Filing at a Glance

Company: AXA Equitable Life Insurance Company

Product Name: AMIGV-2009 et al (AXAEQ)	SERFF Tr Num: ELAS-125849269	State: ArkansasLH
TOI: L08 Life - Other	SERFF Status: Closed	State Tr Num: 40558
Sub-TOI: L08.000 Life - Other	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Authors: Sabrena Lallmohamed, Samra Mekbeb, Maria Castaldo, Audrey Arnold, Roxanne Persaud, Joan Robertson	Disposition Date: 10/22/2008
	Date Submitted: 10/13/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Individual Life
Project Number: AMIGV-2009 et al
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 10/22/2008

Deemer Date:

Filing Description:

Please see cover letter.

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 10/22/2008
Corresponding Filing Tracking Number:

Company and Contact

Filing Contact Information

Estella A. Devian, Vice President
1290 Avenue of the Americas, 14th Floor
New York, NY 10104

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Filing Company Information

AXA Equitable Life Insurance Company
1290 Avenue of the Americas, 14-10
New York,, NY 10104
(212) 314-2921 ext. [Phone]

CoCode: 62944
Group Code: 968
Group Name:
FEIN Number: 13-5570651

State of Domicile: New York
Company Type: LIFE Insurance
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$220.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
AXA Equitable Life Insurance Company	$220.00	10/13/2008	23147230

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/22/2008	10/22/2008

Disposition

Disposition Date: 10/22/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ELAS-125849269*	*State:*	*Arkansas*
Filing Company:	*AXA Equitable Life Insurance Company*	*State Tracking Number:*	*40558*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*AMIGV-2009 et al (AXAEQ)*		
Project Name/Number:	*Individual Life/AMIGV-2009 et al*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Supporting Document	Cover Letter		Yes
Supporting Document	Readability Certification		Yes
Form	Individual Life Application		Yes
Form	Substance Usage Applicaton		Yes
Form	Foreign Residence and Travel Application Supplement		Yes
Form	Aviation Application Supplement		Yes
Form	Avocation Application Supplement		Yes
Form	Financial Application Supplement		Yes
Form	Term Policy/Rider Conversion or Purchase Option Application Supplement		Yes
Form	Variable Universal Life Application Supplement		Yes
Form	Children’s Term Rider Application Supplement		Yes
Form	Optional Benefits Application Supplement		Yes
Form	Medical Application Supplement		Yes

Form Schedule

Lead Form Number: AMIGV-2009 et al

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	AMIGV-2009	Application/ Enrollment Form	Individual Life Application	Revised	Replaced Form #: AMIGV-2005 Previous Filing #:	57	AMIGV-2009, Life Insurance Application.pdf
	180-6000 (2009)	Application/ Enrollment Form	Substance Usage Applicaton	Revised	Replaced Form #: 180-6000 (2005) Previous Filing #:	75	180-6000 (2009), Substance Usage Supplement.pdf
	180-6001 (2009)	Application/ Enrollment Form	Foreign Residence and Travel Application Supplement	Revised	Replaced Form #: 180-6001 (2005) Previous Filing #:	78	180-6001 (2009), Foreign Residence and Travel Supplement.pdf
	180-6002 (2009)	Application/ Enrollment Form	Aviation Application Supplement	Revised	Replaced Form #: 180-6002 (2005) Previous Filing #:	66	180-6002 (2009), Aviation Supplement.pdf
	180-6003 (2009)	Application/ Enrollment Form	Avocation Application Supplement	Revised	Replaced Form #: 180-6003 (2005) Previous Filing #:	76	180-6003 (2009), Avocation Supplement.pdf
	180-6004 (2009)	Application/ Enrollment Form	Financial Application Supplement	Revised	Replaced Form #: 180-6004 (2005) Previous Filing #:	72	180-6004 (2009), Financial Supplement.pdf

180-6005 (2009)	Application/ Enrollment Form	Term Policy/Rider Conversion or Purchase Option Application Supplement	Revised	Replaced Form #: 180-6005 (2005) Previous Filing #:	71	180-6005 (2009),Term Policy-Rider Conversion or Purchase Option Supp..pdf
180-6006a (2009)	Application/ Enrollment Form	Variable Universal Life Application Supplement	Revised	Replaced Form #: 180-6006a (2005) Previous Filing #:	0	180-6006a (2009), VUL Supplement.pdf
180-6008 (2009)	Application/ Enrollment Form	Children's Term Rider Application Supplement	Revised	Replaced Form #: 180-6008 (2005) Previous Filing #:	69	180-6008 (2009), Children's Term Insurance Rider Supplement.pdf
180-6010 (2009)	Application/ Enrollment Form	Optional Benefits Application Supplement	Revised	Replaced Form #: 180-6010 (2005) Previous Filing #:	58	180-6010 (2009), Optional Benefits Supplement.pdf
180-6015 (2009)	Application/ Enrollment Form	Medical Application Supplement	Initial		67	180-6015 (2009), Medical Information Supplement.pdf

AXA EQUITABLE

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

Application for Life Insurance
(Part 1)

PRODUCT AND AMOUNT OF INSURANCE

Riders and Optional Benefits: Complete Optional Benefits Supplement for all non-variable products, and VUL Supplement for variable products.

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

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.

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.

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/ITIN: _____

Unit name: _____ Unit number: _____ Register date: _____

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

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.

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

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: _____

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 #: _____

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

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 Trust Protector? _____

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 Trust: _____

39a. What is nature of relationship between Grantor(s) and Beneficiary(ies)? _____

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

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? _____

BENEFICIARY INFORMATION

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.

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)
		☐ P ☐ C	%
		☐ P ☐ C	%
		☐ P ☐ C	%
		☐ P ☐ C	%

PROPOSED INSURED'S OTHER INSURANCE

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.

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?
☐ 1 ☐ 2		$			☐ P ☐ B ☐ G ☐ A	☐ Yes ☐ No	☐ Yes ☐ No
☐ 1 ☐ 2		$			☐ P ☐ B ☐ G ☐ A	☐ Yes ☐ No	☐ Yes ☐ No
☐ 1 ☐ 2		$			☐ P ☐ B ☐ G ☐ A	☐ Yes ☐ No	☐ Yes ☐ No
☐ 1 ☐ 2		$			☐ P ☐ B ☐ G ☐ A	☐ Yes ☐ No	☐ Yes ☐ No
☐ 1 ☐ 2		$			☐ P ☐ B ☐ G ☐ A	☐ Yes ☐ No	☐ Yes ☐ No
☐ 1 ☐ 2		$			☐ P ☐ B ☐ G ☐ A	☐ Yes ☐ No	☐ Yes ☐ 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?
☐ 1 ☐ 2		$	☐ Competitive ☐ Additional
☐ 1 ☐ 2		$	☐ Competitive ☐ Additional
☐ 1 ☐ 2		$	☐ Competitive ☐ Additional
☐ 1 ☐ 2		$	☐ Competitive ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No
48. Have you, in the last 2 years, been disabled for 2 or more weeks?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No

Q49: If "Yes," please 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
☐ 1 ☐ 2			
☐ 1 ☐ 2			
☐ 1 ☐ 2			

	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)?	☐ Yes ☐ No	☐ Yes ☐ No
52. Have you, in the last year, flown other than as a passenger or do you plan to do so?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No
54. Are you or is the Owner(s) an Active Duty* Member of the Armed Forces?	☐ Yes ☐ No	☐ Yes ☐ No

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.

** "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.

	Proposed Insured 1	Proposed Insured 2
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?	☐ Yes ☐ No	☐ Yes ☐ No

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

	Proposed Insured 1	Proposed Insured 2
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.)*	☐ Yes ☐ No	☐ Yes ☐ No

Proposed Insured 1

Product	Quantity	Current	Past	# Yrs	Date Stopped (mm/dd/yyyy)
Cigarettes	___ /day	☐	☐		
Cigars	___ /day	☐	☐		
Chewing Tobacco	___ /day	☐	☐		
Other	___/day	☐	☐		

Proposed Insured 2

Product	Quantity	Current	Past	# Yrs	Date Stopped (mm/dd/yyyy)
Cigarettes	___ /day	☐	☐		
Cigars	___ /day	☐	☐		
Chewing Tobacco	___ /day	☐	☐		
Other	___ /day	☐	☐		

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

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

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

Q60: The completion of the Medical Information Supplement is optional if a full Paramedical or Medical Exam is required. Best practice is to complete the Medical Information Supplement to enable the underwriter to promptly begin the underwriting process.

	Proposed Insured 1	Proposed Insured 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.)*	☐ Yes ☐ No	☐ Yes ☐ 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.)*	☐ Yes ☐ No	☐ Yes ☐ No

MEDICAL INFORMATION

	Proposed Insured 1	Proposed Insured 2
60. Is a completed Medical Information Supplement attached?	☐ Yes ☐ No	☐ Yes ☐ 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) $

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

	Proposed Insured 1	Proposed Insured 2
61b. In the last 5 years, has either Proposed Insured filed for bankruptcy?	☐ Yes ☐ No	☐ Yes ☐ 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)

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

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

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
☐ Yes ☐ No	☐ Yes ☐ No

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
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?	☐ Yes ☐ No	☐ Yes ☐ No
If "Yes," please state the details of the transaction including name of each company and the number of years the policy was in effect. (Details to be provided in Remarks Section.)		
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.)	☐ Yes ☐ No	☐ Yes ☐ No
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?	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes," please submit a copy of all actual or potential funding, financing, or guarantee documents, and a detailed, third-party prepared Personal Financial Statement signed by the preparer. The above documents are not required if funding is part of a split-dollar arrangement (1) between the employer and the employee or a corporation and its shareholders, provided that the employment and/or shareholder relationship was not entered into to establish a premium funding arrangement, or (2) between the 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.

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.

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 _____ _____ _____

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

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

(If Trust, signature of trustee.)

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 _____

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

X _____

Print Licensed Financial Professional's Name

AXA EQUITABLE

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

Substance Usage Supplement

SUBSTANCE USAGE SUPPLEMENT FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

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

1. Do you currently use or have you ever used:

a. Alcohol? ☐ Yes ☐ No
b. Marijuana? ☐ Yes ☐ No
c. Heroin, morphine, or other narcotic drug? ☐ Yes ☐ No
d. Cocaine, crack? ☐ Yes ☐ No
e. Barbiturates, sedatives, or tranquilizers? ☐ Yes ☐ No
f. Amphetamines? ☐ Yes ☐ No
g. LSD, or any other hallucinogens? ☐ Yes ☐ No
h. Other _____

2. Give details of any "Yes" answers to 1 a-h:

Type	Amount Used	Frequency (daily, weekly, monthly, yearly)	Dates Used

3. If your substance usage habits have lessened, when and why did they change?

_____

_____

4. Have you ever consulted a physician or psychologist or received counseling or treatment for substance usage? ☐ Yes ☐ No

If "Yes", provide details of all counseling or treatments, including dates, length of treatment, name and address of physician, counselor or facility:

_____

_____

5. Do you currently use, or have you used alcohol or drugs since your last treatment for substance usage? ☐ Yes ☐ No

If "Yes", provide details including dates of each occurrence:

_____

_____

6. Have you ever been a member of Alcoholics Anonymous, Narcotics Anonymous, or similar organization?

If "Yes", a. Name of Organization _____

b. Date first attended _____ c. Date last attended _____

d. Are you currently active? ☐ Yes ☐ No e. How often do you attend meetings? _____

7. Have you ever been charged with driving while intoxicated or driving under the influence? ☐ Yes ☐ No

If "Yes", provide details including date, city and state of each occurrence:

_____

_____

8. Please add any additional information that may be relevant to our evaluation:

_____

_____

I represent that the statements and answers in this Supplement are true and complete to the best of my knowledge and belief.

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

AXA EQUITABLE

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

Foreign Residence and Travel Supplement

FOREIGN RESIDENCE AND TRAVEL SUPPLEMENT FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

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

1. FOREIGN NATIONALS

If the Proposed Insured is a foreign national, you must submit a copy of a government issued photo ID evidencing nationality or residence (e.g., Passport, Alien Registration (Green Card)).

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 No. _____ Visa Type _____ Expiration Date _____ (mm/dd/yyyy)

Passport No. _____ Date of Entry into the U.S. _____ (mm/dd/yyyy)

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

Complete question below for all non-resident (foreign) owners. (Individuals, businesses, corporations, trusts and partnerships that are foreign must have a U.S. bank account).

U.S. Bank Name _____ Account Number _____

2. FOREIGN TRAVEL/RESIDENCE

Provide details for every planned stay outside the U.S. or Canada in the next year (other than a two week or less vacation to Western Europe or the Caribbean).

Country	City/Location	Residence/Travel Dates		Purpose of Trip
		Departure from U.S. mm/dd/yyyy	Return to U.S. mm/dd/yyyy	

3. Please add any additional information regarding future travel/residency that you believe was not adequately covered above: _____

_____

I represent that the statements and answers in this Supplement are true and complete to the best of my knowledge and belief.

X _____ Date (mm/dd/yyyy) _____

Signature of 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

AXA EQUITABLE

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

Aviation Supplement

AVIATION SUPPLEMENT FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

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

1. Have you, in the last year, flown as a pilot, student pilot, or crewmember on any type of aircraft? ☐ Yes ☐ No
If "Yes", date of last flight as pilot (mm/dd/yyyy) _____

2. Type of aviation license or certificate: ☐ Student ☐ Private ☐ Commercial ☐ Other _____
Date of Issue (mm/dd/yyyy) _____

3. Do you have an Instrument Flight Rating? ☐ Yes ☐ No

4. Class of FAA medical certificate _____ Date of last FAA medical examination _____ (month/year)

5. Have you flown or do you intend to fly an experimental, ultralight, personally built or assembled, or prototype aircraft? ☐ Yes ☐ No
If "Yes", provide details _____

6. Have you ever been grounded, had any flying accidents, had a written violation or had your license suspended or revoked? ☐ Yes ☐ No
If "Yes", please include dates and full details regarding the circumstances surrounding the infraction.
If it was an accident, please include details regarding the extent of personal injury and/or damage to the aircraft. _____

7. a. Type of flying (include all types):

	Type of aircraft flown	Hours last 12 months	Contemplated hours next 12 months
Student			
Pleasure			
Personal Business			
Scheduled Airline, Including Air Taxi or Commuter			
Non-scheduled Passenger or Freight			
Employer Owned Aircraft			
Student Instruction			
Active Military			
National Guard or Reserve			
Crewmember			
* Other, Specify_____			

* Provide full details of any other flying not specifically classified above (advertising, construction, crop dusting, fire fighting, inspection (pipe, power, telephone line), mapping, medical airlifting and evacuation, oil and natural gas exploration, photography, police and law enforcement, testing, traffic control, weather patrol, hang gliding, gliding, ballooning, etc.)

7. b. Total number of hours flown as a pilot: _____

8. Are flights made only between established airports? ☐ Yes ☐ No *If "No", explain:* _____

9. Please provide any additional information that may be relevant to our evaluation: _____

10. If either is necessary under Company rules, which of the following do you prefer?
☐ Full Aviation coverage at an extra premium ☐ Restricted Coverage without extra premium

11. Other aviation activities: Please provide details regarding any other aviation activities in which you participate:

_____

_____

I represent that the statements and answers in this Supplement are true and complete to the best of my knowledge and belief.

X _____ Date (mm/dd/yyyy) _____

Signature of 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

AXA EQUITABLE

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

Avocation Supplement

AVOCATION SUPPLEMENT FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

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

Complete all sections which apply

SCUBA DIVING

1. Type or purpose of diving: ☐ Recreation ☐ Instruction ☐ Construction ☐ Salvage ☐ Search Work ☐ Cave Diving ☐ Other _____

2. Location in which you dive: ☐ Deep Sea/Ocean ☐ Other _____

3. Type of certification held _____ Date of certification _____ (mm/dd/yyyy) Equipment used _____

4. Do you ever dive alone? ☐ Yes ☐ No

5. Diving activity:

	Past 12 months		Contemplated next 12 months	
Depths of dives	Number of dives	Average time per dive	Number of dives	Average time per dive
0-75 feet				
76-100 feet				
101-150 feet				
Over 150 feet				

ORGANIZED RACING-AUTOMOBILE, BOAT, MOTORCYCLE, SNOWMOBILE

6. Status: ☐ Professional ☐ Amateur ☐ Other

7. Do you hold a competition driver's license from any organization? ☐ Yes ☐ No

If "Yes", list all organizations _____

8. Type of racing: ☐ Stock car ☐ Sports car ☐ Sprint car ☐ Midget ☐ Formula car ☐ Championship ☐ Drag ☐ All-terrain ☐ Motorcycle ☐ Powerboat ☐ Snowmobile ☐ Other _____

9. Vehicle: **a.** Make _____ **b.** Model _____ **c.** Horsepower _____ **d.** Engine displacement (cc) _____

10. Course Type: **a.** ☐ Paved track ☐ Dirt track ☐ Desert/Off road ☐ Drag strip ☐ Road course ☐ Cross-country ☐ Hill climbing ☐ Other _____

b. Length of course _____ **c.** Length of race _____

11. Speed: **a.** Maximum speed attained (mph) _____ **b.** Average speed _____

12. Number of races: **a.** Last 12 months _____ **b.** Contemplated next 12 months _____

☐ **PARACHUTING OR** ☐ **SKYDIVING OR** ☐ **HANG GLIDING**

13. Status: ☐ Professional ☐ Amateur ☐ Other _____

14. Do you belong to an organized club? ☐ Yes ☐ No *If "Yes", name of club* _____

15. Number of jumps: **a.** Last 12 months _____ **b.** Contemplated next 12 months _____

c. Total number of jumps to date _____

16. Type of jumps (stunting, instructional, BASE, etc.) _____

17. Over what type of terrain are jumps made? _____

☐ **MOUNTAIN CLIMBING OR** ☐ **ROCK CLIMBING**

18. Type of climbing: ☐ Trail ☐ Ice ☐ Rock ☐ Glacier ☐ Snow

19. Type of training _____ Years of experience _____

20. Do you belong to an organization? ☐ Yes ☐ No *If "Yes", name of organization* _____

21. Equipment used _____

22. Number of climbs: **a.** Last 12 months _____ **b.** Contemplated next 12 months _____ **c.** Total number climbs to date _____

Climbing Details

Date (mm/dd/yyyy)	Type (mountain, rock,ice, etc.)	Level or Class (A1-A5, 1-6 etc.)	Elevation (specify feet or meters)	Location (Mountain range, State, Country)

23. Other Avocation Activities: Please provide details regarding any other avocation activities in which you participate:

_____

_____

_____

I represent that the statements and answers in this Supplement are true and complete to the best of my knowledge and belief.

X _____ Date (mm/dd/yyyy) _____

Signature of 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

AXA EQUITABLE

1290 Avenue of the Americas, New York, NY 10104

(Select One)

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- ☐ 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**				
		Div/Interest	Rental Income	Pension/Soc Sec	Other (specify):	**Total**
Current Year	$	$	$	$	$	$
Last Year	$	$	$	$	$	$

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

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

AXA EQUITABLE

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

Term Policy/Rider Conversion or Purchase Option Supplement

TERM POLICY/RIDER CONVERSION OR PURCHASE OPTION SUPPLEMENT FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

Complete on Term Policy/Rider Conversion, Option to Purchase Additional Insurance only

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

1. TERM CONVERSION

a. Original policy numbers _____ _____ _____

b. Conversion from: ☐ Term policy ☐ Term rider ☐ Other

c. Conversion date (not later than date to which premiums are paid on original policy) _____ (mm/dd/yyyy)

d. Select the appropriate type of conversion
- ☐ Full Conversion (Entire amount of Term policy/rider being converted)
- ☐ Conversion with Increase (Face Amount on new policy is higher than on Term policy/rider)
- ☐ Partial Term Conversion (Face Amount on new policy is lower than on Term policy/rider)

  If Partial Term Conversion checked, complete the following:
  - ☐ Balance remaining after conversion to be continued, if allowed.
  - ☐ Balance remaining after conversion to be discontinued.

e. Are you currently disabled? ☐ Yes ☐ No

f. Is original policy attached? ☐ Yes ☐ No If "No," is original policy lost? ☐ Yes ☐ No

2. OPTION TO PURCHASE ADDITIONAL INSURANCE ELECTION

a. Original policy numbers _____ _____ _____

b. Is the purchase made under Advanced Privilege/Option B or C (at time other than the scheduled option date)? ☐ Yes ☐ No

i. Option date used _____ (mm/dd/yyyy)

ii. Event

☐ Marriage Date _____ (mm/dd/yyyy) Name of Spouse _____

☐ Birth or finalized legal adoption of child

Name of child _____ Born _____ (mm/dd/yyyy) Date of adoption finalized _____ (mm/dd/yyyy)

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

X _____ Date (mm/dd/yyyy) _____

Signature of Proposed Insured

X _____ Date (mm/dd/yyyy) _____

Signature of Owner

(Owner of original term policy, or policy from which term rider is to be converted, or policy from which purchase option is being exercised must sign this supplement.)

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

AXA EQUITABLE

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

Variable Universal Life Supplement

VARIABLE UNIVERSAL LIFE SUPPLEMENT FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

This Application Supplement must be completed by the Proposed Insured(s) and Owner, if other than the Proposed Insured(s), for Variable Life Application only.

Product (select one): ☐ **IL Optimizer** ☐ **IL Legacy** ☐ **SIL Legacy**

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

1. INITIAL ALLOCATION TO THE INVESTMENT OPTIONS*

Policy No. (if known) _____

See Prospectus for description of investment objective(s) for each Investment Option.

(Whole Percentages Only)

IL LEGACY AND SIL LEGACY: IF ENLG RIDER IS ELECTED, SEE FUND RESTRICTIONS BELOW.**	For Premiums	For Deductions
Guaranteed Interest Account**	%	%
AXA Aggressive Allocation**	%	%
AXA Conservative Allocation**	%	%
AXA Conservative-Plus Allocation**	%	%
AXA Moderate Allocation**	%	%
AXA Moderate-Plus Allocation**	%	%
EQ/AllianceBernstein Common Stock	%	%
EQ/AllianceBernstein Intermediate Government Securities	%	%
EQ/AllianceBernstein International	%	%
EQ/AllianceBernstein Large Cap Growth	%	%
EQ/AllianceBernstein Quality Bond	%	%
EQ/AllianceBernstein Small Cap Growth	%	%
EQ/AllianceBernstein Value	%	%
EQ/Ariel Appreciation II	%	%
EQ/AXA Rosenberg Value Long/Short Equity	%	%
EQ/BlackRock Basic Value Equity	%	%
EQ/BlackRock International Value	%	%
EQ/Boston Advisors Equity Income	%	%
EQ/Calvert Socially Responsible	%	%
EQ/Capital Guardian Growth	%	%
EQ/Capital Guardian Research	%	%
EQ/Caywood-Scholl High Yield Bond	%	%
EQ/Equity 500 Index	%	%
EQ/Evergreen International Bond	%	%
EQ/Evergreen Omega	%	%
EQ/FI Mid Cap	%	%
EQ/GAMCO Mergers and Acquisitions	%	%
EQ/GAMCO Small Company Value	%	%
EQ/International Core PLUS	%	%
EQ/International Growth	%	%
EQ/JPMorgan Core Bond	%	%
EQ/JPMorgan Value Opportunities	%	%

(Whole Percentages Only)

	For Premiums	For Deductions
EQ/Large Cap Core PLUS	%	%
EQ/Large Cap Growth PLUS	%	%
EQ/Legg Mason Value Equity	%	%
EQ/Long Term Bond	%	%
EQ/Lord Abbett Growth and Income	%	%
EQ/Lord Abbett Large Cap Core	%	%
EQ/Lord Abbett Mid Cap Value	%	%
EQ/Marsico Focus	%	%
EQ/Mid Cap Value PLUS	%	%
EQ/Money Market	%	%
EQ/Montag & Caldwell Growth	%	%
EQ/PIMCO Real Return	%	%
EQ/Short Duration Bond	%	%
EQ/Small Company Index	%	%
EQ/T. Rowe Price Growth Stock	%	%
EQ/UBS Growth and Income	%	%
EQ/Van Kampen Comstock	%	%
EQ/Van Kampen Emerging Markets Equity	%	%
EQ/Van Kampen Mid Cap Growth	%	%
EQ/Van Kampen Real Estate	%	%
Multimanager Aggressive Equity	%	%
Multimanager Core Bond	%	%
Multimanager Health Care	%	%
Multimanager High Yield	%	%
Multimanager International Equity	%	%
Multimanager Large Cap Core Equity	%	%
Multimanager Large Cap Growth	%	%
Multimanager Large Cap Value	%	%
Multimanager Mid Cap Growth	%	%
Multimanager Mid Cap Value	%	%
Multimanager Small Cap Growth	%	%
Multimanager Small Cap Value	%	%
Multimanager Technology	%	%
TOTAL	**100%**	**100%**

*In AL, AK, AZ, CA, CO, FL, ID, IA, KS, NJ, OR, PA, PR, TN, USVI, and WY your Policy Account will be allocated according to these percentages. In all other jurisdictions your Policy Account will be allocated according to these percentages on the first business day 20 days after the date of issue of your policy. Before that time, all Policy Account allocations (except to the Guaranteed Interest Account) will be to the EQ/Money Market Investment Option (Money Market Lock-in). Consult the prospectus for Investment Option information.

**** IF EXTENDED NO LAPSE GUARANTEE (ENLG) RIDER is elected:**
a. Investment Options are limited ONLY to the funds BOLDED ABOVE.
b. Premium allocations to the Guaranteed Interest Account are RESTRICTED to a maximum of 25%.
c. DO NOT specify Deduction allocations.

2. SUITABLITY

a. Have you, the Proposed Insured(s) and the Owner, if other than the Proposed Insured(s), received:

(1) a prospectus for policy(ies) applied for? ☐ Yes ☐ No

Date of prospectus _____ Date of any supplements _____; _____;_____

(2) a prospectus for the designated investment company(ies)? ☐ Yes ☐ No

Date of prospectus _____ Date of any supplements _____; _____;_____

b. Do you understand that **(i)** policy values reflect certain deductions and charges, and may increase or decrease depending on credited interest for the Guaranteed Interest Account and/or the investment experience of Separate Account Funds and **(ii)** the cash value may be subject to a surrender charge, if any, upon policy surrender, lapse or face amount reduction? ☐ Yes ☐ No

c. With this in mind, is (are) the policy(ies) in accord with your insurance and long-term investment objectives and anticipated financial needs? ☐ Yes ☐ No

d. Disclosures and Consent for Delivery of Initial Prospectus on CD-Rom for AXA Equitable's and its affiliates' Variable Life products.

☐ By checking the box and signing this application supplement, you acknowledge that you received the initial prospectus on computer readable compact disk "CD", if available for the product chosen, and that you are able to access the CD information. In order to retain the prospectus indefinitely, you must print it. You understand that you may request a prospectus in paper format at any time by calling Customer Service at 1-877-222-2144, and that all subsequent prospectus updates and supplements will be provided to you in paper format, unless you enroll in our electronic delivery service.

3. OPTIONAL BENEFITS/RIDERS

IL Optimizer

☐ Cash Value Plus Rider
☐ Disability Waiver of Premium Rider

OR

☐ Disability Waiver of Monthly Deductions Rider
☐ Children's Term Insurance Rider *(complete Children's Term Insurance Rider Supplement)*
Amount $ _____
☐ Long-Term Care Services Rider *(complete Long-Term Care Services Rider Supplement)* †
☐ Option to Purchase Additional Insurance Rider
Amount $ _____
☐ Other _____

IL Legacy

☐ Disability Waiver of Monthly Deductions Rider
☐ Extended No Lapse Guarantee (ENLG) Rider *(indicate no. of years as measured from the Register Date)*
☐ 20 Years (minimum)
☐ To Age 100 (maximum)
☐ Other (specify no. of years) _____ years
☐ Children's Term Insurance Rider *(complete Children's Term Insurance Rider Supplement)*
Amount $ _____
☐ Long-Term Care Services Rider (complete Long-Term Care Services Rider Supplement) †
☐ Option to Purchase Additional Insurance Rider
Amount $ _____
☐ Other _____

SIL Legacy

☐ Extended No Lapse Guarantee (ENLG) Rider *(indicate no. of years as measured from the Register Date)*
☐ 30 years (minimum)
☐ To Age 100 (maximum)
☐ Other (specify no. of years) _____ years
☐ Estate Protector Rider *(EPR benefit is a maximum of 122% of the base policy face amount)*
☐ Other _____

† Not available in Florida and North Carolina.

4. AUTOMATIC TRANSFER SERVICE *Note: This Service may not be elected if you choose the Asset Rebalancing Service.*
A minimum of $5,000 must be allocated to the EQ/Money Market Investment Option. Up to 8 investment options can receive the monthly automatic transfer. Each transfer must be at least $50. The automatic transfer is effective on the first monthly anniversary after the Money Market Lock-in period ends and will continue until the amount allocated to the EQ/Money Market Investment Option is depleted.

Investment Options to Receive Transfer:	Dollar Amount:
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____

I (we), the undersigned, have read the detailed description of the Automatic Transfer Service in the prospectus. My (our) instructions will remain in effect until **(a)** insufficient funds are available to process transfers, **(b)** I (we) provide new written instructions, or **(c)** the Automatic Transfer Service otherwise terminates as described in the prospectus. I (we) understand that use of the Automatic Transfer Service does not guarantee a profit and will not protect against loss in a declining market.

5. ASSET REBALANCING SERVICE *Note: This Service may not be elected if you choose the Automatic Transfer Service.*
The Guaranteed Interest Account is not available for Asset Rebalancing. Your allocation among the investment options will be periodically re-adjusted according to the percentage you indicated in Section 1 and the frequency you choose below. Asset allocation percentages of 2% or more (in whole percentages) may be specified for all variable investment options up to a maximum of 50 options. Asset Rebalancing is effective on the first monthly anniversary after the Money Market Lock-in period ends.

☐ **Quarterly** ☐ **Semi-annually** ☐ **Annually**

I (we), the undersigned, have read the detailed description of the Asset Rebalancing Service in the prospectus. My (our) instructions will remain in effect until **(a)** I (we) provide new written instructions or **(b)** Asset Rebalancing otherwise terminates as described in the prospectus. I (we) understand that the use of the Asset Rebalancing Service does not guarantee a profit and will not protect against loss in a declining market.

REMARKS

_____

_____

_____

_____

THE UNDERSIGNED UNDERSTAND(S) THAT THE POLICY VALUES AND THE DEATH BENEFIT MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE INVESTMENT EXPERIENCE OF THE VARIABLE SUBACCOUNTS (SUBJECT TO ANY SPECIFIED MINIMUM GUARANTEES).

Date (mm/dd/yyyy) _____

X _____
Signature of Proposed Insured

X _____
Signature of Additional/Joint Proposed Insured

X _____
Signature of Owner, if other than the Proposed Insured(s), who agrees to be bound by the representations and agreements in this and any other part of the application

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

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

AXA EQUITABLE

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

Children's Term Insurance Rider Supplement

CHILDREN'S TERM INSURANCE RIDER SUPPLEMENT

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

Amount $_____

1. List all children proposed for insurance:

Only the natural children, legally adopted children, or stepchildren of the person listed in Question 4 of the Application who have not reached their 18th birthday are eligible for coverage.

Name of Child First/Last/Gender	Date of Birth (mm/dd/yyyy)	Height/Weight	Relationship to Proposed Insured	Name, Address and Phone No. of Primary Care Physician
First: Last: Gender: ☐ Male ☐ Female				
First: Last: Gender: ☐ Male ☐ Female				
First: Last: Gender: ☐ Male ☐ Female				
First: Last: Gender: ☐ Male ☐ Female				

List details of all "Yes" answers to Questions 2 and 3 in chart on page 2.

2. Has any child proposed for insurance:

a. Ever been diagnosed with, treated for, or had symptoms of asthma, diabetes, cancer or tumor, or any disorder of the heart or blood vessels, including heart murmur? ☐ Yes ☐ No

b. In the last 5 years, consulted a physician, or been examined or treated at a hospital or other medical facility? (Include medical checkups in the last 2 years. Do not include colds or minor injuries.) ☐ Yes ☐ No

c. In the last 10 years:

1. Used, except as legally prescribed by a physician, tranquilizers, barbiturates or other sedatives; marijuana, cocaine, hallucinogens or other mood-altering drugs; heroin, methadone or other narcotics; amphetamines or other stimulants; or any other illegal or controlled substances? *(If "Yes", complete Substance Usage Supplement)* ☐ Yes ☐ No
2. Received counseling or treatment regarding the use of alcohol or drugs including attendance at meetings or membership in any self-help group or program such as Alcoholics Anonymous or Narcotics Anonymous? *(If "Yes", complete Substance Usage Supplement)* ☐ Yes ☐ No

d. In the last 10 years, been diagnosed with, or treated for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) by a member of the medical profession? ☐ Yes ☐ No

3. Is any child proposed for insurance receiving special training because of physical or mental disability, or unable to participate actively at work, or in school, or to perform normal activities? ☐ Yes ☐ No

4. ***List details of all "Yes" answers to Questions 2 and 3. (If additional room is needed, use REMARKS section)***

Name of Child	Date of Diagnosis (mm/dd/yyyy) Duration of Illness	Diagnosis/Treatment/Medication/ Restrictions in Activity	Name, Address and Phone Number of Health Professional or facility consulted or seen (Include City & State)

REMARKS

The owner of this Rider is the owner of the life insurance policy unless otherwise specified in the Remarks section of the Application.

I (we) represent that the statements and answers in this Supplement are true and complete to the best of my (our) knowledge and belief, and agree to be bound by the representations and agreements in this and any other part of the application. I (we) understand that the coverage provided under the Children's Term Insurance Rider terminates for each eligible child the earliest of: the termination of the policy; when he/she reaches age 25; and the day before the policy anniversary nearest the Proposed Insured 1's 65th birthday. This coverage applies to all children I (we) currently have, and may have (or adopt) in the future. Because AXA Equitable (or the insurance company checked on page 1 of the Application) does not have any means of knowing how many children I (we) may have (or adopt) in the future, I (we) understand that AXA Equitable (or the insurance company checked on page 1 of the Application) will continue to charge for this rider until the policy anniversary nearest the Proposed Insured 1's 65th birthday. I (we) also understand that if I (we) have no children under age 25 and want to terminate this rider, I (we) must notify AXA Equitable (or the insurance company checked on page 1 of the Application) in writing.

X _____ _____

Signature of Proposed Insured, Applicant, or Parent or Guardian, if Proposed Insured is a Child, Issue Ages 0-14 — Date (mm/dd/yyyy)

X _____ _____

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

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 _____ _____

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

AXA EQUITABLE

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

Optional Benefits Supplement

OPTIONAL BENEFITS SUPPLEMENT FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

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

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

TERM LIFE

☐ Disability Premium Waiver Rider
☐ Children's Term Insurance Rider *(complete Children's Term Insurance Rider Supplement)*
Amount $_____
☐ Other _____

ATHENA UL-LPR (DB OPTION A ONLY)

☐ Disability Waiver of Monthly Deductions Rider
☐ Children's Term Insurance Rider *(complete Children's Term Insurance Rider Supplement)*
Amount $_____
☐ Option to Purchase Additional Insurance Rider
Amount $_____
☐ Cash Value Enhancement Rider
☐ Return of Premium Death Benefit Rider
Premium Percentage _____%* (specify percentage from 15% minimum to 100% maximum)
Accumulation Rate _____%* (specify percentage from 0% minimum to 6% maximum)
☐ Long-Term Care Services Rider *(complete Long-Term Care Services Rider Supplement)*†
☐ Other _____

ATHENA UL-DB

☐ Disability Waiver of Monthly Deductions Rider
☐ Children's Term Insurance Rider *(complete Children's Term Insurance Rider Supplement)*
Amount $_____
☐ Option to Purchase Additional Insurance Rider
Amount $_____
☐ Cash Value Plus Rider
☐ Return of Premium Death Benefit Rider
Premium Percentage _____%* (specify percentage from 15% minimum to 100% maximum)
Accumulation Rate _____%* (specify percentage from 0% minimum to 6% maximum)
☐ Long-Term Care Services Rider *(complete Long-Term Care Services Rider Supplement)*†
☐ Other _____

ATHENA SUL III

☐ Estate Protector Rider (EPR benefit is a maximum of 122% of the base policy face amount)
☐ Lapse Protection Rider (DB Option A only)
☐ Cash Value Enhancement Rider
☐ Return of Premium Death Benefit Rider
Premium Percentage to be Returned _____%* (specify percentage from 15% minimum to 100% maximum)
Accumulation Rate _____%* (specify percentage from 0% minimum to 6% maximum)
☐ Other _____

ATHENA UL-ESLI

- ☐ Disability Waiver of Monthly Deductions Rider
- ☐ Return of Premium Death Benefit Rider
  Premium Percentage _____%* (specify percentage from 15% minimum to 100% maximum)
  Accumulation Rate _____%* (specify percentage from 0% minimum to 6% maximum)
- ☐ Other _____

INTEREST SENSITIVE WHOLE LIFE (ISWL)

- ☐ Disability Premium Waiver Rider
- ☐ Children's Term Insurance Rider *(complete Children's Term Insurance Rider Supplement)*
  Amount $_____
- ☐ Living Benefit Rider
- ☐ Automatic Premium Loan Option
- ☐ Other _____

*** Percentages must be stated in whole numbers (no fractions or decimals).**
† Not available in Florida and North Carolina.

I (we) represent that the options indicated in this Supplement reflect my (our) selections.

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

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

X _____ Date (mm/dd/yyyy) _____
Signature of Owner, if other than the Proposed Insured(s), who agrees to be bound by the representations and agreements in this and any other part of the application.

I certify that I have recorded completely and accurately the options requested by the Proposed Insured(s) and Owner, if other than the Proposed Insured(s).

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

AXA EQUITABLE

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

Medical Information Supplement

MEDICAL INFORMATION SUPPLEMENT FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

This form is to be completed by the Proposed Insured regarding his/her health for underwriting purposes.
The completion is optional if a full Paramedical or Medical Exam is required.

Best practice is to complete this form and answer all medical questions to enable the underwriter to promptly begin the underwriting process.

Incomplete information may delay your application.

PROPOSED INSURED INFORMATION

Policy No. (if known) _____

1. Name: First _____ Middle _____ Last _____

Gender ☐ M ☐ F

2. Date of Birth (mm/dd/yyyy) _____ **3.** Height: _____ ft. _____in. Weight (lbs.) _____

4. Has the Proposed Insured's weight changed by more than 10 pounds in the last 6 months? ☐ Yes ☐ No

If "Yes", Pounds Lost _____ Pounds Gained _____ Reason _____

PERSONAL PHYSICIAN INFORMATION

5. Does the Proposed Insured have a personal physician? ☐ Yes ☐ No

6. If "Yes", Physician Name or Name of Practice or Clinic _____

7. Street Address _____ City _____ State _____ Zip _____

8. Phone No. _____

9. Date and reason last consulted if within the last 5 years:

a. Date (mm/dd/yyyy) _____

b. Reason _____

10. What treatment was given or recommended? ☐ None _____

FAMILY HISTORY

11. Family History

Relationship	Age if Living	Age at Death	Cause of Death if Deceased
Father			
Mother			
Sibling			
Sibling			

MEDICAL INFORMATION

Q12: If "Yes", please check all that apply and provide details in the table below.

List the specific impairments in the table if question contains multiple impairments.

12. Has the Proposed Insured ever had or been treated for any of the following? ☐ Yes ☐ No

a. ☐ High Blood Pressure
b. ☐ Chest Pain
c. ☐ Heart Attack
d. ☐ Heart Murmur
e. ☐ Diabetes
f. ☐ High Cholesterol
g. ☐ Cancer/Tumor/ Polyp/Cyst
h. ☐ Asthma/Bronchitis
i. ☐ Emphysema
j. ☐ Sleep Apnea
k. ☐ Eating Disorder
l. ☐ Stroke/TIA
m. ☐ Depression/Anxiety
n. ☐ Multiple Sclerosis
o. ☐ Parkinson's Disease
p. ☐ Alzheimer's Disease
q. ☐ Memory Loss
r. ☐ Colitis/Ulcer/Hernia
s. ☐ Cirrhosis
t. ☐ Hepatitis
u. ☐ Arthritis/Neuritis/Gout
v. ☐ Lupus
w. ☐ Anemia
x. ☐ Paralysis
y. ☐ Seizures
z. ☐ Tuberculosis

No./ Letter	Name, Address and Phone Number of Health Professional or facility consulted or seen (Include City & State)	Date of Diagnosis (mm/dd/yyyy) and Duration of Illness	Diagnosis/Treatment/Medication

Q13: If "Yes", please check all that apply and provide details in the table below.

13. Other than as indicated above, has the Proposed Insured ever had any disease or disorder of any of the following? ☐ Yes ☐ No

a. ☐ Heart
b ☐ Arteries/Veins
c. ☐ Skin
d. ☐ Blood
e. ☐ Eyes
f. ☐ Prostate
g. ☐ Reproductive Organs/Breasts
h. ☐ Brain/Nervous System
i. ☐ Liver/Pancreas/Gall Bladder
j. ☐ Emotional/Psychological Disorder
k. ☐ Immune System
l. ☐ Gastrointestinal/Digestive System
m. ☐ Ears/Nose/Throat
n. ☐ Lungs/Respiratory System
o. ☐ Muscle/Bones/Joints
p. ☐ Lymph Nodes
q. ☐ Thyroid/Other Glands
r. ☐ Kidney/Bladder

List the specific organ(s), system(s) and/or impairment(s) in the table if question contains multiple items.

No./ Letter	Name, Address and Phone Number of Health Professional or facility consulted or seen (Include City & State)	Date of Diagnosis (mm/dd/yyyy) and Duration of Illness	Diagnosis/Treatment/Medication

MEDICAL INFORMATION Cont'd

List specific item(s) in the table below if question contains multiple items.

If additional space is needed, please complete and sign ADDITIONAL DETAILS section on next page.

14. Is the Proposed Insured now under medical observation or treatment for any reason not stated above? ☐ Yes ☐ No

15. In the last 10 years, has the Proposed Insured been diagnosed with, or treated for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) by a member of the medical profession? ☐ Yes ☐ No

16. Other than as stated in answers to Questions 10-13, has Proposed Insured, within the last 5 years:

a. Had symptoms of or been treated for dizziness, fainting, shortness of breath, chronic headaches, chronic swelling, palpitation, blood spitting, intestinal bleeding, hemorrhoids, kidney stones, sugar, protein or blood in the urine? ☐ Yes ☐ No

b. Consulted or treated by a physician or practitioner, or treated at a hospital, clinic, or other medical facility for any reason? ☐ Yes ☐ No

c. Had any illness, injury or surgery? ☐ Yes ☐ No

d. Had electrocardiogram, x-ray, or other diagnostic test (including lab tests)? ☐ Yes ☐ No

e. Been advised to have any diagnostic test, treatment or surgery which has not been completed? ☐ Yes ☐ No

Details of "Yes" answer(s) to Questions 14 through 16.

No./ Letter	Name, Address and Phone Number of Health Professional or facility consulted or seen (Include City & State)	Date of Diagnosis (mm/dd/yyyy) and Duration of Illness	Diagnosis/Treatment/Medication

Q17: If "Yes", list medications.

17. Are there any medications (prescription or non-prescription) not listed in the details section of questions 12-16 that the Proposed Insured is currently taking? ☐ Yes ☐ No

_____

Q18a: If "Yes", complete Substance Usage Supplement.

Q18b: If "Yes", complete Substance Usage Supplement.

18. In the last 10 years has Proposed Insured:

a. Used, except as legally prescribed by a physician, tranquilizers, barbiturates or other sedatives; marijuana, cocaine, hallucinogens or other mood altering drugs; heroin, methadone or other narcotics; amphetamines or other stimulants; or any other illegal or controlled substances? ☐ Yes ☐ No

b. Received counseling or treatment regarding the use of alcohol or drugs including attendance at meetings or membership in any self-help group or program such as Alcoholics Anonymous or Narcotics Anonymous? ☐ Yes ☐ No

Q19a: If "Yes", please provide details.

19. a. Does the Proposed Insured currently consume alcoholic beverages? ☐ Yes ☐ No

Type: _____ Number of Drinks _____ per ☐ Day ☐ Week

Type: _____ Number of Drinks _____ per ☐ Day ☐ Week

b. If "No", has the Proposed Insured ever consumed alcoholic beverages? ☐ Yes ☐ No

c. If "Yes", please provide: Date Last Used _____ (mm/dd/yyyy)

Reason stopped _____

AUTHORIZATION

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application for insurance or request for policy change or reinstatement, where applicable. The Company indicated on page 1 may rely on them in acting on the application or making the policy change or reinstatement.

X _____ Date (mm/dd/yyyy) _____

Signature of Proposed Insured, Applicant, or Parent or Guardian, if Proposed Insured is a Child, Issue Ages 0-14

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

Please complete if additional space is needed.

ADDITIONAL DETAILS

No./ Letter	Name, Address and Phone Number of Health Professional or facility consulted or seen (Include City & State)	Date of Diagnosis (mm/dd/yyyy) and Duration of Illness	Diagnosis/Treatment/Medication

AUTHORIZATION

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application for insurance or request for policy change or reinstatement, where applicable. The Company indicated on page 1 may rely on them in acting on the application or making the policy change or reinstatement.

X _____ Date (mm/dd/yyyy) _____

Signature of Proposed Insured, Applicant, or Parent or Guardian, if Proposed Insured is a Child, Issue Ages 0-14

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

Rate Information

Rate data does NOT apply to filing.

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 10/08/2008

Comments:

Please see cover letter.

Review Status:

Bypassed -Name: Application 10/08/2008

Bypass Reason: Not applicable to this type of filing.

Comments:

Review Status:

Satisfied -Name: Cover Letter 10/13/2008

Comments:

Attachment:

AR AXAEQ Cover Letter.pdf

Review Status:

Satisfied -Name: Readability Certification 10/13/2008

Comments:

Readability Certification

Attachment:

Readability Certification AXAEQ.pdf

Estella A. Devian, Vice President
Telephone (212) 314-2921
Facsimile (212) 707-7493
estella.devian@axa-equitable.com

VIA SERFF

October 13, 2008

The Honorable Julie Benafield Bowman, Insurance Commissioner
AR Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: AXA Equitable Life Insurance Company (AXAEQ)
AXA Equitable's FEIN: 13-5570651
AXA Equitable's NAIC #: 968-62944
SERFF Tracking Number: ELAS-125849269
Form Nos. AMIGV-2009 – Individual Life Insurance Application
180-6000 (2009) – Substance Usage Supplement
180-6001 (2009) – Foreign Residence and Travel Supplement
180-6002 (2009) – Aviation Supplement
180-6003 (2009) – Avocation Supplement
180-6004 (2009) – Financial Supplement
180-6005 (2009) – Term Policy/Rider Conversion or Purchase Option Supplement
180-6006a (2009) – Variable Universal Life Supplement
180-6008 (2009) – Children's Term Insurance Rider Supplement
180-6010 (2009) – Optional Benefits Supplement
180-6015 (2009) – Medical Information Supplement

Dear Commissioner:

We are filing for approval our general life application, form AMIGV-2009, for use with all of our individual life insurance products: Whole Life, Term Life, Flexible Premium Single and Joint Survivorship Universal Life, and Flexible Premium Single and Joint Survivorship Variable Life, as well as with any future products that we may offer. We certify that we will file any future products for the Department's review and approval prior to use. This application replaces our existing general life application, form AMIGV-2005, which was approved by the Department on 9/29/2005. We are also filing for approval the above-referenced application supplements that replace our previously approved application supplements listed on page 2 of this letter.

Please note that concurrent filings of the identical forms referenced above are being submitted under four company names: AXA Equitable Life Insurance Company and its affiliate companies, AXA Equitable Life and Annuity Company (SERFF Tracking Number: ELAS-125849355), MONY Life Insurance Company of America (SERFF Tracking Number: ELAS-125849305), and MONY Life Insurance Company (SERFF Tracking Number: ELAS-125849446). Therefore, we request that one reviewer be assigned all submissions.

Comparison of Forms: Overall, the questions of the new general life application and application supplements are similar to the questions of the replacement application and supplements. The major difference between the application and supplements is that the new general life application does not contain medical questions; medical questions are included in a separate supplement, also filed herein. Furthermore, the new general life application and application supplements have been completely redesigned and the questions rearranged.

Statement of Variability for the New General Life Application:

1. We have bracketed the Home Office and Mailing Address as they may change in the future. (We have also bracketed the Home Office and Mailing Address on the referenced application supplements.)

2. Please note that we have bracketed the instructional notes and product marketing names on this application to allow for any future changes. However, any such change shall be consistent with the type of instructions now shown.

3. We have bracketed the "Fraud Warning Provision" section of this application so that we may update it any time there is a change in a particular jurisdiction's regulation regarding fraud warning language. We certify that we will never remove, change, or otherwise alter in any way, the current fraud warning, unless we are specifically instructed to do so by the Department, at which time, we will file such change with the Department for approval.

Application Supplements: The following is information concerning the new application supplements. *Note: The application supplements that are being replaced, as mentioned in items 1 thru 4 and 6 thru 10, were approved by the Department on the same date as for the existing general life application referenced on page 1 of this letter.*

1. Form 180-6000 (2009) - Substance Usage Supplement: This application supplement replaces our existing Substance Usage Supplement, form 180-6000 (2005).

2. Form 180-6001 (2009) – Foreign Residence and Travel Supplement: This application supplement replaces our existing Foreign Residence and Travel Supplement, form 180-6001 (2005).

3. Form 180-6002 (2009) – Aviation Supplement: This application supplement replaces our existing Aviation Supplement, form 180-6002 (2005).

4. Form 180-6003 (2009) – Avocation Supplement: This application supplement replaces our existing Avocation Supplement, form 180-6003 (2005).

5. Form 180-6004 (2009) – Financial Supplement: This application supplement replaces our existing Financial Supplement, form 180-6004 (2006), which was approved by the Department on 4/5/06 (State Tracking Numbers: 32314 & 32315).

6. Form 180-6005 (2009) – Term Policy/Rider Conversion or Purchase Option Supplement: This application supplement replaces our existing Term Policy/Rider Conversion or Purchase Option Supplement, form 180-6005 (2005).

7. Form 180-6006a (2009) – Variable Universal Life Supplement: This application supplement replaces our existing Variable Universal Life Supplement, form 180-6006a (2005).

   Statement of Variability: This application supplement will be used only for the Company's variable life products. The product marketing names, Investment Options, product specific optional benefit riders, instructional notes, and service frequency options are bracketed to allow for any future changes by product. We certify that we will not offer any new product specific optional benefit riders without gaining prior approval by the Department.

8. Form 180-6008 (2009) – Children's Term Insurance Rider Supplement: This application supplement replaces our existing Children's Term Rider Supplement, form 180-6008 (2005).

9. Form 180-6010 (2009) – Optional Benefits Supplement: This application supplement replaces our existing Optional Benefits Supplement, form 180-6010.

   Statement of Variability: This application supplement lists the optional benefit riders for the Company's non-variable life products. The product marketing names and product specific optional benefit riders are bracketed to allow for any future changes. We certify that we will not offer any new product specific optional benefit riders without gaining prior approval by the Department.

10. Form 180-6015 (2009) – Medical Information Supplement: This application supplement is new and does not replace any form previously approved by the Department. It includes medical questions for the policy applied for under the new general life application.

General Information:

We have attached a certification reflecting the Flesch readability score for these forms.

We are forwarding to you today, via EFT (Electronic Fund Transfer), $220.00 for the filing fee.

I certify that, to the best of my knowledge and belief, we comply with all the requirements of Arkansas Rule and Regulation 33 regarding variable life insurance.

I certify that, to the best of my knowledge and belief, we comply with all the requirements of Arkansas Rule and Regulation 34 regarding universal life insurance. We will comply with the requirements of Bulletin 11-83. Any change in current cost of insurance rates will be filed with the Department on an informational basis.

I certify that the information required by Ark. Code 23-79-138 is provided with every life insurance policy issued in Arkansas.

The Life and Health Guarantee Association Notice required by Rule and Regulation 49 is provided with each policy delivered in Arkansas. I certify that we comply with this regulation.

We request that the information contained in this letter and any attachments hereto be treated as confidential and be exempted from disclosure in accordance with the state's Freedom of Information law or other similar laws, and that we be notified prior to any proposed release of this information.

These forms are submitted in final printed format, subject to minor modification in paper size and stock, ink, logo, border, and adaptation to electronic printing or desktop publishing software.

If you have any questions or need additional information, please feel free to call me collect at (212) 314-2921 or Maria Castaldo at (212) 314-2226.

Sincerely,

Estella A. Devian

Estella A. Devian, Vice President

AXA Equitable Life Insurance Company

CERTIFICATION OF READABILITY

AXA Equitable Life Insurance Company has reviewed the enclosed forms(s) and certifies that the form(s) meet(s) the minimum Flesch Scale Readability requirements.

FORM	SCORE
AMIGV-2009	57.02
180-6000 (2009)	74.62
180-6001 (2009)	71.77
180-6002 (2009)	65.66
180-6003 (2009)	75.50
180-6004 (2009)	71.83
180-6005 (2009)	71.34
180-6008 (2009)	68.66
180-6010 (2009)	57.59
180-6015 (2009)	66.59

***Please note that form 180-6006a (2009) is used for Variable Life only, therefore it is not subject to readability requirements.**

BY: Estella A. Devian

Signature

Estella A. Devian

Name

Vice President

Title

October 8, 2008

Date