued

Full Name: _____ Date of Birth _____
Contingent Beneficiary #3 (%) Percentage (mm/dd/yyyy) 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
(If corporation, print firm's name, signature and title of authorized officer.)
(If Trust, signature of trustee.)

Dated on (mm/dd/yyyy)

X _____
Signature of Joint Owner

Dated on (mm/dd/yyyy)



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

**SECONDARY ADDRESSEE
 SUPPLEMENTAL FORM**

“AXA” is the brand name of AXA Equitable Financial Services, LLC and its family of companies, including the above companies.

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

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. You may submit this form at the time of application or at any time prior to termination of your policy.

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. If the policy applied for (or existing policy) has multiple owners, all owners must agree on the designated secondary addressee identified in this form.

Name _____

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

City _____ State _____ Zip Code _____ Cell Phone Number _____ Home Number _____

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

 Current Date (mm/dd/yyyy)

X _____
 Signature of Joint Owner

 Current Date (mm/dd/yyyy)

Electronic Delivery Instructions

This authorization form must be fully completed, signed and received by AXA with the application. AXA will not allow a policy to be electronically mailed if the paper policy has already processed, printed and mailed.

Electronic Policy Delivery is NOT allowed if the follow conditions exist:

- Multiple Owners
- International Underwriting Program
- Owner is someone other than the Insured
- Survivorship Products
- Application approved by us with a Declaration of Health (Health Statement) on delivery

For Financial Professional Use only

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

THIS SUPPLEMENTAL FORM WILL BECOME PART OF THE APPLICATION FOR INDIVIDUAL LIFE INSURANCE.

1. Owner's Information

(Please print)

Owner's Name *(First, Middle, Last)*

Owner's Email Address¹

Policy Number *(If known)*

¹ Entity owners (e.g., trusts or corporations) should provide the email address of the authorized signatory for the entity owner.

2. Electronic Delivery Consent

We are required to send you certain documents about your life insurance policy or annuity contract. However, if you consent, the Company (ies) will transmit documents related to your life insurance policy by electronic means, to the extent that electronic transmission is consistent with applicable state and federal law. Any document that we send by electronic means, which complies with applicable law, will have the same force and affect as if that document was sent in paper format. Such documents include, but are not limited to, your policy, policy endorsements, client communications, statements, premium notifications, confirmation notices, privacy policy, prospectuses (if applicable), and all other notices regarding your policy. We may send you certain types of documents by United States Postal Services.

The Company (ies) will only transmit documents to you electronically if you consent. Your consent is voluntary. If the policyholder, insured, or policy owner has permitted electronic transactions in the past, that authorization does not obligate the same procedure regarding this policy as well.

The Company (ies) will deliver documents to you electronically by posting them on www.axa.com and sending a notice to you by email, to the email address you provide below, when an electronic document is posted. Documents will be considered delivered effective upon the Company (ies) sending you an email notice that the document is available on www.axa.com. If applicable law or systems limitations prevent us from delivering certain documents electronically, we will deliver them as otherwise permitted by applicable law.

If you decide that you want to receive documents electronically, the Company (ies) will provide one paper copy per year of any document, at no charge to you, upon your request. Please contact us (877) 222-2144 to request a paper copy.

You can change your mind at any time and have the Company (ies) transmit documents via paper mail by notifying the Company (ies) that you no longer want to be enrolled in our electronic delivery service; and if you wish to correct or change the email address to which documents are sent, you can do so at any time by logging on to [www.axa.com] or calling the Company (ies) at [(877) 222-2144].

If we receive notification indicating that the document(s) sent by electronic transmission was not received by you, we will resend the document(s), initially provided by electronic transmission, by regular mail to you at your last known mailing address in our records within five business days.

The Company (ies) website is www.axa.com.

For purposes of receiving electronic transmission of documents from the Company (ies), as set forth above, my email address is* **(please print)** : _____

*Entity owners (e.g., trusts or corporations) should provide the email address of the authorized signatory for the entity owner.

I consent to receive electronic transmission of documents.

3. Signatures

- **When you sign this form, you are acknowledging that you understand the terms and conditions set forth in this consent form.**

X
Owner's Signature¹

_____ Date

¹ (or entity owner's signature)



TRUSTED CONTACT PERSON

Authorization Form – Life Insurance

AXA Equitable Life Insurance Company
MONY Life Insurance Company of America
AXA Equitable Life and Annuity Company

“AXA” is the brand name of AXA Equitable Financial Services, LLC and its family of companies, including the above companies

DEFINITION OF TRUSTED CONTACT: The trusted contact person is intended to be a resource for AXA in administering your account and protecting assets in connection with possible financial exploitation or diminished capacity. The Trusted Contact Person must be 18 years of age or older. AXA may disclose information about your policy to the Trusted Contact to confirm the specifics of your current contact information, health status, and the identity of any legal guardian, executor, trustee or holder of a power of attorney, and as otherwise permitted by applicable law. The Trusted Contact will not be authorized to transact business on your behalf.

NOTE: The Trusted Contact information below supersedes any previously named Trusted Contact Person. To remove a Trusted Contact without designating a replacement, please check the box indicating you do not want to designate a Trusted Contact.

Account, Contract, Policy or Plan Number:	Financial Professional Name:
---	------------------------------

Primary Insured/Annuitant (if Plan – please list the Plan Name):

First Name	Last Name	Date of Birth (MM/DD/YYYY)
------------	-----------	----------------------------

<p>Account, Contract, Policy Owner or Plan Sponsor: <i>(if different than Primary Insured/Annuitant)</i></p> <hr/> <table style="width:100%"> <tr> <td style="width:50%">First Name</td> <td style="width:50%">Last Name</td> </tr> </table> <p>Trusted Contact Person Information: <input type="checkbox"/> Check this box if you DO NOT want to designate a Trusted Contact and sign the form below.</p> <p>To designate a Trusted Contact, please complete the following fields and sign the form below.</p> <hr/> <table style="width:100%"> <tr> <td style="width:50%">First Name</td> <td style="width:50%">Last Name</td> </tr> </table> <p>Mailing Address Number and Street</p> <hr/> <table style="width:100%"> <tr> <td style="width:33%">City</td> <td style="width:33%">State</td> <td style="width:34%">Zip</td> </tr> </table> <p>Phone Number</p> <hr/> <p>Email Address</p> <hr/> <p>Relationship to Owner</p>	First Name	Last Name	First Name	Last Name	City	State	Zip	<p>Joint Account, Contract, Policy Owner or Plan Sponsor: <i>(For additional owners, please complete a separate form)</i></p> <hr/> <table style="width:100%"> <tr> <td style="width:50%">First Name</td> <td style="width:50%">Last Name</td> </tr> </table> <p>Trusted Contact Person Information: <input type="checkbox"/> Check this box if you DO NOT want to designate a Trusted Contact and sign the form below. <input type="checkbox"/> Check this box if you want to designate the same Trusted Contact as Owner #1. If checked, the fields below do not need to be completed and please sign the form below.</p> <p>To designate a Trusted Contact, please complete the following fields and sign the form below.</p> <hr/> <table style="width:100%"> <tr> <td style="width:50%">First Name</td> <td style="width:50%">Last Name</td> </tr> </table> <p>Mailing Address Number and Street</p> <hr/> <table style="width:100%"> <tr> <td style="width:33%">City</td> <td style="width:33%">State</td> <td style="width:34%">Zip</td> </tr> </table> <p>Phone Number</p> <hr/> <p>Email Address</p> <hr/> <p>Relationship to Owner</p>	First Name	Last Name	First Name	Last Name	City	State	Zip
First Name	Last Name														
First Name	Last Name														
City	State	Zip													
First Name	Last Name														
First Name	Last Name														
City	State	Zip													

The undersigned, agrees that the information in this supplemental form is true and complete to the best of my knowledge and belief.

Owner or Authorized Person Signature _____ Date _____

Joint Owner or Authorized Person Signature _____ Date _____

Owner or Authorized Person Printed Name* _____

Joint Owner or Authorized Person Printed Name* _____

If Authorized Person on behalf on an entity, please indicate your title beside your printed name

Return of the form can be sent to: **Express Mail:**
AXA Equitable Life Insurance Company
Life Operations
8501 IBM Drive Suite 150
Charlotte, NC 28262-4333

Regular Mail:
AXA Equitable Life Insurance Company
Life Operations
P.O. Box 1047
Charlotte, NC 28201-1047

Catalog #: 158508 (10/2017)

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

AXA Equitable Life and Annuity Company
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Denver, Colorado 80202
(212) 554-1234

**MONY Life Insurance
Company of America**
525 Washington Blvd.
Jersey City, New Jersey 07310
(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 and Printed Name

Date

Joint Owner's Signature and Printed Name

Date

Producer's Signature and Printed Name

Date

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.

Reprinted by . . .

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.

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.



Privacy Policy

This notice describes the privacy policy of AXA Equitable Life Insurance Company, AXA Equitable Life and Annuity Company, MONY Life Insurance Company of America, U.S. Financial Life Insurance Company, AXA Advisors, LLC, and AXA Network, LLC (“us,” “we,” or “our”).

We are committed to keeping all personal information we have about you confidential and secure. This policy describes how we protect your privacy.

Our Privacy Pledge

- Our business is to offer quality financial products and services to our clients.
- We use client information only to conduct our business.
- We do not sell or rent client lists or data about our clients to others. We may market products jointly with other financial companies.
- We require all employees, financial professionals and vendors providing services for us to keep client files confidential.

Keeping Your Files Secure

We have security programs that protect client data from unauthorized use or disclosure. Access to your files is limited to those who need it to conduct our business. Our privacy policy applies to both current and former clients.

Information We Collect About You

We collect personal information about you to conduct our business, check your identity and comply with laws. The data we collect varies for different products and services and may include your:

- name, age, address, phone number, and Social Security number
- occupation and income
- financial goals and preferences
- assets and liabilities, insurance, savings and investments
- health and high-risk hobbies such as skydiving or auto racing
- information about the products and services you purchase from us

You provide most of this information yourself. We may also ask others about you, including:

- doctors, hospitals and other health care providers
- the Medical Information Bureau (a non-profit group of insurers)
- your employer, attorney, accountant and bank
- credit reporting agencies and state and federal agencies
- companies whose products and services you purchase through us
- marketing firms acting on our behalf

Information about your health, insurance rating and credit standing is used only to underwrite and administer the products and services you purchase from us.

With Whom We Share Data

We may share personal information about you with:

- your financial professional
- companies whose products and services you purchase through us
- companies that have joint marketing agreements with us
- vendors that perform support services for us, including those who:
 - provide underwriting services
 - assist in managing claims
 - print and mail account statements
 - support our computer systems
 - clear and settle trades
 - help market our products and services to you



Our vendors are required to keep client data confidential and to use appropriate security measures to protect it. They must also agree in writing to use client data only to provide services for us. We disclose information about you to affiliates, government agencies, including foreign tax and/or other governmental authorities pursuant to a U.S. court order, and others as required or permitted by law. We may disclose health information about you to the Medical Information Bureau. Some financial professionals offer products and services only through us. Others may also offer products and services from other sources. This privacy policy does not apply to data that your financial professional may collect for these other products and services.

Reviewing Your Information

If you own, or are applying for, a life insurance or annuity product issued by one of our insurance companies, you may write to request a summary of the data about you in our files. You may also request copies of your files. This does not apply to information relating to disputes or legal proceedings between us. We may charge you a reasonable fee to cover the cost. If you believe your files are incorrect or incomplete, you may ask us to make corrections. To obtain information from our files or a copy of our access and correction policy, please write to:

AXA Equitable
National Operations Center
P. O. Box 1047
Charlotte, NC 28201-1047
Attention: Customer Service Department

Privacy Policy Changes

We may make changes to this privacy policy in the future. Before we do, we will send you a revised privacy policy. And as long as you continue to be a client, we will send you a current privacy policy once a year.

To Contact Us

Questions? Call our Privacy Information Center at 1-877-806-4573.

Notice to Clients of AXA Advisors, LLC

The Financial Industry Regulatory Authority (FINRA) has published an investor brochure that describes its Public Disclosure Program. You may obtain a copy of the brochure by calling FINRA's Public Disclosure Program Hotline at 1-800-289-9999 or by visiting FINRA's website at www.finra.org

You may contact AXA Advisors, LLC directly regarding any matter, including the filing of a complaint, by calling 1-866-487-7484 or writing to:

AXA Advisors
1290 Avenue of the Americas,
New York, NY 10104

AXA Advisors, LLC
General Conflicts of Interest Disclosure

AXA Advisors, LLC (“AXA”) is providing you this document because you are purchasing or opening a new account (using the term broadly herein to include an account, a contract, or a policy). This document describes how AXA and the AXA Advisor providing services to you (“Your Advisor”) are compensated for providing advice or other services in connection with your account, and how such compensation creates conflicts of interest that may influence the advice or other services provided. This document does not create any ongoing obligations to monitor your account to ensure the investment recommendation remains appropriate for you over time or to track and advise you of any key deadlines associated with any feature or functionality of any investment product in your account. Additionally, the absence of advice should not be interpreted as a “hold” recommendation. This document pertains only to compensation and conflicts of interest generally, and is in addition to and not in lieu of all other agreements and disclosures, some of which contain more detailed information regarding compensation and conflicts.

AXA and Your Advisor face conflicts when Your Advisor makes recommendations to you for your account due to a variety of circumstances such as: the compensation we receive if you implement Your Advisor’s recommendations, the compensation our affiliates receive if you purchase their products and services, the compensation we receive if you rollover or transfer retirement plan or other assets to an account with us, and the differences in the compensation (“differential compensation”) we and our affiliates receive, depending on types of investments, types of account and whether the investment or account is issued or managed by an affiliate (“proprietary products”). Compensation arrangements and related conflicts are discussed below.

AXA Compensation and Conflicts. If your account is a brokerage account or insurance contract, AXA earns compensation: when investments are purchased; when additional amounts are added for investment; when stocks and bonds are purchased or sold; and for certain investments, on an ongoing basis for so long as the investment is held in your account. Such compensation includes without limitation sales loads, commissions and placement fees (“Sales Charges”¹), networking fees², and additional compensation in the form of gifts and entertainment in connection with purchases and sales of mutual funds, annuities and

alternative investments, all of which is typically paid by the issuer and/or a sponsor of the issuer (“Investment Sponsor”). Because the Investment Sponsor pays us directly rather than you, these payments are sometimes called “third party compensation.” In certain circumstances, AXA also receives trails/12b-1 fees³ and other third party compensation, from the Investment Sponsor which is calculated as an annual percentage of assets invested in the mutual fund, annuity or alternative investment. As is common in the industry, Investment Sponsors may also pay the Company revenue sharing payments to support AXA’s product marketing and sales force education and training efforts. The amount that is earned differs depending on the investment for which the compensation is earned. If your account is an advisory account, AXA earns ongoing fees calculated as a percentage of assets in your account.

Also, we do not offer all investment products and accounts available in the marketplace for accounts. Moreover, we do not necessarily offer investments, products and services at the lowest cost, or for the least compensation to us in the marketplace, or at the same or lower compensation or cost we offer in connection with sales to other similarly situated clients. This variable compensation means that we receive more or less compensation depending on which investment you make and that Your Advisor

¹ Sales Charges vary and are typically paid at the time you invest, and reduce the amount available to invest. Investments with a higher Sales Charges result in greater compensation to the Company. In addition, the more transactions into which you enter, the more compensation we receive. ² Investment Sponsors may pay AXA networking fees to link accounts to AXA systems and accounts. These fees by product and are typically based on the number of AXA client positions in the investment product. These fees give AXA a financial incentive for clients to invest with Investment Sponsors that make these payments. Your Advisor does not share in these networking payments. ³ AXA and Your Advisor receive this ongoing compensation which is calculated as an annual percentage of invested assets, and is shared between AXA and Your Advisor. The amount of compensation varies from product to product and there is an incentive to recommend that you purchase or hold investments that generate greater trails.

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may have an incentive to recommend one investment over another. In short, the compensation that we receive varies depending on which recommendations made by Your Advisor that you choose to implement for your account and this variation creates incentives for Your Advisor to make recommendations that result in more compensation for Your Advisor, AXA and our affiliates.

Your Advisor's Compensation and Conflicts. Your Advisor is entitled to receive compensation and other benefits from AXA based on the percentage of revenue he or she generates from sales of products and services relating to your account. As a general matter, Your Advisor's total cash compensation depends upon his or her agreements with AXA and increases as the revenue he or she generates increases. Your Advisor can earn a greater percentage of revenue for recommending one type of investment product or service over another. This creates an incentive to recommend some transactions, products and services over others. Your Advisor is also able to receive a portion of the 12b-1 fees described above. Compensation will also determine the amount that Your Advisor can receive for expense reimbursement and their eligibility to receive other benefits that we provide, such as practice management support, enhanced service support levels, club levels that confer a variety of benefits, conferences (e.g., for education, networking, training, and personal and professional development), recognition awards, trips, health, welfare and retirement benefits and other non-cash compensation. Benefits also include equity awards from AXA's parent company, AXA Equitable Holdings, Inc. ("AXA Equitable"), free or reduced-cost marketing materials, reimbursement or credits of fees for administrative services or technology, and recruiting and retention bonuses which could be in the form of repayable or forgivable loans (e.g., for retention purposes or to assist an advisor to grow his or her practice).

Other Conflicts for Your Advisor. Your Advisor might also be engaged in activities outside AXA or have particular business models that could present their own conflicts. Your Advisor could be an accountant, attorney, or refer clients to other service providers and receive referral fees, for example. Your Advisor may provide advisory services through an independent investment advisory firm, provide benefit plan administrative support or sell insurance through a

separate business. Your Advisor may receive greater compensation through the outside business than through AXA, or have another incentive to recommend or sell products through the outside business. Certain AXA advisors have their own interests in a reinsurance company which earns compensation for providing reinsurance on some AXA Equitable life insurance policies sold by those Advisors. There are also some Advisors who offer brokerage or advisory services on the premises of unaffiliated financial institutions, like banks and credit unions. AXA typically shares compensation with the financial institution, including a portion of the brokerage commissions and fees your AXA Advisor generates.

Management Compensation and Conflicts. AXA pays compensation to its field managers based on sales of products and services generated for supervision, training and administrative or sales support to the advisors in their branch. When a field manager is compensated based on sales made by the person he or she is managing, the field manager may benefit more from certain sales and recommendations than others.

Affiliate-Level Conflicts: AXA is a wholly-owned indirect subsidiary of AXA Equitable. AXA Equitable is a public company listed on the New York Stock Exchange; a majority of AXA Equitable shares are owned by AXA SA, a global financial services company headquartered in Paris, France. AXA is also affiliated with AXA Equitable Life Insurance Company (including the trusts underlying certain products), MONY Life Insurance Company of America, EQ AZ Life Reinsurance Company, Alliance Bernstein, AXA Equitable Funds Management Group (1290 Advisors), and PlanMember Securities. AXA sells products and utilizes services of these affiliates, which, accordingly, may earn more or less revenue depending upon your investment strategy.

Rollovers and Transfers: If you decide to transfer or roll assets into an AXA account (for example, out of a retirement plan and into an IRA), AXA has a financial incentive to recommend that you invest those assets in an account, because it will receive payments on those assets, for example, through commissions, fees and third party payments. For retirement assets, you should be aware that such fees and commissions likely will be higher than those you pay through your existing plan, and there can be custodial and other

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maintenance fees. As securities held in a retirement plan generally cannot be transferred to an IRA, commissions charged on transactions in the IRA will be in addition to commissions and sales charges previously paid on transactions in the plan. For non-retirement assets, there may be similar commissions, fees and expenses that are higher at AXA than at the prior provider.

AXA has adopted policies and procedures that are intended to address the conflicts of interest discussed in this disclosure.

Further information about our conflicts of interest and more specific information relating to our fees and

compensation is available in your account agreement and in the prospectus, disclosures, Form ADV or offering document associated with your investment. You may also contact Your Advisor with any specific questions you have. Note that not all of the conflicts described in this Disclosure apply to Your Advisor specifically, and you may ask Your Advisor about whether he or she receives the forms of compensation outlined above.

Should you have any questions regarding this disclosure please contact Your Advisor.



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 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 a 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 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 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.)

Life Insurance Products: • Are Not a Deposit of Any Bank • Are Not FDIC Insured • Are Not Insured by Any Federal Government Agency • Are Not guaranteed by Any Bank or Savings Association
• Variable Life Insurance May Go Down in Value

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 part or 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 part or 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 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 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 net death benefit.

TEN MONTHS LATER:

Lien	\$75,000
Interest on Lien ²	\$4,968
Lien Plus Interest	\$79,968
Death Benefit Net of Policy Loan and 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.

The Living Benefits rider is issued by AXA Equitable Life Insurance Company (AXA Equitable), New York, NY 10104 in New York and Puerto Rico or by MONY Life Insurance Company of America (MLOA), an Arizona Stock Corporation, with main administrative office in Jersey City, NJ in all other jurisdictions. When sold by New York state-based (i.e., domiciled) financial professionals, this rider is issued by AXA Equitable. The Living Benefits rider is included automatically with any eligible life insurance policy issued unless it is declined by the policy owner. This brochure is intended for use with any product that includes the Living Benefits rider.

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