

APPLICATION INSTRUCTIONS

As the Financial Professional/Insurance Broker, you are responsible for facilitating the completion of the necessary forms required to process and underwrite this application. All forms must be completed in full and must be legible. Please follow these instructions carefully.

1. Complete the application legibly in blue or black ink or use “e-Forms for Life” available on axa-equitable.com under “Tools and Marketing” or “Quick Links”.
2. Use the state-specific application for the state where the Owner will sign the application.
3. Make sure the appropriate issuing Company is elected on pages 1, 12, 14, and 16 of the application and on page 1 of all supplements. Please select only one Company to which you wish to apply.
 - Level Term, ART, ISWL, AUL, ASUL, Indexed UL, IL Optimizer II, SIL Legacy, and Corporate Owned IL are issued through AXA Equitable Life Insurance Company in all jurisdictions.
 - IL Legacy II is issued through MONY Life Insurance Company of America (MLOA) in all jurisdictions, **except** in NY and PR where it is issued through AXA Equitable Life Insurance Company.
 - One Year Term is offered through each Company listed on the application.
4. The Proposed Insured and the Owner must sign. If the Proposed Insured is a child, Issue Ages 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 corporation or a Trust, an authorized officer of the corporation or Trustee must sign, respectively. If the Owner is a corporation, print the firm’s name and the title of an authorized officer. If the Owner is a Trust, indicate “Trustee” after the signature. If the Owner is a partnership, a partner involved in the purchase must sign.
5. If the Owner is a Trust and the Proposed Insured is 70 or older, regardless of the face amount, please provide a copy of the executed Trust document for review.
6. Please note that irrevocable beneficiary designations are not permitted. Irrevocable Life Insurance Trusts are permitted.
7. In order to comply with the Patriot Act, federal law requires all financial institutions to obtain, verify, and record information that identifies each owner of life insurance.
8. If a change is required to an answer on the application or supplements, 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 to answers for personal information and any pertaining to insurability. If the Proposed Insured is a minor, a parent or legal guardian must initial all changes on behalf of the minor (Proposed Insured).
9. If the transaction involves a replacement, ensure that the appropriate paperwork is completed.
10. 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 must accompany the application. Also enter the amount paid in the section on the application titled “Complete if Money is paid with Application.”
11. **Best practice** is to complete the Medical Information Supplement to enable the underwriter to promptly begin the underwriting process. However the completion of the Medical Information Supplement is optional if a paramedical or medical exam is required. In all cases, if the Proposed Insured is age 0–15, complete the Medical Information Supplement.
12. In order to expedite the underwriting process, promptly schedule any required paramedical or medical exams and/or other tests.
13. To determine the Ultimate Death Benefit:
 - Include Ultimate increasing death benefit amounts as are available on Return of Premium Riders.
 - Include Benefit riders with additional payouts such as Term Riders and Estate Protector Riders.
 - **Do not include** amounts related to Accidental Death Benefit Riders, Purchase Options, or base policy Death Benefit Options on UL/VL policies that include policy account value amounts (i.e., Death Benefit Option B).
14. Backdating to save age is permitted in accordance with our published guidelines but in no event can the policy be backdated more than 6 months* prior to the application date (*3 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.
15. Survivorship policies: Complete one application for both Proposed Insureds. Complete one Indexed UL Supplement, one VUL Supplement, and one Optional Benefits Supplement, as necessary. Complete a separate application supplement for each Proposed Insured when submitting information specific to each individual, for example Medical Information Supplement, Substance Usage Supplement, and Foreign Residence and Travel Supplement.
16. Choice of CVAT vs. GPT is more important in heavier funding situations. Under the GPT it generally takes longer for the policy to reach corridor, thus resulting in higher cash value than with the CVAT, especially in later policy years. However a significant reduction in face amount or in benefits can result in current or future force-outs with GPT. CVAT uses higher corridor factors resulting in more death benefit than GPT in heavier funding scenarios, especially in early policy years. CVAT also allows for payment of the full non MEC (i.e. 7-pay) premium in the first 7 policy years for Option A policies, which may not be possible under GPT. It may even allow for higher funding levels during the first 7 policy years than under GPT Option B, especially for females.
17. If Guaranteed Issue (one Owner and one Insured): DO NOT complete questions 46–68; complete the Guaranteed Issue Supplement.



- (Select One) AXA Equitable Life Insurance Company
 AXA Equitable Life and Annuity Company
 MONY Life Insurance Company of America
 MONY Life Insurance Company

Application for Life Insurance
(Part 1)

1290 Avenue of the Americas, New York, NY 10104

PRODUCT AND AMOUNT OF INSURANCE

The Indexed Universal Life Supplement must always be completed for all Indexed Universal Life products; the Variable Universal Life Supplement must always be completed for all Variable Life products; the Optional Benefits Supplement must be completed when electing riders/optional benefits for all Non-Variable Life products, except Indexed Universal Life products.

Variable products are not available through AXA Equitable Life and Annuity Company and MONY Life Insurance Company.

Q2: If Proposed Insured(s) is age 65 or older and sum of face amounts applied for with AXA Equitable and all affiliated companies within past 12 months equals \$2 million or more, Financial Supplement II is required. For Proposed Insured(s) under age 65 and sum of face amounts applied for with AXA Equitable and all affiliated companies within past 12 months equals \$2 million or more, Financial Supplement is required.

Q7: If address is a P.O. Box or not an actual residence, proof of residence is required.

***Q7:** County required in AL, FL, GA, KY, LA and SC.

Q9: Max 6 months prior to application date (3 months in OH).

Q11: If "Yes," provide license number; if "No," provide government ID number, if any.

Q14: If "No," complete Foreign Residence and Travel Supplement.

Q15: If less than 1 year at current occupation, give previous employment in Remarks section.

Q16: Complete the "Employer address" question by providing the Proposed Insured's physical worksite address.

1. **Product Name:** _____ 2. **Amount of Insurance:** \$ _____

3. Is this a Term Conversion or Purchase Option? Yes No (If Yes, complete Term Policy/Rider Conversion or Purchase Option Supplement.)

PROPOSED INSURED 1

4. Name: _____

First Middle Last

5. SS#: _____

6. Gender: Male Female

7. Residence Address: _____

No. & Street Bldg./Apt./Suite

City/Municipality County* State Zip Code

8. Date of birth: _____
(mm/dd/yyyy)

8a. Birthplace: _____

Country State

9. Backdate to save age: Yes No

10. Marital status: Single Married Widowed
 Divorced Separated

11. Do you have a driver's license? Yes No
Number: _____
State: _____ Expiration date: _____

12. Phone numbers: Home _____
Work _____ Cell _____
Best time to call: _____ a.m. p.m.
 Home Work Cell

13. E-mail address: _____

14. U.S. citizen: Yes No

15. Currently employed: Yes No Retired
Years at current job: _____

16. Current occupation: _____

Title Employer name

Occupation/Duties

Employer address (No. & Street)

(City, State, Zip Code)

PROPOSED INSURED 2 (IF APPLICABLE)

4. Name: _____

First Middle Last

5. SS#: _____

6. Gender: Male Female

7. Residence Address: _____

No. & Street Bldg./Apt./Suite

City/Municipality County* State Zip Code

8. Date of birth: _____
(mm/dd/yyyy)

8a. Birthplace: _____

Country State

9. Backdate to save age: Yes No

10. Marital status: Single Married Widowed
 Divorced Separated

11. Do you have a driver's license? Yes No
Number: _____
State: _____ Expiration date: _____

12. Phone numbers: Home _____
Work _____ Cell _____
Best time to call: _____ a.m. p.m.
 Home Work Cell

13. E-mail address: _____

14. U.S. citizen: Yes No

15. Currently employed: Yes No Retired
Years at current job: _____

16. Current occupation: _____

Title Employer name

Occupation/Duties

Employer address (No. & Street)

(City, State, Zip Code)

APPLICANT, IF PROPOSED INSURED IS UNDER AGE 15

Applicant is the party who initiates and applies for the life insurance. In most cases, applicant and owner are the same, but in some instances, like parent as policy owner, grandparent as applicant, they are different.

17. Complete if Proposed Insured is under age 15:

a) Total amount of insurance in force on the life of: Applicant: \$ _____
 Total amount of insurance in force on the life of: Parent(s)/Legal Guardian if other than Applicant: \$ _____

b) Any other children in family insured for a lesser amount? Yes No If Yes, details: _____

c) Is Applicant different from Owner? Yes No Applicant's name: _____
 Applicant's SS#: _____ Relationship to Proposed Insured: _____
 Applicant's Address: _____
No. & Street Bldg./Apt./Suite City/Municipality State Zip Code

PREMIUM AND COVERAGE-RELATED INFORMATION

Complete questions 18 and 19 for UL and VUL only.

18. Death Benefit Option: Option A (Level) Option B (Increasing)

19. Definition of Life Insurance Test: Guideline Premium Test Cash Value Accumulation Test

20. Premium amount: \$ _____ (For VUL and UL, enter planned periodic premium.)

21. Initial premium: \$ _____ (For VUL and UL, state initial premium if different than planned periodic premium.)

22. Method of Payment: a. Bank draft* (Voided Check is Required) Monthly Quarterly (UL and VUL products only.)
 Start date: _____ (dd/mm/yyyy) Draft date on _____ of each deduction (VUL and UL only.)
 *If bank account holder is not the Owner or Proposed Insured, please complete Systematic Payment Enrollment Form.

b. Direct Monthly Quarterly Semi-annually Annually

c. Single payment \$ _____ (No further billing will be sent.)

d. Salary Allotment:* Monthly Quarterly Semi-annually Annually
 *If Allotter is not Proposed Insured, provide Name: _____ SSN#/EIN/TIN: _____
 Unit name: _____ Unit number: _____ Register date: _____

Q22: To authorize use of a CWA checking account for systematic drafts, please write the following statement in the REMARKS section: "use CWA Check in lieu of Voided Check".

OWNERSHIP INFORMATION Complete if Proposed Insured is not the Owner (If additional space is required, use Remarks Section)

Complete for Individual, Trust, Corporation, Partnership, Entity, et al:

23. Owner's name: _____

23a. Person(s) authorized to transact business on behalf of Owner.
 Name: _____ Title: _____

24. SSN EIN or ITIN: _____ 25. Relationship to Proposed Insured: _____

26. Address: _____
No. & Street City State Zip Code

Complete Question 27 for all non-resident (foreign) Owners. If the Owner is not a U.S. Person (U.S. Citizen or U.S. Corporation, Partnership or Trust established or organized under the laws of a state of the United States), then he, she or it may have to provide additional documentation, including IRS form W-8 BEN. Any foreign Owner (Individual, Trust, Corporation, Partnership, Entity, et al;) must have a US bank account.

27. U.S. bank name: _____ Account number: _____

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

Q26: Billing notices will be sent to the Owner at this address unless otherwise directed in Remarks Section. If P.O. Box, put residential address in Remarks Section.

Individual

28. Do you have a driver's license? Yes No
 Number: _____ State: _____ Expiration date: _____

29. Date of birth: _____ (mm/dd/yyyy) 30. Currently employed? Yes No Retired

31. Employer name: _____ 32. Occupation: _____

33. U.S. citizen?: Yes No (If "No" please complete "a" and "b" or "c," where applicable.)

a) Country of citizenship: _____ Date of entry into the U.S.: _____ (mm/dd/yyyy)

b) Residents with legal permanent status (Resident Alien) in U.S. only
 Green card/Visa type: _____ Expiration date: _____ (mm/dd/yyyy)

c) Residents residing in the U.S. temporarily (Non-Resident Alien) with valid visa only
 Visa #: _____ Visa type: _____ Expiration date: _____ (mm/dd/yyyy)
 Form I-94 expiration date: _____ (mm/dd/yyyy) Passport #: _____

Q28: If "Yes," provide license number; if "No," provide government ID number, if any.

Trust

- 34.** Situs of Trust: The Trust is subject to the laws of the state of _____ **35.** Date of Trust: _____ (mm/dd/yyyy)
- 36.** Name(s) of Grantor(s): _____
- 37.** Name(s) and title(s) of current Trustee(s): _____
- 37a.** How long has the Trustee known the Proposed Insured? _____
- 37b.** What is the nature of the relationship between the Proposed Insured and the Trustee? _____
- 37c.** Is the Trust Revocable? Irrevocable? (Check appropriate box.)
- 37d.** Can interests in the Trust be sold without changing the terms of the Trust? Yes No
- 38.** Did the Proposed Insured and/or the Owner retain an attorney to prepare the Trust documents? Yes No
 If yes, provide name and address of attorney. If no, provide the name and address of the person or entity that did prepare the Trust.
 Please provide the relationship of the preparer of the Trust to the Proposed Insured.
 Name: _____ Relationship to the Proposed Insured: _____
 Address: _____
- 39.** Name(s) of current Beneficiary(ies) of the Trust: _____
- 39a.** What is the nature of the relationship between the Grantor(s) and Beneficiary(ies)? _____
- 40.** Is there a Trust Protector? Yes No (If Yes, answer **40a** and **40b**.)
- 40a.** How long has the Trustee known the Trust Protector? _____
- 40b.** What is the nature of the relationship between the Proposed Insured and the Trust Protector? _____

Q36-40: If additional space is required for Trust, use Remarks Section.

Q40: A Trust Protector is a third party appointed by the Grantor to provide direction and guidance to the Trustee.

Q41: 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.

Q42: Include any policy that has been sold, assigned or settled to or with a settlement or viatical company or any other person or entity.

BENEFICIARY INFORMATION

- 41.** Beneficiary Information. If no contingent beneficiary is selected, 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.

| Full Name | Relationship to Insured | P-Primary C-Contingent | % (Percentage) |
|-----------|-------------------------|---|-------------------|
| | | <input type="checkbox"/> P <input type="checkbox"/> C | % |
| | | <input type="checkbox"/> P <input type="checkbox"/> C | % |
| | | <input type="checkbox"/> P <input type="checkbox"/> C | % |
| | | <input type="checkbox"/> P <input type="checkbox"/> C | % |

PROPOSED INSURED'S OTHER INSURANCE

- 42.** Do you have any other life insurance/annuity(ies), including ultimate death benefit amounts of any policy/rider in effect with AXA Equitable, its affiliated companies or any other life insurance company? Yes No
- 43.** Will the coverage applied for replace, change, or affect any existing policy or contract? Yes No
 (If the answer to Question 42 or 43 is "Yes," complete the chart below.)

| Proposed Insured | Name of Company | Face Amount 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"/> 1 <input type="checkbox"/> 2 | | \$ | | | <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"/> 1 <input type="checkbox"/> 2 | | \$ | | | <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"/> 1 <input type="checkbox"/> 2 | | \$ | | | <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"/> 1 <input type="checkbox"/> 2 | | \$ | | | <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"/> 1 <input type="checkbox"/> 2 | | \$ | | | <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"/> 1 <input type="checkbox"/> 2 | | \$ | | | <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 |

44. Do you have any formal applications pending with AXA Equitable, its affiliated companies or any other life insurance companies? Yes No (If "Yes," complete the chart below. Include ultimate death benefit amounts of any policy/rider.)

| Proposed Insured | Name of Company | Amount Applied For | Competitive or Additional? |
|---|-----------------|--------------------|---|
| <input type="checkbox"/> 1 <input type="checkbox"/> 2 | | \$ | <input type="checkbox"/> Competitive <input type="checkbox"/> Additional |
| <input type="checkbox"/> 1 <input type="checkbox"/> 2 | | \$ | <input type="checkbox"/> Competitive <input type="checkbox"/> Additional |
| <input type="checkbox"/> 1 <input type="checkbox"/> 2 | | \$ | <input type="checkbox"/> Competitive <input type="checkbox"/> Additional |
| <input type="checkbox"/> 1 <input type="checkbox"/> 2 | | \$ | <input type="checkbox"/> Competitive <input type="checkbox"/> Additional |

45. Including this application, any other applications pending with AXA Equitable, its affiliated companies and other companies, what is the total amount of life insurance that will be placed or put in effect? (Include ultimate death benefit amounts of any policy/rider.)

Proposed Insured 1: \$ _____ Proposed Insured 2: \$ _____

PROPOSED INSURED'S PERSONAL HISTORY

When providing details in the Remarks Section of the application, include each Proposed Insured's name next to the statement(s) applicable to that Proposed Insured if any question is answered "Yes" for either Proposed Insured.

List details of answers noted "Yes" for questions 46–50 in section after question 50.

| | Proposed Insured 1 | Proposed Insured 2 |
|---|--|--|
| 46. Have you ever had a driver's license suspended, revoked or restricted? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 47. Have you, in the last 5 years, been convicted of, or pled guilty or no contest to, reckless or negligent driving, two or more moving violations or driving under the influence of alcohol or drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 48. Have you, in the last 2 years, been disabled for 2 or more weeks? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 49. Have you ever had an application for life or health insurance declined, postponed, required an extra premium or other modification or had a life or health policy or contract that was cancelled, recalled or denied renewal? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 50. 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Q49: If "Yes," please state state companies and provide full details.

Q50: If "Yes," state offense and penalty, date of probation, duration of probation and end date.

| Proposed Insured | Question Number | Date (mm/dd/yyyy) | Description of Event |
|---|-----------------|-------------------|----------------------|
| <input type="checkbox"/> 1 <input type="checkbox"/> 2 | | | |
| <input type="checkbox"/> 1 <input type="checkbox"/> 2 | | | |
| <input type="checkbox"/> 1 <input type="checkbox"/> 2 | | | |
| <input type="checkbox"/> 1 <input type="checkbox"/> 2 | | | |

Q51: If "Yes," complete Foreign Residence and Travel Supplement.

Q52: If "Yes," complete Aviation Supplement.

Q53: If "Yes," complete Avocation Supplement.

Q54: If "Yes," you must also submit a completed and signed Life Insurance/Annuity Disclosure to Active Duty Members of the Armed Forces.

| | Proposed Insured 1 | Proposed Insured 2 |
|---|--|--|
| 51. Do you have any plans to travel or reside outside the United States or Canada in the next year (other than a two-week or less vacation to Western Europe or the Caribbean)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 52. Have you, in the last year, flown other than as a passenger or do you plan to do so? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 53. Have you, in the last year, engaged or 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 54. Are you or is the Owner(s) an Active Duty* Member of the Armed Forces? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

* "Active Duty" means full-time duty in the active military service of the United States and includes members of the reserve component (National Guard and Reserve) while serving under published orders for active duty or full-time training. The term does not include members of the reserve component who are performing active duty or active duty for training under military calls or orders specifying periods of less than 31 calendar days.

ALCOHOL/DRUG/TOBACCO USE

Q55: If "Yes," complete Substance Usage Supplement.

Q56: Quantity: Specify number of cigarettes or other tobacco products per day.

55. 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?

| | |
|--|--|
| Proposed Insured 1 | Proposed Insured 2 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Do not complete if Proposed Insured is age 0–17.

56. Have you ever used tobacco or nicotine products in any form (including but not limited to: cigarettes, cigars, cigarillos, pipe, chewing tobacco, nicotine patches or gum)? (If "Yes," provide details in chart below.)

| | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|

Proposed Insured 1

| Product | Quantity | Current | Past | # Yrs | Date Stopped (mm/yyyy) |
|-----------------|----------|--------------------------|--------------------------|-------|------------------------|
| Cigarettes | ___/day | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Cigars | ___/day | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Chewing Tobacco | ___/day | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Other | ___/day | <input type="checkbox"/> | <input type="checkbox"/> | | |

Proposed Insured 2

| Product | Quantity | Current | Past | # Yrs | Date Stopped (mm/yyyy) |
|-----------------|----------|--------------------------|--------------------------|-------|------------------------|
| Cigarettes | ___/day | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Cigars | ___/day | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Chewing Tobacco | ___/day | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Other | ___/day | <input type="checkbox"/> | <input type="checkbox"/> | | |

Section to be completed only when submitting medical examinations of another insurance company.

MEDICAL CERTIFICATION IF ANOTHER INSURANCE COMPANY'S EXAM IS TO BE USED

| 57. Proposed Insured | Name of Insurance Company | Date of Exam (mm/dd/yyyy) |
|----------------------|---------------------------|---------------------------|
| 1 | | |
| 2 | | |

58. To the best of your knowledge and belief, do the statements in the Exam remain true and complete today? (If "No," complete the Medical Information Supplement.)

| | |
|--|--|
| Proposed Insured 1 | Proposed Insured 2 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

59. Have you consulted a medical doctor or other practitioner since the Exam indicated in question 57 above? (If "Yes," complete the Medical Information Supplement.)

| | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|

MEDICAL INFORMATION

Q60: For Proposed Insured(s) issue age(s) 0–15: the Medical Information Supplement MUST be completed. For Proposed Insured(s) issue age(s) 16 and over: If a full Paramedical or Medical Exam is NOT required, complete the Medical Information Supplement. If a full Paramedical or Medical Exam is required, the Medical Information Supplement is optional. Best practice is to complete the Medical Information Supplement to enable the underwriter to promptly begin the underwriting process.

60. Is a completed Medical Information Supplement attached?

| | |
|--|--|
| Proposed Insured 1 | Proposed Insured 2 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

PROPOSED INSURED'S FINANCIAL DETAILS

61a. Income (Complete chart below.)

| Proposed Insured 1 (If minor, complete for parents) | | Proposed Insured 2 | |
|--|---|--|---|
| Gross Earned Annual Income: (Salary, commissions, bonuses) \$ _____ | Gross Annual Household Income: \$ _____ | Gross Earned Annual Income: (Salary, commissions, bonuses) \$ _____ | Gross Annual Household Income: \$ _____ |
| Gross Unearned Annual Income: (Dividends, pension, interest, real estate income, etc.) \$ _____ | Total Net Worth: \$ _____ Liquid Net Worth: (Excluding residence) \$ _____ | Gross Unearned Annual Income: (Dividends, pension, interest, real estate income, etc.) \$ _____ | Total Net Worth: \$ _____ Liquid Net Worth: (Excluding residence) \$ _____ |

61b. In the last 5 years, has either Proposed Insured filed for bankruptcy?

| | |
|--|--|
| Proposed Insured 1 | Proposed Insured 2 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If "Yes," Proposed Insured 1 Chapter: _____ Date opened: _____ (mm/dd/yyyy) Date closed: _____ (mm/dd/yyyy)

Proposed Insured 2 Chapter: _____ Date opened: _____ (mm/dd/yyyy) Date closed: _____ (mm/dd/yyyy)

Q61b: Please put additional information or details in the Remarks Section.

PURPOSE OF INSURANCE**Complete either a. or b.**

62. a. Personal: Family protection/Income replacement Mortgage/Debt repayment Estate Planning
 Charitable/Gifting Other: _____

b. Business: Key Person Buy-Sell Deferred Comp Other: _____
 Loan indemnification: Amount of loan: \$ _____ Duration: _____
Interest charged on loan: _____ Collateral pledged to secure loan: _____

1. Type: Sole Proprietorship Partnership Corporation Limited Liability Corp.

2. Proposed Insured's % of ownership in Business/Corporation: Proposed Insured 1: _____
Proposed Insured 2: _____

3. Business/Corporation finances: (Complete chart below for prior fiscal year.)

| | | | | |
|--|----------|-----------------------|----------|---|
| a. Total assets: | \$ _____ | d. Total liabilities: | \$ _____ | Total net worth (a. minus d.) \$ _____ |
| b. Total revenue: (including sales) | \$ _____ | e. Total expenses: | \$ _____ | |
| c. Net profit: | \$ _____ | f. Fair market value: | \$ _____ | |

4. Business insurance on other Owners, Officers, Partners, or Key Persons: (If additional space is required, use Remarks.)

| Name and Title | % of Business Owned | Amount In Force or Applied for |
|----------------|---------------------|--------------------------------|
| | | |
| | | |
| | | |

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

SOURCE OF FUNDS

63. a. Do you intend to finance any of the premium required to pay for this policy through a financing or loan agreement? Yes No

b. Indicate the source of funds used to purchase this insurance. (Check box **and** circle sub-item(s). If more than one box is checked, provide % breakdown.)

- Cash: Death Claim, Gift, Inheritance, Checking, Savings, Money Market, Payroll Deduction: _____%
- Borrowing: Mortgage, Personal Loan, Credit: _____%
- Policy-Related: Surrender/Exchange, Policy Loan, Dividend, Withdrawal: _____%
- Sale of 401k Mutual Fund Shares: _____%
- Sale of Other Qualified or Non-Qualified Mutual Fund Shares: _____%
- Sale of Existing Pension Plan Assets, Stocks, Bonds, CDs: _____%
- Other: Sale of (i) Car, (ii) Home, (iii) Business, or (iv) Other Asset (specify: _____),
(v) Legal Settlement, (vi) Lottery/Gaming Proceeds, (vii) Other: _____ : _____%

64. a. TO THE OWNER: Do you intend to use or transfer the policy for any type of pre-death financial settlement, such as viatical settlement, senior settlement, life settlement, or for any other settlement in the secondary market? Yes No

| | | |
|---|--|--|
| b. TO THE PROPOSED INSURED(S): Do you intend to cause the Owner to use or transfer the policy for any type of pre-death financial settlement, such as viatical settlement, senior settlement, life settlement, or for any other settlement in the secondary market? | Proposed Insured 1 | Proposed Insured 2 |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Q63: If "Yes," submit a copy of the financing or loan agreement.

SOURCE OF FUNDS CONT'D

Questions 65–67 are not required if completing Financial Supplement II.

When providing details in the Remarks Section of the application, include each Proposed Insured's name next to the statement(s) applicable to that Proposed Insured if any question is answered "Yes" for either Proposed Insured.

| | Proposed Insured 1 | Proposed Insured 2 |
|---|--|--|
| <p>65. Has either Proposed Insured(s), Owner, or Beneficiary, or any Trust or other entity in which they have an interest, sold or transferred any life insurance policy or an interest therein, within the last 5 years?</p> <p>If "Yes," please state the details of the transaction including name of each company and the number of years the policy was in effect. (Details to be provided in Remarks Section.)</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>66. 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 offered directly or indirectly to any of the following in connection with applying for and or purchasing 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? If "Yes," please state the compensation or inducement that will be received or could be received and by whom. (Details to be provided in Remarks Section.)</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>67. Will any other person or entity (i.e., a person or entity different than the owner or beneficiary initially named in the policy) provide any funding, financing, or guarantees for any premium payment on the policy, or are any potential or alternate sources of funding, financing or guarantees under consideration?</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If "Yes," please submit a copy of all actual or potential funding, financing, or guarantee documents, and a detailed, third-party prepared Personal Financial Statement signed by the preparer. The above documents are not required if funding is part of a split-dollar arrangement (1) between the employer and the employee or a corporation and its shareholders, provided that the employment and/or shareholder relationship was not entered into to establish a premium funding arrangement, or (2) between the insured and another family member (i.e., in either case, there is no third-party unaffiliated entity or non-related individual involved). Please also answer the following questions:

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

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

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

d. Will a letter of credit or personal guarantee be posted?

(If "Yes," state the details, including details relating to the assets backing the letter of credit.)

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

COMPLETE IF MONEY IS PAID WITH APPLICATION

Q68: All premium checks must be payable to company selected on page 1 of application. Do not make checks payable to financial professional or leave the payee blank.

68. Amount paid with this Application: \$ _____

- a. Has the Owner(s) read, signed and received the Temporary Insurance Agreement/Receipt? Yes No
- b. Does the Owner(s) understand and agree to all of the conditions of the Temporary Insurance Agreement/Receipt? Yes No
- c. Has the Proposed Insured(s) read and signed the the Temporary Insurance Agreement/Receipt? Yes No
- d. Does the Proposed Insured(s) understand and agree to all of the conditions of the Temporary Insurance Agreement/Receipt? Yes No

If any of the above questions are answered "No," or any Insurability Question on the Temporary Insurance Agreement/Receipt is answered "Yes," a premium may not be paid before the policy is delivered and **no temporary insurance will be in effect.**

REMARKS

Please provide details for any questions. Reference question number with remarks.

AUTHORIZATIONS

ACKNOWLEDGMENT OF OUR UNDERWRITING PROCESS

I (we) acknowledge that I (we) have reviewed the statement of the Underwriting Process of the Company(ies) (the "Statement") which describes from whom and why the Company(ies) obtain information on my (our) insurability, to whom such information may be reported and how I (we) may obtain it. The Statement contains the notice required by the Fair Credit Reporting Act.

I (we) acknowledge that in the event the Company(ies) use lab results from another insurance company authorized by me (us), it does so with the belief that I (we) have satisfied all consent and disclosure procedures for the other insurance company.

AUTHORIZATION TO OBTAIN HEALTH INFORMATION

I (we) authorize any physician, hospital, clinic, medical practitioner, medical testing laboratory, pharmacy, prescription drug or pharmacy benefit manager or administrator or viatical company, life settlement company, viatical or life settlement broker/provider, other health care provider, health plan or insurance company (including our Company(ies) with respect to other coverages) and the Medical Information Bureau to disclose to the Company(ies) and its authorized representatives any and all information, whether fact or opinion, they may have about any diagnosis, treatment, prognosis, genetic records, findings and/or results regarding my (our) past, present or future physical or mental condition.

AUTHORIZATION TO OBTAIN NON-HEALTH INFORMATION

I (we) authorize any employer, business associate, government unit, financial institution, consumer reporting agency, the Medical Information Bureau, my (our) insurance agency and my (our) financial professional to disclose to the Company(ies) and its authorized representatives any information they may have about my (our) occupation, avocations, insurance activities, finances, driving record, character and general reputation. I (we) authorize the Company(ies) to obtain investigative consumer reports, as appropriate.

PURPOSE OF AUTHORIZATIONS

I (we) understand that the information obtained will be used by the Company(ies) to determine my (our) eligibility for life insurance coverage and such other uses specified in accordance with the Statement attached to this application. In addition, information may be disclosed to the Medical Information Bureau (MIB).

COVERAGE CONDITIONS

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

ADDITIONAL AUTHORIZATIONS

You have advised me (us) that the Company(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 obligated to provide these additional authorizations but that, if I (we) choose not to provide them, this application and any claim made under the policy, if issued, may be rejected.

DURATION

Unless otherwise revoked, I (we) agree that this authorization will expire on the earlier of the date that the Company(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 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.

AUTHORIZATION IF BANK DRAFT IS ELECTED

I (we) request and authorize you 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 above, and if charges are overlooked or inadvertently not made, the Company checked above may charge my (our) account at a later date provided the policy(ies) is (are) active.

I (we) understand that the use of the Bank Draft Payment Plan does not change any policy provision.

I (we) understand this authorization is to remain in full force and in effect, unless terminated. I (we) understand this Plan may be terminated by the depositor, the Policy Owner or the Company checked above 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 with you or upon receipt of my bankruptcy.

I (we) understand if this Plan is terminated, premiums for regular or scheduled premium policies will be payable directly to the Company checked on the page one of this application.

I (we) agree that this Plan may be terminated if any debit is not honored by the Bank or Depository named for any reason. I (we) further agree that if any such charge is dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance.

THIS PAGE MUST BE SUBMITTED WITH THE COMPLETED, SIGNED APPLICATION

COPY OF AUTHORIZATIONS

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

AGREEMENT. Each signer of this Application agrees that:

- 1) The statements and answers in all parts of this Application and any application supplements are true and complete to the best of my (our) knowledge and belief. We (the Company checked on page one of this application) will rely on them in acting on this Application.
- 2) 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.
- 3) If temporary insurance is required, 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.
- 4) 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.
- 5) No financial professional or medical examiner has authority to modify this Application or its supplements, the Temporary Insurance Agreement/Receipt (if applicable), or to waive any of our rights or requirements. We shall not be bound by any information unless it is stated in Application Part 1, the Medical Information Supplement, or Application Part 2 (Paramedical or Medical exam).
- 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 only for parties related by blood or law, those who 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).

Taxpayer Identification Number Certification... Under the penalties of perjury, I (we) certify that (i) the number showing on this form is my (our) correct Taxpayer Identification Number (Social Security Number, Employer Identification Number or other Taxpayer Identification Number), and (ii) I (we) am (are) not subject to backup withholding because (A) I (we) am (are) exempt from backup withholding or (B) I (we) have not been notified by the Internal Revenue Service (IRS) that I (we) am (are) subject to backup withholding as a result of a failure to report all interest or dividends or (C) the IRS has notified me (us) that I (we) am (are) no longer subject to backup withholding and (iii) I (we) am (are) a U.S. person (including a U.S. resident alien).

Certification Instructions: You must cross out item (ii) above if you have been notified by the Internal Revenue Service that you are currently subject to backup withholding because you have failed to report all interest or dividends on your tax return.

The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

FOR THE APPLICANT'S PROTECTION, THE LAWS OF CERTAIN STATES REQUIRE THIS NOTICE: ANY PERSON WHO WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, FILES ANY APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT AS TO ANY MATERIAL FACT MAY BE GUILTY OF INSURANCE FRAUD, WHICH MAY RESULT IN LOSS OF COVERAGE UNDER THIS POLICY AND MAY SUBJECT THE APPLICANT/CLAIMANT TO CRIMINAL PROSECUTION.

D.C.: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

OHIO: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

WASHINGTON: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

I (We), the undersigned, by my (our) signature(s) below understand that I (we) am (are) agreeing to all the terms and conditions of this application, including, but not limited to, the Acknowledgment and Authorization.

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

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

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 43 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.)

X _____ Dated on (mm/dd/yyyy)
Signature of Licensed Financial Professional/Insurance Broker

Print Licensed Financial Professional's Name

COMPANY COPY

(Select One)

- AXA Equitable Life Insurance Company
- AXA Equitable Life and Annuity Company

- MONY Life Insurance Company of America
- MONY Life Insurance Company

LIMITED TEMPORARY INSURANCE AGREEMENT/RECEIPT

Instructions: If the full initial premium is paid with the Application, 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, only one Temporary Insurance Agreement/Receipt should be used, and both Proposed Insured(s) and the Owner must sign below. If the full initial premium is not paid with the Application, both the Company Copy and the Proposed Insured/Owner Copy of this Agreement must accompany the Application.

In this Agreement, "we," "our," and "us" mean AXA Equitable Life Insurance Company, or the insurance company selected 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 this Agreement 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 temporary and is subject to the conditions stated below. The temporary insurance will be in the Limited Amount (as defined below) and in accordance with the terms of the policy we would issue.

Insurability Questions:

- (1) Is any Proposed Insured less than 15 days or over 70 years of age? Yes No
- (2) Within the past 12 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
- (3) Within the past 10 years has any Proposed Insured been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) by a member of the medical profession? Yes No
- (4) Within the past 90 days has any Proposed Insured: been admitted, or medically advised to be admitted, to a hospital or other licensed health care facility; had surgery performed or recommended; or been medically advised to have any diagnostic test (excluding AIDS-related test) that was not completed? Yes No
- (5) Within the past 12 months has any Proposed Insured been declined for a life or health insurance policy? Yes No

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

- (a) Any of the Insurability Questions is answered YES or LEFT BLANK.
- (b) Any material misstatement or misrepresentation is made in any part of the Application, any application supplement or in this Agreement.
- (c) The amount paid in consideration for this Agreement is less than the full initial premium required for the policy death benefit and for any riders or a properly signed approved payment authorization is not submitted.
- (d) The check or authorized withdrawal submitted with this Agreement is dishonored when first presented for payment.

Date Temporary Insurance Coverage Starts: Any temporary insurance under this Agreement shall take effect on the life of any Proposed Insured in accordance with the terms and conditions of the Temporary Insurance Agreement, only after our receipt of the full initial premium, a signed Application, and on the latest of:

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

To be completed by the financial professional/insurance broker: A Medical Information Supplement

- Is required for Proposed Insured 1 Is not required for Proposed Insured 1; and
- Is required for Proposed Insured 2 Is not required for Proposed Insured 2

OR

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

To be completed by the financial professional/insurance broker: An Application Part 2 (Paramedical or Medical Exam)

- Is required for Proposed Insured 1 Is not required for Proposed Insured 1; and
- Is required for Proposed Insured 2 Is not required for Proposed Insured 2

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

Limited Amount: The Limited Amount 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 other subsidiaries or affiliates, not to exceed \$1,000,000 in total.

COMPANY COPY

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

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

Coverage Not Provided:

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

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

Receipt: Received from **X** _____

\$ _____, which is at least the full initial premium required for the policy's death benefit, for proposed insurance on the life of each Proposed Insured in accordance with an Application to the insurance company checked above.

The payment indicated above will be refunded (without interest) if any temporary insurance under this Agreement ends (other than because of death) without a policy replacing it.

Affirmations:

In signing below, I (we) agree that I (we) have reviewed and received a copy of all parts of the Application and applicable supplements and, as of date below, I (we) affirm that the statement and answers made in all parts of that Application and applicable supplements continue to be true and complete to the best of my (our) knowledge and belief, without material change. I (we) have read and understand that if the conditions listed in the Agreement are not met, no temporary insurance will take effect. I (we) also have read and understand the provisions contained in this Agreement regarding: (1) the limitation on the amount of temporary coverage provided; (2) when temporary coverage will begin and end; and (3) the coverage that is **not** provided under this Agreement. I (we) explicitly agree to all of the terms and conditions contained in this Agreement as written and understand **that no financial professional, insurance broker or agent has the authority to modify the Application, its supplements or this Agreement, or to bind the company indicated on the first page of this Agreement by making any promise or representation contrary to the terms and conditions contained in the Application or this Agreement.**

I (we), the undersigned, by my (our) signature(s) below understand that I (we) am (are) agreeing to all the terms and conditions of this application, including, but not limited to, the Acknowledgment and Authorization.

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

X _____
Signature of Proposed Insured 2

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

Signed by Owner at City, State

Dated on (mm/dd/yyyy)

I am not aware of any other information that would adversely affect Proposed Insured's eligibility, acceptability or insurability.

On the date of this Agreement, I received the amount indicated above in exchange for the benefits provided under this Agreement. This Agreement bears the same date as the Application Part 1. I agree that I am not authorized to change or waive the terms of this Agreement and represent that I have not attempted to do so. I have explained the terms of this Agreement to the Proposed Insured(s) and Owner(s) who has (have) stated to me that she/he (they) understand them.

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

OWNER COPY

(Select One)

- AXA Equitable Life Insurance Company
- AXA Equitable Life and Annuity Company

- MONY Life Insurance Company of America
- MONY Life Insurance Company

LIMITED TEMPORARY INSURANCE AGREEMENT/RECEIPT

Instructions: If the full initial premium is paid with the Application, 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), with a copy to the Proposed Insured(s), if different. If the policy applied for is a survivorship policy, only one Temporary Insurance Agreement/Receipt should be used, and both Proposed Insured(s) and the Owner must sign below. If the full initial premium is not paid with the Application, this unsigned Agreement must accompany the Application.

In this Agreement, "we," "our," and "us" mean AXA Equitable Life Insurance Company, or the insurance company selected 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 this Agreement 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 temporary and is subject to the conditions stated below. The temporary insurance will be in the Limited Amount (as defined below) and in accordance with the terms of the policy we would issue.

Insurability Questions:

- (1) Is any Proposed Insured less than 15 days or over 70 years of age? Yes No
- (2) Within the past 12 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
- (3) Within the past 10 years has any Proposed Insured been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) by a member of the medical profession? Yes No
- (4) Within the past 90 days has any Proposed Insured: been admitted, or medically advised to be admitted, to a hospital or other licensed health care facility; had surgery performed or recommended; or been medically advised to have any diagnostic test (excluding AIDS-related test) that was not completed? Yes No
- (5) Within the past 12 months has any Proposed Insured been declined for a life or health insurance policy? Yes No

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

- (a) Any of the Insurability Questions is answered YES or LEFT BLANK.
- (b) Any material misstatement or misrepresentation is made in any part of the Application, any application supplement or in this Agreement.
- (c) The amount paid in consideration for this Agreement is less than the full initial premium required for the policy death benefit and for any riders or a properly signed approved payment authorization is not submitted.
- (d) The check or authorized withdrawal submitted with this Agreement is dishonored when first presented for payment.

Date Temporary Insurance Coverage Starts: Any temporary insurance under this Agreement shall take effect on the life of any Proposed Insured in accordance with the terms and conditions of the Temporary Insurance Agreement, only after our receipt of the full initial premium, a signed Application, and on the latest of:

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

To be completed by the financial professional/insurance broker: A Medical Information Supplement

- Is required for Proposed Insured 1 Is not required for Proposed Insured 1; and
- Is required for Proposed Insured 2 Is not required for Proposed Insured 2

OR

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

To be completed by the financial professional/insurance broker: An Application Part 2 (Paramedical or Medical Exam)

- Is required for Proposed Insured 1 Is not required for Proposed Insured 1; and
- Is required for Proposed Insured 2 Is not required for Proposed Insured 2

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

Limited Amount: The Limited Amount 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 other subsidiaries or affiliates, not to exceed \$1,000,000 in total.

OWNER COPY

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

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

Coverage Not Provided:

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

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

Receipt: Received from **X** _____

\$ _____, which is at least the full initial premium required for the policy's death benefit, for proposed insurance on the life of each Proposed Insured in accordance with an Application to the insurance company checked above.

The payment indicated above will be refunded (without interest) if any temporary insurance under this Agreement ends (other than because of death) without a policy replacing it.

Affirmations:

In signing below, I (we) agree that I (we) have reviewed and received a copy of all parts of the Application and applicable supplements and, as of date below, I (we) affirm that the statement and answers made in all parts of that Application and applicable supplements continue to be true and complete to the best of my knowledge and belief, without material change. I (we) have read and understand that if the conditions listed in the Agreement are not met, no temporary insurance will take effect. I (we) also have read and understand the provisions contained in this Agreement regarding: (1) the limitation on the amount of temporary coverage provided; (2) when temporary coverage will begin and end; and (3) the coverage that is **not** provided under this Agreement. I (we) explicitly agree to all of the terms and conditions contained in this Agreement as written and understand **that no financial professional, insurance broker or agent has the authority to modify the Application, its supplements or this Agreement, or to bind the company indicated on the first page of this Agreement by making any promise or representation contrary to the terms and conditions contained in the Application or this Agreement.**

I (we), the undersigned, by my (our) signature(s) below understand that I (we) am (are) agreeing to all the terms and conditions of this application, including, but not limited to, the Acknowledgment and Authorization.

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

X _____
Signature of Proposed Insured 2

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

Signed by Owner at City, State

Dated on (mm/dd/yyyy)

I am not aware of any other information that would adversely affect Proposed Insured's eligibility, acceptability or insurability.

On the date of this Agreement, I received the amount indicated above in exchange for the benefits provided under this Agreement. This Agreement bears the same date as the Application Part 1. I agree that I am not authorized to change or waive the terms of this Agreement and represent that I have not attempted to do so. I have explained the terms of this Agreement to the Proposed Insured(s) and Owner(s) who has (have) stated to me that she/he (they) understand them.

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

(Select One)

AXA Equitable Life Insurance Company

MONY Life Insurance Company of America

AXA Equitable Life and Annuity Company

MONY Life Insurance Company

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

TO OBTAIN HEALTH INFORMATION In this authorization, "we" "our" and "us" mean AXA Equitable Life Insurance Company, or the insurance company selected above. I (we) authorize any physician, hospital, clinic, medical practitioner, medical testing laboratory, pharmacy or other health care provider, health plan or insurance company (including the Company checked above, with respect to other the Company checked above coverages) and the Medical Information Bureau to disclose to the Company checked above and its authorized representatives (collectively hereinafter "the Company checked above") any and all information, whether fact or opinion, they may have about any diagnosis, treatment and prognosis regarding my past, present or future physical or mental condition.

RE-DISCLOSURE OF HEALTH INFORMATION I (we) understand that any disclosure of information to the Company checked 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 (we) understand that the information obtained will be used by the Company checked above to determine my (our) eligibility for life insurance coverage, 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 you in its file to another member company with whom you apply for life or health insurance or to whom a claim for benefits may be submitted; when requested by a government agency; in connection with a legal or arbitration proceeding; or for other purposes as required or permitted by applicable law.

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

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

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

UNDERWRITING PROCESS INFORMATION

YOUR INSURANCE APPLICATION & HOW IT IS HANDLED

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

OUR UNDERWRITING PROCESS

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

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

To help establish eligibility for insurance, an investigative consumer report (including information on finances, character and general reputation) may be requested. It would be based on interviews with your employer, business associates, financial institutions, governmental units, and references you name. You may also be interviewed yourself.

You may write to us for more complete details on consumer reports. You also have the right to know whether a consumer report was made, the name and address of the agency which made it, and to obtain a copy of the report from them. You can obtain a summary of all your rights under the Fair Credit Reporting Act from the Consumer Reporting Agency.

MEDICAL INFORMATION BUREAU (MIB)

The MIB is a non-profit organization of life insurance companies. Its members exchange information in order to protect the majority of applicants from the few who might not disclose significant facts in applying for coverage. Member companies report to it information of underwriting significance as authorized by applicants and policy holders. This information is, in turn, available only to other member companies when appropriately authorized to secure it. While the MIB may help us identify areas about which we need additional information for our underwriting evaluation, we do not use MIB reports as the basis for our underwriting decisions.

Upon request, the MIB will arrange for disclosure to you of any information it may have concerning you. If you question the accuracy of this information, you may request a correction according to the federal Fair Credit Reporting Act. You may contact MIB, Inc at 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone: (866) 692-6901.

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

Where to Write to Us. 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.

FINANCIAL PROFESSIONAL/BROKER CERTIFICATION

Brokerage Name/Agency Code: _____

1. Rate Class/Tobacco Class quoted: Proposed Insured 1 _____
 Proposed Insured 2 _____

Q2: If "Yes," please provide details in the box. Do not accept money and/or execute a Temporary Insurance Agreement/Receipt.

| | | 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? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Proposed Insured 1 | Proposed Insured 2 | |

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

3a. Does the Owner speak and understand English? Yes No

Q3 & 3a: If "No," please explain how questions were asked and answered. In what language should the Personal History Interview be conducted? Indicate details in the box provided.

| Proposed Insured 1 | Proposed Insured 2 | Owner |
|--------------------|--------------------|-------|
| | | |

4. Did you: (i) Verify the identity of the Proposed Insured(s) and Policy Owner by reviewing the driver's license/passport?
 Proposed Insured 1: Yes No Proposed Insured 2: Yes No Owner: Yes No
- (ii) Inquire about the source of the customer's assets and income?
 Proposed Insured 1: Yes No Proposed Insured 2: Yes No Owner: Yes No
- (iii) Confirm that the Proposed Insured(s), Policy Owner or Applicant is not (nor is a family member of or associated with) a foreign military, government or political official?
 Proposed Insured 1: Yes No Proposed Insured 2: Yes No Owner: Yes No
- (If "No," to 4.(i), (ii), or (iii), money may not be taken without Company home office approval.)*

5. How long have you known Proposed Insured 1? _____ Proposed Insured 2? _____

6. Your relationship, if any, to the 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)

COMMISSION INFORMATION

8.

| Financial Professional(s) 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) |
| | | | | <input type="checkbox"/> Do not prepay (4) <input type="checkbox"/> Prepay (5) |

____ 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 “Disclosure of Results” and “Consent” sections of this form. Original form must be submitted with the application. Give copy to Proposed Insured at time of application.

NOTICE OF AIDS VIRUS (HIV) ANTIBODY TESTING AND CONSENT FOR TESTING

AIDS. Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include those who have had sexual contact with an infected person, intravenous drug users and hemophiliacs. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a significant chance of developing AIDS over the next 10 years.

The HIV Antibody Test. Before consenting to testing, please read the following important information.

1. **Purpose.** This test is being run to determine whether you may have been infected with HIV. If you are infected, your options for obtaining life and health insurance may be limited. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.
2. **Positive Test Results.** If you test positive, you should seek medical follow-up with your personal physician because you may be infected with HIV.
3. **Accuracy.** An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Specifically, this continuation procedure means that a positive result on an initial ELISA test is confirmed by a repeat ELISA test, which is in turn confirmed by a Western Blot test. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:
 - a. **False positives:** The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high-risk behavior. Retesting should be done to help confirm the validity of a positive test.
 - b. **False negatives:** The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4 to 12 weeks for a positive test result to develop after a person is infected.
4. **Possible Adverse Effects of Test.** A positive test result may cause you significant anxiety. A positive test result may limit your ability to obtain life, health or disability insurance coverage in the future. Although prohibited by law, discrimination in housing, employment or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.
5. **Disclosure of Results.** A final positive test result will be disclosed to you. You may choose to have information about your HIV test results communicated to you through your physician, through the county health department or directly. Because a trained person should deliver that information so that you can understand clearly what the test results mean, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result: _____

Address: _____

If you want to know the results of the test through the county health department, give name and address of the County Health Department:

If you want results of the test directly, initial here: _____

An HIV positive result shall not be disclosed directly to you except upon your specific request, after a renewed opportunity is given to you to name a physician.

6. **Confidentiality.** Like all medical information, HIV test results are confidential. An insurer, insurance agent or insurance support organization is required to maintain the confidentiality of HIV test results. Certain disclosures of your test results may occur, however, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to affiliates, reinsurers, employees and contractors of the insurer in relation to the underwriting of the insurance application. In addition, a positive result from a blood or oral specimen maybe reported to the Medical Information Bureau, a national insurance data bank, as a non-specific abnormality determined by the testing of blood or oral specimen.
7. **Prevention.** Persons who have a history of high-risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.
8. **Information.** Further information about HIV testing and AIDS can be obtained by calling the Oregon AIDS hotline within the Portland area at 223-AIDS and outside the Portland area at 1-800-777-AIDS. Health insurance may be available through the Oregon Medical Insurance Pool for persons who are not otherwise able to obtain coverage. The telephone number for the Oregon Medical Insurance Pool is 1-800-542-3104 or 1-503-373-1692.

Consent. I have read and I understand this Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing. I voluntarily consent to the withdrawal of my blood or oral specimen, the testing of my blood or oral specimen for HIV antibodies and the disclosure of the test results as described above. This consent authorization is limited to six months.

Signature of Proposed Insured _____ Date _____

Name of Proposed Insured (Please Print) _____

Address _____

NOTE: A copy of this form must be given to the proposed insured.

Privacy Policy

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 Number at 1-800-289-9999 or by visiting FINRA's Web site 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 at 1290 Avenue of the Americas, New York, NY 10104.

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

(Rev.7/10)

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Cat. #134310



Privacy Policy

AXA Equitable Life Insurance Company
AXA Equitable Life and Annuity Company
MONY Life Insurance Company
MONY Life Insurance Company of America
U.S. Financial Life Insurance Company
AXA Advisors, LLC
AXA Network, LLC

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.



Privacy Policy

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 only products and services 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



STATE OF OREGON FINANCIAL PROFESSIONAL'S REPLACEMENT KIT*

FOR LIFE BUSINESS

TO OREGON'S NEW REPLACEMENT REGULATION

Effective November 1, 2001

What You Need To Know About the New Replacement Regulation

This Guide is designed to acquaint you with Oregon's amended replacement regulation. It is part of the training program that AXA Equitable Life Insurance Company, AXA Equitable Life and Annuity Company, MONY Life Insurance Company, and MONY Life Insurance Company of America (collectively, "the Companies") are required to establish under the Oregon insurance regulation. All financial professionals who hold Oregon insurance licenses (resident or non-resident) must read and comply with the provisions of this Guide.

The Oregon Insurance Regulation Prohibits the Companies from Processing Applications That Do Not Contain All of the Required Information and Documentation

For Broker/Dealer Use
Financial Professional Use Only. Not for distribution to the public.
Annuity contracts and life insurance policies are issued by
AXA EQUITABLE LIFE INSURANCE COMPANY
and distributed by AXA DISTRIBUTORS, LLC.
1290 Avenue of the Americas, New York, NY 10104

*To make this Guide easier to read, we use the phrase financial professional when referring to the insurance producer or associate. Although we use this phrase, it has the same meaning as the insurance producer or associate.

AXA Equitable Life's Replacements Policy

AXA Equitable Life has long emphasized the importance of continuing the benefits of existing life insurance and annuity contracts. However, in particular cases it may be appropriate and in the best interests of a client to replace or change existing coverage or to transfer some or all annuity contract values to another contract. In other cases, the disadvantages to the client may outweigh the benefits of the new policy or contract. As a result, in connection with any proposed replacement, associates must ensure that they comply with the following three requirements:

1. The advantages and disadvantages of the proposed sale are fully disclosed to the client and the sale is suitable for the client;
2. The proposed replacement is properly and completely disclosed on the application and sales illustration, and
3. All applicable state and company replacement requirements are satisfied.

What Financial Professionals Need To Know About the New Replacement Regulation in OREGON

A new replacement regulation has been adopted in Oregon. The regulation is effective **November 1, 2001**. The regulation will apply to all new life insurance policies and annuity contracts purchased and delivered (or issued for delivery) in Oregon. Among other things, the new regulation:

- requires that an **Important Notice** form be **read by or to the applicant**, and be completed and signed by *every applicant where an existing policy or contract is indicated on the application, whether or not a replacement will occur*;
- broadens the definition of a replacement (both internal and external) and narrows its exemptions, thus increasing the number of situations in which a replacement is deemed to exist;
- imposes important other new responsibilities on insurers and financial professionals in connection with replacement transactions.

This Guide is intended to provide an overview of the new regulation and your responsibilities. It also sets forth the procedures that must be followed for all Oregon life and annuity applications submitted on or after November 1, 2001. **More information, including the new forms that you will need and instructions for completing those forms, is available on www.axa-equitable.com.**

The Definition of Replacement Has Been Broadened

The new regulation expands the definition of replacement. Under the new regulation, a replacement occurs if a new life or annuity contract is purchased **and** any of the following occurs *or is expected to occur* with regard to an existing contract:

- the contract is allowed to **lapse or forfeit**,
- the contract is **surrendered** (in whole or part, including surrender of dividend additions or accumulations),
- a **non-forfeiture option is exercised**,
- the contract is **reduced** in value with a release of dividends or cash value,
- the contract is **continued with a stoppage of premium payments**,
- **benefits are reduced** under the contract, or
- used in a **financed purchase**. Financed purchase means the purchase of a **new life insurance policy** involving the actual or intended use of funds obtained by the withdrawal, surrender, or borrowing from values of an existing policy to pay all or part of any premium due on a new life insurance policy.

Significant changes from the old regulation include the elimination of the "25% threshold" for loans, surrenders and withdrawals. Under the old regulation, surrendering or borrowing dividends or cash value was viewed as a replacement only when 25% of the loan value was affected. Now a replacement occurs if *any* loan, surrender or withdrawal occurs.

If you are in doubt about whether a specific action may be deemed a replacement, you should first review the Important Notice form, which is available on www.axa-equitable.com.

Exemptions Have Been Narrowed

The new regulation has narrowed the number of exemptions that apply to the definition of replacement. The new regulation exempts the following from the definition of replacement:

- the exercise of a conversion privilege
- replacement of nonrenewable, nonconvertible term insurance with 5 years or less to its expiration,
- sales in which the new coverage is provided under
 - a group life insurance or annuity program – **except where** the financial professional or the insurer directly solicits the certificate holder or participant for the new coverage or where an insurance company has been notified that plan participants may choose among two or more life insurance or annuity providers, or
 - an individual life or annuity contract if the cost is borne **totally** by the employer or an association.
- structured settlement contracts.

Significant changes from the old regulation include the elimination of exemptions for internal replacements -- transactions where the replacing insurer and the existing insurer are the same, or are subsidiaries or affiliates under common ownership or control -- and certain sales to tax qualified plans. The new regulation also narrows the group insurance exemptions by requiring that the full cost of the insurance or annuity contract must be paid by the employer or an association for the exemption to apply.

An Overview of Some of the Changes Affecting Financial Professionals

New Forms. The new regulation modifies the current replacement forms that must be used and implements one new form. These forms will be posted on www.axa-equitable.com.

- The **Important Notice** form has been modified to include a new 30-day "free look" period. Also, the applicant must now acknowledge receipt of the form by signing it.
- The **Sales Material Used in a Replacement Transaction** form must be completed and submitted whenever a replacement sale is made.

Sales Material must be identified or submitted. The new regulation also requires you to identify all AXA Equitable Life-approved sales materials used, submit to the AXA Equitable Life all sales materials not prepared by AXA Equitable Life (including the illustration, proposal or quote) used to solicit the proposed replacement contract together with the application, and to leave copies of **all** sales materials with the applicant. AXA Equitable Life is required to confirm directly with the policy owner that the sales materials have been left with the applicant. This will be done through written confirmation to the policy owner at the time of policy/contract issue

After the Application is Submitted

Inaccuracies or deficiencies in the necessary forms must be corrected. When existing insurance is admitted on the application, the insurer, name of insured/annuitant, policy or contract number if available (or alternative identification), and whether a replacement or financed purchase is involved or not, must be completed. AXA Equitable Life is required to notify the replaced insurer of the replacement and furnish copies of any illustration or policy summary within 5 days of receiving the application. Since it is expected that such materials will be closely scrutinized, you should carefully complete and review them prior to submission.

If proper and complete forms are not submitted with the application, a letter will be sent by the service center outlining the incomplete requirements to both the applicant and financial professional as required by the new regulation.

30-Day Free Look

The new regulation requires that the replacing company allow a 30-day free look period on the new policy/contract issued as a replacement.

Prohibited Actions

It is prohibited under the new regulation and AXA Equitable Life policy for you to:

- make any deceptive or misleading statements or give any deceptive or misleading information in the **Important Notice** or in any proposal, including the sales material used in the replacement sale;
- fail to ask the applicant the pertinent questions relating to the probability of financing or replacement when completing the application;
- incorrectly record an answer;
- advise an applicant to respond negatively in order to prevent notice to the insurer being replaced; or
- advise a policy/contract owner to write directly to the insurer in such a way as to attempt to obscure the identity of the replacing producer or insurer.

Although policy/contract owners have the right to replace existing policies after stating that they did not intend to, the Oregon Insurance Department and AXA Equitable Life will consider patterns of such action by owners involving the same financial professional(s) to be an indication that replacement was intended.

Penalties

Violation of the provisions of this regulation can lead to monetary fines, forfeiture of any commission or compensation paid and/or the suspension or revocation of your license and may also subject you to discipline under AXA Equitable Life's procedures.

MANDATORY PROCEDURES FOR ALL OREGON INSURANCE SALES (EFFECTIVE NOVEMBER 1, 2001)

The following procedures apply to all applications submitted on or after NOVEMBER 1, 2001 for new life insurance policies purchased and delivered (or issued for delivery) in Oregon.

Step 1 — Determine if the proposed applicant has any existing life insurance.

For life insurance applications, indicate on the application whether existing coverage exists and if such coverage exists, list all existing coverage. If there are no existing life insurance policies, proceed with the application in the usual manner.

If any existing life insurance policies are indicated on the application, proceed to **Step 2**.

Step 2 — Completion of Oregon Appendix A “Important Notice”

The **Important Notice** form must be fully completed, including the reading of the notice to the applicant (unless they initial that they do not want it read aloud).

- If both of the questions on the **Important Notice** form are answered “NO”, the transaction is not a replacement. Proceed to **Step 4** to submit the completed and signed **Important Notice** with the application directly to the processing office.
- If either of the two questions on the **Important Notice** form is answered “YES”, then the transaction is a replacement. Information concerning the existing policy(ies) or contract(s) that the applicant intends to replace must be provided on the **Important Notice** form. Remember to complete the “YES” answer to the replacement question on the application. A copy of the **Important Notice** must be left with the applicant.

Proceed to **Step 3**.

Step 3 – Completion of AXA Equitable Life’s “Sales Material Used in a Replacement Transaction” Form

The **Sales Material Used in a Replacement Transaction** form must be fully completed to certify whether sales materials, including illustrations, proposals or quotes, were used in the transaction.

- Identify AXA Equitable Life-approved sales materials by catalog number, compliance control number or title.
- If the transaction included presentation of sales materials not prepared by AXA Equitable Life, including a sales illustration, proposal or quote, indicate this on the form and submit a copy of the sales material with the application.
- Initial the appropriate certification if no sales materials, illustrations, proposals or quotes were used in the transaction.

Copies of all sales materials must also be left with the applicant. If a policy is issued, AXA Equitable Life will confirm that all sales materials have been left with the applicant by corresponding directly with the policy owner.

Proceed to **Step 4**, which lists the required documents and processing instructions.

Step 4 — Forwarding of Application and Replacement Documents

The application and complete package of replacement documents will be forwarded to the appropriate Service Center for processing. Listed below are the required documents:

- the fully completed, signed and dated application, and for applicable life insurance policies, a conforming illustration;
- the fully completed, signed and dated Appendix A – “**Important Notice**” form;
- the fully completed, signed and dated “**Sales Material Used in a Replacement Transaction**” form and copies of any individualized sales material used in the sale, including the sales illustration, proposal, quote, or electronically presented sales material, if applicable; and
- Other appropriate Companies’ transfer forms, such as:
 - 1035 Exchange Form
 - IRA Transfer/Rollover Form
 - Other forms as may be required.

By Regular Mail:
AXA Equitable Life Insurance Company
PO Box 4024
Farmington, CT 06034

By Express Mail:
AXA Equitable Life Insurance Company
80 Scott Swamp Road
Farmington, CT 06032

**The Oregon Insurance Regulation Prohibits the
Companies from Processing Applications That Do Not
Contain All of the Information and Documentation
Discussed Above**

Questions? **Call (800) 924-6669**

OREGON

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements. A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase. A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement. You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured. We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? YES _____ NO _____
2. Are you considering using funds from your existing policies or contracts to pay the premiums due on the new policy or contract? YES _____ NO _____

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

| INSURER NAME | CONTRACT OR POLICY NUMBER | INSURED or ANNUITANT | REPLACED (R) or FINANCING (F) |
|--------------|---------------------------|----------------------|-------------------------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. [If you request one, an in-force illustration, policy summary or available disclosure document must be sent to you by the existing insurer.] Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision. The existing policy or contract is being replaced because _____

You have the right, within 30 days from the date of delivery of a new life insurance policy or an annuity contract, to return it to the insurer and receive an unconditional full refund of all premiums or considerations paid on it, or in the case of a variable or market value adjustment policy or contract, a payment of the cash surrender benefits provided under the policy or contract, plus the amount of all fees and other charges deducted from gross considerations or imposed under the life insurance policy or annuity contract.

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature and Printed Name

Date

Producer's Signature and Printed Name

Date

I do not want this notice read aloud to me. _____

(Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS: Are they affordable?
Could they change?
You're older—are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES: New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY: If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?
Is this a tax-free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

OREGON

SALES MATERIAL USED IN A REPLACEMENT TRANSACTION

Pursuant to Oregon Rules OAR 836-080-0001 to 836-080-0043 — Replacement of Life Insurance and Annuities, when an associate engages in a replacement transaction, he / she must leave an original, or a copy, of all sales materials used in the transaction with the applicant. In addition, the associate must provide to the insurer to which an application for a policy or contract is presented a statement identifying any pre-printed or electronically presented insurer-approved sales materials used in the transaction, and copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased. Oregon rules define sales material as any sales illustration and other written, printed or electronically presented information, which describes the benefits, features and costs of the specific product purchased, and is given to the policy or contract owner. Any material presented to the applicant, that was created, completed or provided by the issuing company and / or the associate, is included in the Oregon rules' sales material definition. Furthermore, the associate must give the applicant a printed copy of all electronically presented sales material no later than when delivery of the policy or contract occurs.

Associate Certification:

Sales Materials: (Initial all certifications that apply)

_____ I hereby certify that all sales materials used in this sales transaction have been approved by AXA Equitable Life Insurance Company and / or AXA Life and Annuity Company and are specified below. I further certify that the applicant received originals and / or copies of all sales material, and that printed copies of all electronically presented information will be given to the applicant at, or prior to, delivery of the policy or contract.

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

_____ I hereby certify that the **attached** individualized sales materials were used in this transaction. I further certify that the applicant received originals and / or copies of all sales material, and that printed copies of all electronically presented information will be given to the applicant at, or prior to, delivery of the policy or contract.

_____ I hereby certify that **no** sales materials were used in this transaction.

Illustrations or Proposals: (Initial all certifications that apply)

_____ I hereby certify that the **attached** sales illustration or proposal was used in this transaction. I further certify that the applicant received originals and / or copies of the sales illustration or proposal.

_____ I hereby certify that **no** sales illustration or proposal was used in this transaction.

Applicant's Name: _____

Applicant's Complete Address: _____

Producer's Printed Name

Producer's Signature

Date



1290 Avenue of the Americas, New York, NY 10104

(Select One)

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

Financial Supplement

FINANCIAL SUPPLEMENT FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

Name of Proposed Insured _____ Policy No. (if known) _____ Date of Birth _____
(mm/dd/yyyy)

PERSONAL FINANCIAL STATEMENT (FOR PERSONAL INSURANCE)

1. Balance Sheet

| a. Current Assets | Amount | b. Current Liabilities | Amount |
|-------------------|--------|---------------------------|--------|
| Liquid \$ | \$ | Mortgage | \$ |
| Other (specify): | \$ | Other (specify) | \$ |
| | | c. Total Net Worth | \$ |

2. Income

| | Earned Income | | Unearned Income | | | Total |
|---------------------|---------------|--------------|-----------------|-----------------|------------------|-------|
| | | Div/Interest | Rental Income | Pension/Soc Sec | Other (specify): | |
| Current Year | \$ | \$ | \$ | \$ | \$ | \$ |
| Last Year | \$ | \$ | \$ | \$ | \$ | \$ |

3. How was the proposed face amount determined for this application? State what formula was used (e.g., estate tax calculation, survivor needs, estimated fair market value or book value of the business, capitalization of earnings, etc.)

If none, state none. _____

4. Do you expect any changes greater than 15% in income or net worth in the next 12 months? Yes No

If "Yes", explain _____

BUSINESS INFORMATION

5. Name of business _____ Nature of business _____

6. How long has business been in operation? _____ years

7. Percentage (%) of business owned by the Proposed Owner, if other than the Proposed Insured _____%

Are all members of business being similarly insured? Yes No

If "Yes", provide details of business coverage issued or applied for on other members: (use separate sheet if necessary):

| Name and Position/Title | % of Business Owned | Amount in force or applied for |
|-------------------------|---------------------|--------------------------------|
| | | |
| | | |

If "No", explain reason _____

8. Business finances for past 2 years:

| Year | Total Assets | Total Liabilities | Total Revenue (including sales) | Total Expenses | Net Profit |
|------|--------------|-------------------|------------------------------------|----------------|------------|
| | \$ | \$ | \$ | \$ | \$ |
| | \$ | \$ | \$ | \$ | \$ |

REFERENCES (PERSONAL AND/OR BUSINESS INSURANCE)

Attorney:

| Name | Business Address | Telephone No. |
|------|------------------|---------------|
|------|------------------|---------------|

Accountant:

| Name | Business Address | Telephone No. |
|------|------------------|---------------|
|------|------------------|---------------|

Other:

| Name | Branch | Title of Account |
|------|--------|------------------|
|------|--------|------------------|

| Name | Branch | Title of Account |
|------|--------|------------------|
|------|--------|------------------|

Have the above named References such as attorney, accountant and banker been authorized to release information? Yes No

If "No", explain _____

I (we) represent that the statements and answers in this Supplement are true and complete to the best my (our) knowledge and belief.

X _____ Date (mm/dd/yyyy) _____
Signature of Proposed Insured

X _____ Date (mm/dd/yyyy) _____
Signature of Owner, if other than the Proposed Insured

I certify that I have asked and recorded completely and accurately the answers to all questions on this Supplement, and know of nothing affecting the risk that has not been recorded herein.

X _____ Date (mm/dd/yyyy) _____
Signature of Licensed Financial Professional/Insurance Broker