

SERFF Tracking Number: ELAS-126665474 State: Arkansas
 Filing Company: MONY Life Insurance Company of America State Tracking Number: 45916
 Company Tracking Number:
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: AXASAV-2010- MLOA
 Project Name/Number: Tele-Underwriting Application/AXASAV-2010

Filing at a Glance

Company: MONY Life Insurance Company of America

Product Name: AXASAV-2010- MLOA

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: ELAS-126665474 State: Arkansas

SERFF Status: Closed-Approved-
 Closed State Tr Num: 45916

Co Tr Num:

State Status: Approved-Closed

Reviewer(s): Linda Bird

Authors: Audrey Arnold, Samra
 Mekbeb, Roxanne Persaud,
 Sabrena Lallmohamed

Disposition Date: 06/16/2010

Date Submitted: 06/09/2010

Disposition Status: Approved-
 Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Tele-Underwriting Application

Project Number: AXASAV-2010

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: We are preparing these filings simultaneously; and will submit this filing in our state of domicile, New York, for AXA Equitable Life Insurance Company; and Arizona, for MONY Life Insurance Company of America.

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/16/2010

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 06/16/2010

Created By: Sabrena Lallmohamed

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Sabrena Lallmohamed

Filing Description:

VIA SERFF

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June 9, 2010

Commissioner Jay Bradford
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: MONY Life Insurance Company of America (MLOA)
MLOA's NAIC No.: 968-78077
MLOA's FEIN: 86-0222062
SERFF Tracking Number: ELAS-126665474
Form Nos.: AXASAV-2010 – Individual Life Insurance Application Part 1
AXALAPP2-10 – Individual Life Insurance Application Part 2
180-6017 (2010) – Proposed Insured/Owner Residency/Travel Supplement
180-6018 (2010) – Trust Certification Supplement

Dear Commissioner:

We are filing for your approval, the above-referenced Individual Life Insurance Application forms; these are new forms and do not replace any forms on file with the Department. The forms will be used in the general market for use with all of our individual life insurance products: Whole Life, Current Assumption Whole Life, Term Life, Flexible Premium Universal Life, and Flexible Premium Variable Life, as well as with any future products that we may offer. We will file, as required, any future products for the Department's review and approval prior to use.

The above-referenced application forms are used as an alternative method to applying for Individual Life Insurance; our intent is to provide financial professionals a simplified method of the application process. The Company's published underwriting guidelines are followed in this process. These application forms will not be used in Guaranteed Issue situations.

Please note that a concurrent filing of the identical forms referenced above is being submitted for use with products issued by AXA Life Insurance Company (SERFF Tracking Number: ELAS-126665473), therefore we request that one reviewer be assigned all submissions.

AXASAV-2010 (Part 1) is a short application form that is completed and signed by the Proposed Insured and Owner. Please note that the replacement questions are contained in AXASAV-2010 that is completed and signed by the Financial Professional, the Proposed Insured and the Owner at point of sale. The Proposed Insured's replacement

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questions are on page 2, questions 40 and 41; and the agent's replacement question is on page 6, near the bottom of the page where the agent signs the application.

This application will be used in conjunction with AXALAPP2-10 (Part 2) which contains full underwriting medical questions and is completed via a telephone or a face-to-face interview of the Proposed Insured.

The Company's telephone interview procedures are outlined below (please note that the procedures for a face-to-face interview are identical to those in a tele-interview as described below, except that the interview is conducted in person):

The tele-interviewer will call the Proposed Insured and ask the Proposed Insured the questions from AXALAPP2-10 (Part 2). A tele-interviewer (interviewer) is not a licensed agent nor is he/she acting in the capacity of an agent. The Proposed Insured's responses to the questions are recorded and transcribed onto AXALAPP2-10. Additional drill-down questions may be used during the interview, and are based on the questions shown on form AXALAPP2-10. After the interview, the Proposed Insured is then provided a copy of the completed AXALAPP2-10 to review for accuracy and to sign, except if he/she chooses the Voice Signature option. Both completed and signed forms (Applications Part 1 and Part 2) are submitted to the Company, whereby they will undergo the Company's review and underwriting process. If a policy is issued, both AXASAV-2010 and AXALAPP2-10 are attached to and made part of the issued Life Insurance Policy, which is sent to the Licensed Financial Professional, who in turn delivers the policy to the policy owner. This delivery process is the same when a tele-interview or a face-to-face interview is used as when all parts of an application are completed in person.

The following forms are also submitted for your approval: form no. 180-6017 (2010), Proposed Insured/Owner Residency/Travel Supplement, will be used when the Proposed Insured/Owner is a not a U.S. Citizen and form no. 180-6018 (2010), Trust Certification Supplement, will be used if the policy is owned by a trust. We may also use any previously approved application supplements for use with the forms submitted in this filing.

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.

Sincerely,

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Estella A. Devian, Vice President

Company and Contact

Filing Contact Information

Estella A. Devian, Vice President estella.devian@axa-financial.com
 1290 Avenue of the Americas, 14th Floor 212-314-2921 [Phone]
 New York, NY 10104 212-707-7493 [FAX]

Filing Company Information

MONY Life Insurance Company of America CoCode: 78077 State of Domicile: Arizona
 1290 Avenue of the Americas, 14th Floor Group Code: 968 Company Type: Insurance
 Company
 New York, NY 10104 Group Name: State ID Number:
 (212) 314-2921 ext. [Phone] FEIN Number: 86-0222062

Filing Fees

Fee Required? Yes
 Fee Amount: \$200.00
 Retaliatory? No
 Fee Explanation: \$50.00 per form.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
MONY Life Insurance Company of America	\$200.00	06/09/2010	37116627

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/16/2010	06/16/2010

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Disposition

Disposition Date: 06/16/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Form	Application For Life Insurance-Part 1		Yes
Form	Application Part 2 To: Medical and Non-Medical Questions Individual Life Insurance		Yes
Form	Trust Certification Supplement		Yes
Form	Proposed Insured/Residency/Travel Supplement		Yes

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	AXASAV-2010	Application/ Enrollment Form	Application For Life Insurance-Part 1	Initial		64.790	AXASAV-2010 Filing.pdf
	AXALAPP-10	Application/ Enrollment Form	Application Part 2 To: Medical and Non-Individual Life Insurance	Initial		67.980	AXALAPP-10 Part 2 Filing.pdf
	180-6018 (2010)	Application/ Enrollment Form	Trust Certification Supplement	Initial		78.760	180-6018 (2010) Trust Cert Supp Filing.pdf
	180-6017 (2010)	Application/ Enrollment Form	Proposed Insured/Residency/Travel Supplement	Initial		74.430	180-6017 (2010) Residency Travel Supp Filing.pdf



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

**APPLICATION FOR
INDIVIDUAL LIFE
INSURANCE-
PART I**

1290 Avenue of the Americas, New York, NY 10104

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

PRODUCT AND AMOUNT OF INSURANCE

This Application can only be used with the Tele-Underwriting Part 2 process.

This Application cannot be used for Premium Financed Policies.

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

Q10. Billing notices will be sent to this address unless otherwise directed in Remarks section.

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

Q14. Max 6 months prior to application date (3 months in OH).

Q19b. If less than one year at current job, give previous occupation information in Remarks section.

Q21. Provide physical work site address.

1. **Product Name** _____ 1a. **Product Type** Whole Life Term Life
 Universal Life Variable Universal Life
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)
- Complete questions 4 and 5 for UL and VUL only.**
4. **Death Benefit Option** Option A (Level) Option B (Increasing)
5. **Definition of Life Insurance Test** Guideline Premium Test Cash Value Accumulation Test

PROPOSED INSURED

6. Full Name First _____ Middle _____ Last _____
- 6a. Previous Name _____
7. Gender Male Female
8. SSN _____ 9. Email address _____
10. Primary residential address _____ Bldg/Apt/Suite _____
 City/Municipality _____ County/Parish* _____ State _____ Zip _____
11. Are you a U.S. citizen? Yes No (If "No," please complete a Proposed Insured/Owner Residency/Travel Supplement)
12. Preferred phone number to be contacted for phone interview _____ Home Cell Work
13. Date of birth _____ (mm/dd/yyyy)
14. Backdate to save age Yes No
15. Place of birth _____ (Country/State)
16. Do you have a driver's license? Yes No If "Yes," provide license number, state and expiration date.
 Number _____ State _____ Expiration Date _____ (mm/dd/yyyy)
 If no driver's license, do you have a government issued ID? Yes No
 If "Yes" to government issued ID, type of ID _____ Government ID number _____
17. Name of physician or medical facility last seen _____
 Date _____ (mm/dd/yyyy) Reason for consultation/visit _____
 Treatment or medication prescribed _____

EMPLOYMENT INFORMATION

18. Currently employed? Yes No Retired
19. Current occupation(s) a. Title _____ b. Years at current job _____ c. Duties _____
20. Employer name _____
21. Work site address _____
22. Annual earned income (income from occupation) \$ _____
23. Net worth \$ _____

PREMIUM PAYMENT INFORMATION

***Bank Draft Only one account is allowed. Draft dates available between the 1st day and 28th day of the month.

Refer to instructions sheet for help with completing bank draft questions.

If bank account holder is not the Owner or Proposed Insured, please complete Systematic Payment Enrollment Form.

24. **a. Initial Premium \$** _____ Check Bank Draft** **b. Balance Premium Payment:** Check Bank Draft**
25. **Subsequent Payments:**
a. Direct Billing (By Mail): VUL / UL: Premium Amount \$ _____ Monthly Quarterly Semi-annually Annually
Term: _____
 Quarterly Semi-annually Annually
- b. Bank Draft** **VUL/ UL:** Monthly Quarterly: Start Date _____ (dd/mm/yyyy) ***Draft on _____ day
Term: Monthly

****Bank Draft Information Required**

Name of Financial Institution/Bank _____
 Routing Number _____ Account Number _____

- c. Salary Allotment (VUL/UL/Term):** Monthly Quarterly Semi-Annually Annually
 Unit name _____ Unit number _____ Register date _____ (mm/dd/yyyy)
 If Allotter is not Proposed Insured, provide Name _____ SSN/EIN/ITIN _____
- d. Single Payment (VUL/UL):** Amount: \$ _____ (No further billing will be sent.)

OWNERSHIP INFORMATION

Complete for Individual, Corporation, Partnership, Other Entity. If Trust owned, complete Trust Certification/ Supplement.

26. Owner Type: Sole Proprietorship Partnership Corporation Trust LLC Group Plans
27. Owner's name: First _____ Middle _____ Last _____
28. Person(s) authorized to transact business on behalf of Owner
 Name _____ Title _____
29. SSN EIN ITIN _____ 30. Email Address _____
31. Relationship to Proposed Insured _____
32. Address _____ City _____ State _____ Zip Code _____
- Complete Question 33 for all non-resident (foreign) Owners. If the Owner is not a U.S. Person (U.S. Citizen or U.S. Corporation, Partnership or Trust established or organized under the laws of a state of the United States), then he, she or it may have to provide additional documentation, including IRS form W-8 BEN. Any foreign Owner (Individual, Trust, Corporation, Partnership, Other Entity) must have a US bank account.
33. U.S. bank name _____ Account number _____

Individual

34. Are you a U.S. citizen? Yes No (If "No," please complete a Proposed Insured/Owner Residency/Travel Supp.)
35. Do you have a driver's license? Yes No If "Yes," provide license no., state and expiration date.
 Number _____ State _____ Expiration Date _____ (mm/dd/yyyy)
 If no driver's license, do you have a government issued ID? Yes No
 If "Yes" to government issued ID, type of ID _____ Government ID number _____
36. Date of birth _____ (mm/dd/yyyy)
37. Currently employed? Yes No Retired
38. Occupation _____ Employer name _____

BENEFICIARY

39. Beneficiary Information. If no contingent beneficiary is selected, the contingent beneficiary will be: (1) the Proposed Insured's surviving children, if any, in equal shares; or (2) if the Proposed Insured has no surviving children, the contingent beneficiary will be the Proposed Insured's estate.

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

Complete Owner Information if Proposed Insured is not the Owner.

Q32. 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.

For **Multiple 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.

Beneficiary
 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.

Q40. Include any policy that has been sold, assigned or settled to or with a settlement or viatical company or any other person or entity.

PROPOSED INSURED'S OTHER INSURANCE

40. Do you have any other life insurance/annuity(ies), including ultimate death benefit amounts of any policy/rider in effect with the Company checked on page 1 of this Application, its affiliated companies or any other life insurance company? Yes No
41. Will the coverage applied for replace, change, or affect any existing policy or contract? Yes No
(If the answer to Question 40 or 41 is "Yes," complete the chart below.)

Name of Company	Face Amount Plus Riders	Year Issued	Policy/ Contract #	P-Personal G-Group B-Business A-Annuity	To Be Replaced Changed or Affected?	1035 Exchange
				<input type="checkbox"/> P <input type="checkbox"/> B <input type="checkbox"/> G <input type="checkbox"/> A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> P <input type="checkbox"/> B <input type="checkbox"/> G <input type="checkbox"/> A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> P <input type="checkbox"/> B <input type="checkbox"/> G <input type="checkbox"/> A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

42. Do you have any formal applications pending with the Company checked on page 1 of this Application, 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.)

Name of Company	Amount Applied For	Competitive or Additional
	\$ _____	<input type="checkbox"/> Competitive <input type="checkbox"/> Additional
	\$ _____	<input type="checkbox"/> Competitive <input type="checkbox"/> Additional

43. Including this Application, applications pending with other carriers, and existing life insurance, what is the total amount of life insurance (base policy face amount plus amounts attributable to additional benefit riders) that will be in effect? \$ _____

PURPOSE OF INSURANCE Complete either a. or b.

44. 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. Proposed Insured's % of ownership in Business/Corporation _____
2. Total Net Worth of Business \$ _____

SOURCE OF FUNDS

45. 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 % of breakdown. Percentages must equal 100%.
- 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: (i) Sale of Car, Home, Business, or Other Asset (specify _____) _____%
 - (ii) Legal Settlement, (iii) Lottery/Gaming Proceeds, (iv) Other (specify _____) _____%

MILITARY SERVICE

46. Are you or is the Owner(s) an Active Duty[†] Member of the Armed Forces? Yes No
[†] "Active Duty" means full-time duty in the active military service of the United States and includes members of the reserve component (National Guard and Reserve) while serving under published orders for active duty or full-time training. The term does not include members of the reserve component who are performing active duty or active duty for training under military calls or orders specifying periods of less than 31 calendar days.

All premium checks must be payable to the Company selected on page 1 of this Application. Do not make checks payable to financial professional or leave the payee blank.

COMPLETE IF MONEY IS PAID WITH APPLICATION

47. Amount paid with this Application \$ _____

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

If any of the above questions (47a-d) are answered "No," or any Insurability Question on the Temporary Insurance Agreement/Receipt is answered "Yes," or left blank, a premium may not be paid before the policy is delivered and **no temporary insurance will be in effect.**

REMARKS

When providing details to questions, please reference question number.

THIS PAGE MUST BE SUBMITTED WITH THE COMPLETED, SIGNED APPLICATION

AGREEMENT/ACKNOWLEDGEMENT/AUTHORIZATIONS

Each signer of this Application agrees that:

- (1) The statements and answers in all parts of this Application are true and complete to the best of my knowledge and belief. The Company checked on page 1 of this Application may rely on them in acting on this Application.
- (2) The Temporary Insurance Agreement states the conditions that must be met before any insurance takes effect if the full initial premium is paid with the 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.
- (3) Except when the required money is paid with this Application and as stated in the Temporary Insurance Agreement/Receipt, no insurance shall take effect on this Application: (a) until the date the policy and all amendments are delivered to the Owner(s) and all delivery requirements have been completed; (b) before any Register Date of the policy; and (c) unless the statements and answers in all parts of this Application and any applicable supplements continue to be true and complete to the best of my (our) knowledge and belief, without material change, as of the latest of the date: (i) the policy and all amendments are delivered to the Owner(s); (ii) all delivery requirements have been completed; and (iii) the full initial premium is paid, while the Proposed Insured is living.
- (4) No financial professional, medical examiner or tele-interviewer has authority to modify this Agreement or the Temporary Insurance Agreement or waive any of our rights or requirements. The Company checked on page 1 shall not be bound by any information unless it is stated in Application Part 1, or Part 2 (Medical Questions).
- (5) I acknowledge receipt of the Living Benefits Brochure (Accelerated Death Benefit Rider Brochure), where applicable.
- (6) 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 engendered by love and affection, or those who have a lawful and substantial economic interest in the continued life of the Proposed Insured.

ACKNOWLEDGEMENT OF UNDERWRITING PROCESS

I (We) acknowledge that I (we) have received a statement of the Underwriting Process of the Company(ies) which describes from whom and why the Company(ies) obtains 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.

I (We) understand that information about me (us) as outlined in this authorization may be collected by telephone interview.

TO OBTAIN HEALTH INFORMATION

I (We) authorize any physician, hospital, clinic, examination facility, telephone interviewer, 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 the 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.

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 and any telephone interviewer to disclose to the Company(ies) and its authorized representatives any information they may have about my (our) occupation, avocations, 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 Underwriting Practices attached to this Application. In addition, information may be disclosed to the Medical Information Bureau (MIB) who, upon request, may disclose such information about me in its file to another member company with whom I (we) apply for life or health insurance or to whom a claim for benefits may be submitted; when requested by a government agency; in connection with a legal or arbitration proceeding; or for other purposes as required or permitted by applicable law. If a policy is issued to me (us), this information may also be used in the future to administer my (our) policy and process claims made under the policy.

THIS PAGE MUST BE SUBMITTED WITH THE COMPLETED, SIGNED APPLICATION

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.

COPY OF AUTHORIZATIONS

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

BUSINESS AND EMPLOYER-OWNED POLICIES

Any employer-owned life insurance arrangement on an employee or director as well as any corporate, trade, or business use of a life insurance policy should be carefully reviewed by your tax advisor with attention to the rules discussed below, as well as to any other rules which may apply, including other possible pending or recently enacted legislative proposals which may apply. Note, these rules are not limited to corporations and may apply to other types of employers or businesses including partnerships, sole proprietorships and LLCs.

REQUIREMENTS FOR INCOME TAX FREE DEATH BENEFITS FOR EMPLOYER-OWNED LIFE INSURANCE

The Pension Protection Act of 2006 imposes additional new requirements for employer-owned life insurance policies. These requirements include detailed notice and consent rules (which must be satisfied before the policies are issued), tax reporting requirements and limitations on those employees (including directors) who can be insured under the life insurance policy. Failure to satisfy applicable requirements will result in death benefits in excess of premiums paid by the employer being includible in the employer's income upon the death of the employee.

The PPA rules generally apply to life insurance contracts issued after August 17, 2006 with a possible very limited exception for contracts issued after that date pursuant to a tax-free exchange under section 1035 of the Internal Revenue Code for a contract issued on or prior to that date. Note, however, that material increases in death benefit or other material changes of an existing contract or one subject to a 1035 will generally cause it to be treated as a new contract and thus subject to the new requirements. The term "material" has not yet been fully defined but is not expected to include automatic increases in death benefits pursuant to the terms of the contract or in order to maintain compliance with the life insurance policy tax qualification rules under the Code. Other federal tax law provisions include policy gains and death benefits being taken into account in calculating whether a corporation is subject to alternative minimum taxes and limits in interest deductibility in connection with business-owned life insurance unless the insured persons are officers, directors, employees or 20% or more owners of the trade or business entity when the coverage commences.

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.

AXA Equitable offers a broad term life insurance portfolio including Annually Renewable Term (ART), One Year Term (TermOne), Level Term (Term 10, Term 15 and Term 20). AXA Equitable also offers a broad range of permanent products including whole life, universal life and variable universal life insurance policies. You should consult with your financial professional to see which product best fits your needs and the rates at which our products are available.

THIS PAGE MUST BE SUBMITTED WITH THE COMPLETED, SIGNED APPLICATION

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.

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

ARKANSAS AND DISTRICT OF COLUMBIA: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

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 Acknowledgement and Authorization. The Owner represents, warrants and certifies to AXA Equitable Life Insurance Company that none of the monies utilized to fund this policy derive directly or indirectly from illegal activities or sources and/or tax evasion.

Signature of Proposed Insured _____

Signature of Owner, if not Proposed Insured

Signed by Owner in 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 life insurance or annuities be replaced or changed (or has it been) assuming the insurance applied for will be issued? Yes No

If "Yes," is the information provided in question 41 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.)

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

Print Licensed Financial Professional's Name _____

(Select One)

AXA Equitable Life Insurance Company

MONY Life Insurance Company of America

VOICE SIGNATURE AUTHORIZATION

THE COMPANIES INDICATED ABOVE ARE REFERRED TO AS "THE COMPANY(IES)"

Name of Proposed Insured First _____ Middle _____ Last Name _____

Policy number (if known) _____

"You," "your" and "my" refer to the person signing this form.

You may reject the voice signature option by not signing this authorization. If you decide to use voice signature, please sign this form with your hand written signature or your electronic signature if using e-forms for life.

This Voice Signature Authorization form is being presented as part of a tele-application process. A voice signature is an electronic representation of an individual's signature, and provides the same legal effect as a hand-written signature.

The Voice Signature Authorization allows you to verbally agree to the statements and answers you give during the telephone interview and allows the Company(ies) to act on this telephonic information without your hand written signature.

Once you sign this Voice Signature Authorization and your Application is submitted to the Company(ies), you will be contacted to complete a telephone interview. At the conclusion of the interview you will be asked if you wish to provide a voice signature. If you agree, you will be asked to confirm your understanding and agreement to certain statements, including statements confirming your understanding of the intent of the voice signature. You will be asked for the answers to the identity questions found below.

If you decide to provide a voice signature and your answers to the identity questions match the information provided on this Authorization form, a transcription of the questions and answers collected during the telephone interview, will be submitted to the Company(ies) for review. The signature line on the Application, and any related documents as applicable, will be marked, "Voice Signed" to indicate that a voice signature was received.

If you decide not to provide a voice signature during the telephone interview process, or if your answers to the identity questions do not match the information provided on this Authorization form, your Application, and any related documents as applicable, will be provided to you for your review and hand written signature.

IDENTITY VERIFICATION INFORMATION

Please complete the following questions. Your answers will be used to verify your identity:

Name _____

Last four digits of SSN _____

Date of Birth _____ (mm/dd/yyyy)

Mother's Maiden Name _____

Signed in City, State _____ Dated on* _____
(mm/dd/yyyy)

X _____
Signature of Proposed Insured (must be age 18 or over)

***This Authorization will end 90 days from the date of this form.**

Any applications, agreement or other documents for which my voice signature was used as authorized during this 90 day period remain valid.

Signed by Proposed Insured in City, State _____ Dated on _____
(mm/dd/yyyy)

Witness to Signature: _____
(Signature of Licensed Financial Professional/Insurance Broker)

MEDICAL INFORMATION

For each "Yes" answer below give full details in Remarks Section.

Has the Proposed Insured:

2. Ever had or been treated for heart trouble, high blood pressure, chest pain, diabetes, tumor, cancer, depression, kidney, respiratory, sleep apnea, circulatory (blood or blood vessel) disorder, epilepsy or seizure or any other neurological disorder? Yes No
3. Ever smoked Cigarettes? Yes No
4. Ever used any other form of tobacco? Yes No If "Yes" give Type of tobacco used _____
5. If "Yes" to 3 or 4, date last smoked cigarettes or used tobacco products _____
6. **In the last 10 years:**
- a. Used, except as legally prescribed by a physician, tranquilizers, barbiturates or other sedatives; marijuana, cocaine, hallucinogens or other mood-altering drugs; 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
7. Received medical treatment or prescription drugs for any disease, condition, or disorder not indicated in prior Health Questions? Yes No
8. 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
9. Family History

	Age if living	Cause of Death	Age at Death
Father			
Mother			
Sibling			

GENERAL INFORMATION**Has (Does) the Proposed Insured:**

10. Ever had a driver's license suspended revoked or restricted, or within 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
11. Have any plans to travel or reside outside the United States or Canada within the next year? (Other than a two-week or less vacation to Western Europe or the Caribbean.) Yes No
12. Been disabled for 2 or more weeks within the last 2 years? Yes No
13. In the last year flown other than as a passenger or plan to do so? Yes No
14. Engaged within the last year or any 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
15. Ever had an application for life or health insurance that was declined, postponed, required extra premium or other modification or had a life or health policy or contract that was cancelled, recalled or denied renewal? Yes No
16. In the last 10 years, have you been convicted of, or pled guilty or "no contest" to, a felony, or are current felony charges pending? Yes No

(Select One)

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

1290 Avenue of the Americas, New York, NY 10104

TRUST CERTIFICATION SUPPLEMENT FORMING PART OF THE APPLICATION FOR LIFE INSURANCEName of Proposed Insured _____ Policy No. (if known) _____ Date of Birth _____
(mm/dd/yyyy)

1. Name of Owner _____
 EIN or ITIN _____
2. Person(s) authorized to transact business on behalf of Owner
Name _____ Title _____
3. Email address _____
4. Relationship to Proposed Insured _____
5. Address _____ City _____ State _____ Zip Code _____

Complete Question 6 for all non-resident (foreign) Owners. If the Owner is not a U.S. Person (U.S. Citizen or U.S. Corporation, Partnership or Trust established or organized under the laws of a state of the United States), then he, she or it may have to provide additional documentation, including IRS form W-8 BEN. Any foreign Owner (Individual, Trust, Corporation, Partnership, Other Entity) must have a US bank account.

6. U.S. bank name _____ Account number _____
7. Situs of Trust: the Trust is subject to the laws of the state of _____
8. Date of Trust (mm/dd/yyyy) _____
9. Name(s) of Grantor(s) _____
10. Name(s) and title(s) of current Trustee(s) _____
11. How long has the Trustee known the Proposed Insured? _____
12. What is the nature of the relationship between the Proposed Insured and the Trustee? _____
13. Is the Trust Revocable Irrevocable (Check appropriate box.)
14. Can interests in the Trust be sold without changing the terms of the Trust? Yes No
15. 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: _____
16. Name(s) of current Beneficiary(ies) of the Trust: _____
17. What is the nature of the relationship between the Grantor(s) and Beneficiary(ies)? _____
18. Is there a Trust Protector? Yes No (If "Yes," answer 19. and 20.)
(a Trust Protector is a third party appointed by the Grantor to provide direction and guidance to the Trustee.)
19. How long has the Trustee known the Trust Protector? _____
20. What is the nature of the relationship between the Proposed Insured and the Trust Protector? _____

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 Owner/Trustee

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

(Select One)

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

1290 Avenue of the Americas, New York, NY 10104

PROPOSED INSURED/OWNER RESIDENCY/TRAVEL 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 Owner _____ Date of Birth _____
 (mm/dd/yyyy)

PROPOSED INSURED — complete if the Proposed Insured is not a U.S. Citizen
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) _____

2. FOREIGN TRAVEL/RESIDENCE (complete this section only if you are planning to travel outside of the U.S. or Canada)

Provide details for every planned stay outside of 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: _____

OWNER — complete if the Owner is not a U.S. Citizen
1. FOREIGN NATIONALS

If the Owner 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) _____

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

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

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

SERFF Tracking Number: ELAS-126665474 State: Arkansas
Filing Company: MONY Life Insurance Company of America State Tracking Number: 45916
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: AXASAV-2010- MLOA
Project Name/Number: Tele-Underwriting Application/AXASAV-2010

Supporting Document Schedules

Item Status: **Status**
Date:

Satisfied - Item: Flesch Certification

Comments:

See attached Readability Certification.

Attachment:

AR Readability Certification-MLOA.pdf

Item Status: **Status**
Date:

Satisfied - Item: Statement of Variability

Comments:

See attached Statement of Variability.

Attachment:

Statement of Variability AXASAV-2010 et al.pdf

MONY Life Insurance Company of America

CERTIFICATION OF READABILITY

MONY Life Insurance Company of America has reviewed the enclosed forms(s) and certifies that the form(s) meet(s) the minimum Flesch Scale Readability requirements of Arkansas.

<u>FORM NUMBER</u>	<u>SCORE</u>
AXASAV-2010	64.79
AXALAPP-10	67.98
180-6018 (2010)	78.76
180-6017 (2010)	74.43

BY:

Estella A. Devian

Signature

Estella A. Devian

Name

Vice President

Title

06-09-2010

Date

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

STATEMENT OF VARIABILITY

This Statement of Variability describes the bracketed material contained in the below-referenced forms. Variability is denoted by the use of bracketing on the forms. This allows the Company to make the changes in accordance with the statements below without refiling

Form Number
AXASAV-2010

Form Description
Individual Life Insurance Application

1. **Company Address (top of the first page):** We have bracketed the Home Office address, as it may change in the future.
2. **Instructional Notes:** We have bracketed the instructional notes and product types to allow for any future changes. However, any such change shall be consistent with the type of instructions now shown.
3. **Product Types:** We have bracketed the product types to account for future changes in our portfolio. We will always get department approval for the product before we offer it to the public.
4. **Fraud Warning (page 7):** We have bracketed the fraud warnings so that we may update them 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.

Form Numbers
AXALAPP-10
180-6017 (2010)
180-6018 (2010)

Form Description
Life Insurance Application Supplement - Medical Part 2
Life Insurance Application Supplement - Residency/Travel
Life Insurance Application Supplement - Trust Certification

1. **Company Address (top of the first page):** We have bracketed the Home Office address, as it may change in the future.