

SERFF Tracking Number: ELAS-127720416 State: Arkansas
Filing Company: AXA Equitable Life Insurance Company State Tracking Number: 50093
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Individual Life Insurance Application
Project Name/Number: Refile For Rebating/AXA-Life-2011 (rev. 11/11)

Filing at a Glance

Company: AXA Equitable Life Insurance Company

Product Name: Individual Life Insurance SERFF Tr Num: ELAS-127720416 State: Arkansas

Application

TOI: L08 Life - Other

SERFF Status: Closed-Approved- State Tr Num: 50093
Closed

Sub-TOI: L08.000 Life - Other

Co Tr Num: State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Audrey Arnold, Samra Disposition Date: 10/26/2011

Mekbeb, Sabrena Lallmohamed,

Jillian Rios

Date Submitted: 10/24/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Refile For Rebating

Status of Filing in Domicile: Not Filed

Project Number: AXA-Life-2011 (rev. 11/11)

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: We are preparing these filings simultaneously and will submit this filing to our state of domicile, New York.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: Resubmission

Previous Filing Number: ELAS-127186216

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 10/26/2011

State Status Changed: 10/26/2011

Deemer Date:

Created By: Audrey Arnold

Submitted By: Audrey Arnold

Corresponding Filing Tracking Number:

Filing Description:

John R. Finneran

Assistant Vice President

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Project Name/Number: Refile For Rebating/AXA-Life-2011 (rev. 11/11)
Telephone: (212) 314-2922
Facsimile: (212) 707-7493
john.finneran@axa-equitable.com
October 24, 2011

VIA SERFF

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

RE: AXA Equitable Life Insurance Company (AXAEQ)
NAIC No.: 968-62944 FEIN No.: 13-5570651
Form Nos.: AXA-Life-2011AR (rev. 11/11) – Individual Life Insurance Application
AXA-OWNER-2011 (rev. 11/11) – Owner Questionnaire
AXA-FIN-2011 (rev. 11/11) – Financial Questionnaire
SERFF Tracking Number: ELAS-127720416

Dear Commissioner Bradford:

We are filing for your approval the above-referenced Individual Life Insurance Application forms; the above-listed forms replace the forms approved on June 14, 2011, SERFF Tracking No. ELAS-127186216, State Tracking Number 49041, (AXA-Life-2011AR, AXA-OWNER-2011 and AXA-FIN-2011, respectively). 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, Survivorship Universal Life, Joint Universal Life, Corporate Owned 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. This application will be used as a paper application as well as electronically.

Please note that a concurrent filing of the identical forms referenced above is being submitted for use with products issued by MONY Life Insurance Company of America (SERFF Tracking Number ELAS-127720417), therefore we request that one reviewer be assigned all submissions.

The submitted forms are the same as the previously approved forms, except for the following changes:

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We have moved some of the "Other Information" questions from AXA-FIN-2011 (formerly questions 5 and 6) to the "Source of Funds" section in AXA-Life-2011AR (rev. 11/11), questions 37b and 37c; we have also added these questions to the "Source of Funds" section of AXA-OWNR-2011 (rev. 11/11) questions 30 and 31.

We have reworded question 29 of AXA-Life-2011AR (rev. 11/11), to clarify whether the Proposed Insured has flown or engaged in motor racing, diving, etc. during the past 2 years and/or may engage in those activities during the next 2 years.

We have included a definition of "Reserves" as part of question 30 of AXA-Life-2011AR (rev. 11/11) and question 13 of AXA-FIN-2011 (rev. 11/11).

We have added another component to question 38 (changed 38b and renumbered the remaining questions) in the "Juvenile Insurance" section of AXA-Life-2011AR, the new question asks about the relationship between the Proposed Insured and the Applicant if the Applicant is not the Proposed Insured's parent or legal guardian.

We have fixed a few typographical errors on AXA-Life-2011AR (rev. 11/11) and modified the statement preceding the signature, clarifying that the certification applies to VUL policies only, while the signature is for all policies.

We certify that form Nos. AXA-Life-2011AR (rev. 11/11), AXA-OWNR-2011 (rev. 11/11), AXA-FIN-2011 (rev. 11/11), achieve a Flesch Readability Score of 51.88, 63.41, and 50.05, respectively. Our signed certification of readability is enclosed.

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.

We are submitting the filing fee in the amount of \$150.00 through EFT.

These forms are submitted in final printed format, subject to minor modification in paper size and stock, ink, logo, border, pagination, 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) 314-2922 or Jordana Starr, at (212) 314-5307.

Sincerely,

John R. Finneran
Assistant Vice President

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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

AXA Equitable Life Insurance Company CoCode: 62944 State of Domicile: New York
 1290 Avenue of the Americas, 14-10 Group Code: 968 Company Type: LIFE Insurance
 New York,, NY 10104 Group Name: State ID Number:
 (212) 314-2921 ext. [Phone] FEIN Number: 13-5570651

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
AXA Equitable Life Insurance Company	\$150.00	10/24/2011	53096240

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/26/2011	10/26/2011

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Disposition

Disposition Date: 10/26/2011

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		Yes
Supporting Document	Statement of Variability		Yes
Form	Individual Life Insurance Application		Yes
Form	Owner Questionnaire		Yes
Form	Financial Questionnaire		Yes

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Form Schedule

Lead Form Number: AXA-Life-2011 (rev.11/11)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	AXA-Life-2011AR (rev. 11/11)	Application/ Enrollment Form	Individual Life Insurance Application	Revised	Replaced Form #: AXA-Life-2011AR Previous Filing #: ELAS-127186216	51.880	AXA-Life-2011AR (rev. 11.11).pdf
	AXA-OWNR-2011 (rev. 11/11)	Other	Owner Questionnaire	Revised	Replaced Form #: AXA-OWNR-2011 Previous Filing #: ELAS-127186216	63.410	AXA-OWNR-2011 (rev. 11.11).pdf
	AXA-FIN-2011 (rev. 11/11)	Other	Financial Questionnaire	Revised	Replaced Form #: AXA-FIN-2011 Previous Filing #: ELAS-127186216	50.050	AXA-FIN-2011 (rev. 11.11).pdf

[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.

SECTION A-PROPOSED INSURED INFORMATION

PROPOSED INSURED	Plan Name _____	Face Amount _____	
	1. Name First _____ Middle _____ Last _____		
	2. SSN _____	3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
	4. Is the Proposed Insured the Owner? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," complete Owner Questionnaire or see Survivorship Product Questionnaire if applicable)		
	5. Primary residential address _____		Bldg/Apt/Suite _____
	City/Municipality _____	County/Parish* _____	State _____ Zip _____
	<small>* County/Parish required only in AL, FL, GA, KY, LA, SC</small>		
	6. Are you a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," complete Foreign Residence and Travel Questionnaire)		
	7a. Phone # _____	<input type="checkbox"/> Daytime <input type="checkbox"/> Cell <input type="checkbox"/> Evening	b. Best time to call _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
	8. Date of birth _____ (mm/dd/yyyy)	9. Place of birth _____ (Country/State)	
	10. Email address _____		
11. Do you have a driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes," to government issued ID, type of ID _____		Government ID number _____	

EMPLOYMENT	12. Currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Retired <input type="checkbox"/> Other _____		
	If "Yes," to question 12, complete questions 13-15		
	13. Occupation(s) a. Title _____		b. Years at current job** _____
	<small>**If less than one year at current job, give previous occupation information in remarks section</small>		
	c. Duties _____		
14. Employer name _____			
15. Work site address _____			
City _____		State _____ Zip Code _____	

FINANCIAL DETAILS	16. Income (If minor, complete for Parent/Guardian)			
	Gross Earned Annual Income (salary, commissions, bonuses)	Gross Unearned Annual Income (dividends, pensions, interest, real estate income, etc)	Gross Annual Income (Household)	Total Net Worth (Household)
	\$ _____	\$ _____	\$ _____	\$ _____
17. In the last 5 years, have you filed for bankruptcy? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If "Yes," Chapter _____		Date opened _____ (mm/dd/yyyy)	Date Closed _____ (mm/dd/yyyy)	

BENEFICIARY	18. If no contingent beneficiary is named, the contingent beneficiary will be: (1) the Proposed Insured's surviving children, if any, in equal shares; or (2) if the Proposed Insured has no surviving children, the contingent beneficiary will be the Proposed Insured's estate. Total percentage must equal 100% for each category of beneficiary. If percentage shares are left blank, the shares will be deemed equal. If beneficiary is a Trust other than Owner, include full name and date of Trust.			
	Full Name	Relationship to Insured	Beneficiary Type	(%) Percentage
			<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
			<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
			<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	

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

19. Complete for Personal Insurance

Income Replacement Mortgage/Debt Repayment Estate Planning Charitable/Gifting Other _____

20. Complete for Business Insurance

Key Person Buy-Sell Deferred Comp Other (please specify) _____

Loan indemnification (Security for Loan) Amount of loan \$ _____ Duration _____
Interest charged on loan _____ Collateral pledged to secure loan _____

- a. Type Sole Proprietorship Partnership Corporation Limited Liability Corp.
- b. Name of business _____ Nature of business _____
- c. How long has the business been in operation? _____ Years
- d. % of business owned by Proposed Insured _____%
- e. Fair market value of the business: \$ _____
- f. Are all members of the business being similarly insured? Yes No
If "Yes," provide details of business coverage issued or applied for on other members. (Use remarks section if additional space is needed)

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

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

If "Yes," explain _____

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

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

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

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

- a. Do you have any life insurance / annuities currently in force, including any policy that has been sold, settled or assigned to or with a settlement or viatical company or any other person or entity? Yes No
- b. Will the coverage applied for replace, change, or affect any existing policy(ies) or contract(s)? Yes No
- c. Do you have any other formal life insurance applications pending? Yes No
- d. Including this application, what is the total amount of life insurance coverage pending (base policy face amount plus amounts attributable to additional benefits and riders) that you plan to accept on the Proposed Insured? _____

Chart for questions 21a and b

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

Chart for question 21c

Name of Company	Total Amount (Face Plus Riders)	Competitive or Additional
	\$ _____	<input type="checkbox"/> Competitive <input type="checkbox"/> Additional
	\$ _____	<input type="checkbox"/> Competitive <input type="checkbox"/> Additional

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

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

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

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

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

Do not complete if Proposed Insured is age 0-17

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

Product Type(s)	Amount and Frequency Indicate amount and frequency of use	Indicate date last used (mm/yyyy)
<input type="checkbox"/> Cigarettes	# ___ per <input type="checkbox"/> Day <input type="checkbox"/> Month <input type="checkbox"/> Year	
<input type="checkbox"/> Cigars <input type="checkbox"/> Cigarillos	# ___ per <input type="checkbox"/> Day <input type="checkbox"/> Month <input type="checkbox"/> Year	
<input type="checkbox"/> Pipe <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Nicotine Patch or Gum	Not Applicable	
<input type="checkbox"/> Other (please specify) _____		

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

If "Yes" to questions 34 or 35, complete a Medical Information Questionnaire

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

REMARKS

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

SECTION D-AUTHORIZATION/AGREEMENT SIGNATURE

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

**ACKNOWLEDGEMENT
OF OUR UNDERWRITING
PROCESS**

I (We) acknowledge that I (we) have reviewed the statement of the Underwriting Process of the Company(ies) (the "Statement") which describes from whom and why the Company(ies) obtains information about me (us), to whom such information may be reported and how I (we) may obtain a copy of it. The Statement contains the notice required by the Fair Credit Reporting Act.

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

**AUTHORIZATION TO
OBTAIN NON-HEALTH
INFORMATION**

I (We) authorize any employer, business associate, government unit, financial institution, consumer reporting agency, the Medical Information Bureau, my (our) insurance agency and my (our) financial professional to disclose to the Company(ies) and its authorized representatives any information they may have about my (our) occupation, avocations, insurance activities, finances, driving record, character and general reputation(s). 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 the Statement attached to this application. In addition, information may be disclosed to the Medical Information Bureau (MIB).

**COVERAGE
CONDITIONS**

I (We) understand that the Company(ies) may not issue coverage unless I (we) provide this authorization, and that, while I (we) may refuse to sign this authorization, my (our) refusal to do so could result in coverage not being issued.

**ADDITIONAL
AUTHORIZATIONS**

I (We) understand that the Company(ies) may request additional authorizations in order to obtain the information the Company(ies) needs to complete its review of my (our) application and, if the policy is issued, in connection with any claim asserted under the policy, I (we) understand that I (we) am (are) not required to provide these authorizations but that, if I (we) choose not to provide them, this application and any claim made under the policy, if issued, may be rejected.

DURATION

Unless otherwise revoked, I (we) agree that this authorization will expire on the earlier of the date that the Company(ies) declines my application for coverage or, if a policy is issued, 24 months from the date of my (our) application. I (We) understand that I (we) may revoke my (our) authorizations at any time, except to the extent that the Company(ies) has (have) taken action in reliance on this authorization, and that this application and any claim made under the policy, if issued, may be rejected. My (Our) revocation must be submitted in writing to: Corporate Chief Underwriter, [1290 Avenue of the Americas, New York, New York 10104.]

SECTION D-AUTHORIZATION/AGREEMENT SIGNATURE

AUTHORIZATION IF BANK DRAFT IS ELECTED

I (We) request and authorize my (our) Bank to charge monthly or quarterly my (our) checking account to pay premiums due under the policy(ies). It is understood that debits will be made automatically after the effective date determined by the Company checked on page 1 above section A of the Application and/or any other affiliated companies and if charges are overlooked or inadvertently not made, the Company checked on page 1 above section A of the Application and/or any other affiliated companies may charge my (our) account at a later date provided the policy(ies) is (are) active.

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

I (We) understand this authorization is to remain in full force and in effect, unless terminated. I (We) understand this Plan may be terminated by the depositor, the Owner or the Company checked on page 1 above section A of the Application and/or any other affiliated companies. upon 30 days written notice to the other parties or if any charge due is not paid or is reversed by the Bank. I (We) understand this Plan may be terminated upon closing of my account.

I (We) understand if this Plan is terminated, premiums for regular or scheduled premium policies will be payable directly to the Company checked on the page 1 of section A of the Application.

I (We) agree that this Plan may be terminated if any debit is not honored by my (our) Bank or Depository for any reason. I (We) further agree that if any such charge is dishonored, whether with or without cause and whether intentionally or inadvertently, Company checked on page 1 above section A of the Application and/or any other affiliated companies shall be under no liability whatsoever, even if such dishonor results in the forfeiture of insurance.

AGREEMENT

Each signer of this Application agrees that:

1) Except when the required money is paid with this Application and as stated in any Temporary Insurance Agreement/Receipt, no insurance shall take effect on this Application: (a) until the date the policy and all amendments are delivered to the Owner(s) and all delivery requirements have been completed; (b) before any Register Date of the policy; and (c) unless the statements and answers in all parts of this Application and any applicable supplements continue to be true and complete to the best of my (our) knowledge and belief, without material change, as of the latest of the date: (i) the policy and all amendments are delivered to the Owner(s); (ii) all delivery requirements have been completed; and (iii) the full initial premium is paid while the person(s) proposed for insurance is (are) living.

2) If temporary insurance is to be provided, the full initial premium must accompany this Application; the Proposed Insured(s) and Owner(s) understand and agree to the terms of the Temporary Insurance Agreement/Receipt and have executed and the Owner(s) has received a copy of the Temporary Insurance Agreement/Receipt.

3) The Temporary Insurance Agreement/Receipt states the conditions that must be met before any insurance takes effect if the full initial premium is paid with this Application. Temporary insurance is not provided for a policy or benefit applied for under the terms of a guaranteed insurability option or a conversion privilege.

4) No financial professional or medical examiner has authority to modify this Application and/or its supplements or questionnaires, the Temporary Insurance Agreement/Receipt (if applicable), and/or to waive any of the Company's rights or requirements.

5) We shall not be bound by any information unless it is stated in Application Part 1, Application Part 2 or any of its supplements or questionnaires.

6) I (We) acknowledge receipt of the Living Benefits Brochure (Accelerated Death Benefit Rider Brochure), where applicable.

7) I (We) acknowledge that no representation is made that a particular rate or risk classification is being offered based on the information provided in response to the policy Application questions.

8) If applicable, the Trustee(s) represent(s) that the Trust named as Owner is allowed to purchase life insurance and securities under the trust document. I (We) further represent that beneficial interests in the Trust are at this time, and currently intend to be, only for parties who are related closely by blood or law, and have a substantial interest in the Proposed Insured(s) engendered by love and affection, or those who have a lawful and substantial economic interest in the continued life of the Proposed Insured(s).

9) I/We represent and certify to the Company checked on page 1 above section A of the Application and/or any other affiliated companies that none of the monies utilized to fund this policy derived directly or indirectly from illegal activities or sources and/or tax evasion

TAXPAYER IDENTIFICATION
NUMBER CERTIFICATION

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

SECTION D-AUTHORIZATION/AGREEMENT SIGNATURE

STATE FRAUD DISCLOSURES

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

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.

ACKNOWLEDGMENTS

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

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

Section A –Proposed Insured Information

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

- Term Life
- Universal Life (Athena UL)
- Indexed Universal Life (Athena IUL) (I have received a copy of the Client Brochure for the policy)
- Variable Universal Life (IL Optimizer II)
- Variable Universal Life (IL Legacy II)
- Survivorship Universal Life (ASUL III)
- Survivorship Variable Universal Life (SIL Legacy)
- Interest Sensitive Whole Life (ISWL)
- Employer Sponsored Life Insurance (ESLI)
- Corporate Owned IL (COIL)

Section C-Additional Underwriting Requirements

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

SIGNATURES

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

X _____

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

X _____

Signature of Proposed Insured 2

X _____

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

Signed by Owner at City, State

Dated on (mm/dd/yyyy)

FINANCIAL PROFESSIONAL TO COMPLETE THIS SECTION

Will any existing insurance be replaced, changed or affected (or has it been) assuming the insurance applied for will be issued? Yes No
If "Yes," is the information provided in question 21 on Part 1 of the Application for Proposed Insured 1, and question 21 of the Survivorship Product Questionnaire for Proposed Insured 2, if applicable, complete and accurate? Yes No
If "No," provide details _____

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

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

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

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

X _____

Signature of Licensed Financial Professional/Insurance Broker

Dated on (mm/dd/yyyy)

Print Licensed Financial Professional's Name

License Number

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

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

COMPLETE FOR ALL OWNER TYPES

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

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

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

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

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

COMPLETE IF INDIVIDUALLY OWNED

8. Do you have a driver's license? Yes No If "Yes," provide license #, state and expiration date
 Number _____ State _____ Expiration Date _____ (mm/dd/yyyy)
 If no driver's license, do you have a government issued ID? Yes No
 If "Yes," to government issued ID, type of ID _____ Government ID # _____
9. Date of birth _____ (mm/dd/yyyy) 10. Currently employed? Yes No Retired (If "Yes," complete question 11)
11. Occupation _____ Employer name _____

12. Income

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

13. Are you a member of the armed forces, including the reserves? (reserves includes active duty or full-time training of 31 days or more per year) Yes No
 (If "Yes," you must also submit a completed and signed Life Insurance/Annuity Disclosure to Active Duty Members of the Armed Forces)

14. Are you a U.S. citizen? Yes No (If "No," please complete "a" and "b" or "c," where applicable)
- a. Country of Citizenship _____ Date of Entry into the U.S. _____ (mm/dd/yyyy)
- b. Residents with legal permanent status (Resident) in U.S. only
 Green Card/Visa Type _____ Expiration Date _____ (mm/dd/yyyy)
- c. Residents residing in the U.S. temporarily (Non-Resident) with valid Visa only
 Visa # _____ Visa Type _____ Expiration Date _____ (mm/dd/yyyy)
 Form I-94 Expiration Date _____ (mm/dd/yyyy) Passport # _____

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

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

OTHER INSURANCE

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

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

COMPLETE IF TRUST OWNED

- 17a. Situs of Trust: The Trust is subject to the laws of the state of _____ 17b. Date of Trust _____ (mm/dd/yyyy)
18. Name(s) of Grantor(s) _____
19. Name(s) and title(s) of current Trustee(s) _____
20. a. How long has the Trustee known the Proposed Insured? _____
 b. What is the nature of the relationship between the Proposed Insured and the Trustee? _____
 c. Is the Trust? Revocable Irrevocable (Check appropriate box)
 d. Can interests in the Trust be sold without changing the terms of the Trust? Yes No
21. Did the Proposed Insured and/or the Owner retain an attorney to prepare the Trust documents? Yes No
 If "Yes," provide name and address of attorney. If "No," provide the name and address of the person or entity that did prepare the Trust documents.
 Please provide the relationship of the preparer of the Trust to the Proposed Insured
 Name _____ Relationship to the Proposed Insured _____
 Address _____
22. Name(s) of current Beneficiary(ies) of the Trust _____
23. What is the nature of the relationship between the Grantor(s) and Beneficiary(ies)? _____
24. Is there a Trust Protector? Yes No (If "Yes," answer 25a and b)
A Trust Protector is a third party appointed by the Grantor to provide direction and guidance to the Trustee
25. a. How long has the Trustee known the Trust Protector? _____
 b. What is the nature of the relationship between the Proposed Insured and the Trust Protector? _____

PURPOSE OF INSURANCE

26. Complete For Personal Insurance
 Income Replacement Mortgage/Debt Repayment Estate Planning Charitable/Gifting Other _____
27. Complete for Business Insurance
 Key Person Buy-Sell Deferred Comp Other (please explain) _____
 Loan indemnification/Amount of loan \$ _____ Duration _____
 Interest charged on loan _____ Collateral pledged to secure loan _____
- a. Type: Sole Proprietorship Partnership Corporation Limited Liability Corporation
 b. Name of Business _____ Nature of Business _____
 c. How long has the business been in operation? _____ Years d. Fair market value of the business \$ _____
 e. % of business owned by Proposed Owner, if other than the Proposed Insured _____ %
 f. Are all members of the business being similarly insured? Yes No
If "Yes," provide details of business coverage issued or applied for on other members (use separate sheet if necessary)
- | Name and Title | % of Business Owned | Amount In Force or Applied for |
|----------------|---------------------|--------------------------------|
| | | |
| | | |
- g. Has the business filed for bankruptcy and/or reorganization in the past 5 years? Yes No
 If "Yes," explain _____
- h. Business/Corporation finances: (Complete chart below for the past 2 years)
- | Year | Assets | Liabilities | Gross Sales | Net Profit |
|------|--------|-------------|-------------|------------|
| | \$ | \$ | \$ | \$ |
| | \$ | \$ | \$ | \$ |
- For employer owned life insurance there are notice and consent requirements, established in the Tax Code, that must be met before issuance of the contract, as well as tax limitations on those who can be insured. When purchasing insurance on employees or directors, you should consult your tax advisor to avoid adverse tax consequences.

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

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

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

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

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

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

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

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

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

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

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

SECTION I PERSONAL FINANCIAL STATEMENT OF THE PROPOSED INSURED(S)	1. Balance Sheet						
	Assets				Liabilities		
	Description	Amount		Description	Amount		
	Cash	\$		Mortgages	\$		
	Stocks, Bonds, Securities	\$		Loans	\$		
	Real Estate (including primary residence)	\$		Notes	\$		
	Retirement Plans	\$		Other (please specify)	\$		
	Business Equity	\$		Other (please specify)	\$		
	Other (please specify)	\$		Other (please specify)	\$		
	Other (please specify)	\$		Other (please specify)	\$		
Total	\$		Total	\$			
			Net Worth (total assets – total liabilities)	\$			
2. Income							
	Earned Income		Unearned Income				
	Income	Dividends/Interest	Rental Income	Pension/Social Sec.	Other (please specify)	Total	
Current Year	\$	\$	\$	\$	\$	\$	
Last Year	\$	\$	\$	\$	\$	\$	
3. How was the proposed face amount determined for this application? State what formula was used (e.g., estate tax calculation, survivor needs, estimated fair market value or book value of the business, capitalization of earnings, etc.); if none, state "None" _____							
4. Do you expect any changes greater than 15% in income or net worth in the next 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please explain _____ _____							

SECTION II (CONT'D on NEXT TWO PAGES) OTHER INFORMATION	<p>"Parties" refers to the following: the Proposed Insured, the Owner or Beneficiary, the Beneficiary of any Trust owning the policy, and/or the Owner of any legal entity owning the policy.</p>	
	<p>5. Do any of the Parties intend to use or transfer the policy for any type of pre-death financial settlement, such as a viatical settlement, senior settlement, life settlement, or for any other settlement in the secondary market? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

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

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

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

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

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

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

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

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

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

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

11. Has any entity, other than the Company checked on page 1 above section A of the Application, medically evaluated the Proposed Insured to determine life expectancy or will such an evaluation occur? Yes No
 If "Yes," please state who has conducted or will conduct the examination, and when the examination occurred or will occur.

Please complete this References section if:

the Proposed Insured is **[under age 70]** and the sum of the Face Amount(s) of *all* concurrent and/or pending applications with the Company checked on page 1 above section A of the Application and/or any other affiliated companies equals **[\$10 million or more]**;

or

the Proposed Insured is **[age 70 or older]** and the sum of the Face Amount(s) of *all* concurrent and/or pending applications with the Company checked on page 1 above section A of the Application and/or any other affiliated companies equals **[\$5 million or more]**.

Attorney Accountant

Name, Title	Business Address	Telephone No.
-------------	------------------	---------------

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

If "No," please explain _____

If you did not provide a reference, please explain _____

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

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

- (1) I (We) have not relied on any representations by the Company checked on page 1 above section A of the Application, and/or any other affiliated companies, or its Agents/Insurance Brokers, regarding the benefits and risks of such a transaction; and
- (2) there are no guarantees that I (we) will be successful and I (we) may incur costs or other disadvantages and risks of such a transaction. The disadvantages and risks of such a transaction include, but are not limited to, the risk of tax consequences, the loss of death benefits, the loss of insurability, or the loss of other rights or interests that I (we) are not aware of.

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

SERFF Tracking Number: ELAS-127720416 State: Arkansas
Filing Company: AXA Equitable Life Insurance Company State Tracking Number: 50093
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Individual Life Insurance Application
Project Name/Number: Refile For Rebating/AXA-Life-2011 (rev. 11/11)

Supporting Document Schedules

Item Status: **Status**
Date:

Satisfied - Item: Flesch Certification

Comments:

Attached is our signed readability certification.

Attachment:

AXAEQ AR Readability Certification.pdf

Item Status: **Status**
Date:

Satisfied - Item: Application

Comments:

Attached is the previously approved application form AXA-Life-2011AR, that was approved on June 14, 2011, SERFF Tracking Number ELAS-127186216, State Tracking Number 49041.

Attachment:

AXA-Life-2011AR.pdf

Item Status: **Status**
Date:

Satisfied - Item: Statement of Variability

Comments:

Attached is our statement of variability.

Attachment:

Statement of Variability AR -- PRF Revised 10-13-11.pdf

AXA Equitable Life Insurance Company

CERTIFICATION OF READABILITY

AXA Equitable Life Insurance Company has reviewed the enclosed forms and certifies that the forms meet the minimum Flesch Scale Readability requirements of Arkansas.

<u>FORM</u>	<u>SCORE</u>
AXA-Life-2011AR (rev. 11/11)	51.88
AXA-OWNER-2011 (rev. 11/11)	63.41
AXA-FIN-2011 (rev. 11/11)	50.05

BY:

Estella A. Devian

Signature

Estella A. Devian

Name

Vice President

Title

October 24, 2011

Date

Filename: AR Readability Certification
Directory: C:\Users\aarold\Desktop\Documents
Template: C:\Users\aarold\AppData\Roaming\Microsoft\Templates\Normal.dotm
Title: MONY LIFE INSURANCE COMPANY OF AMERICA
Subject:
Author: move
Keywords:
Comments: This certification is used in the following states:DC, CT, IN, GA, KY, ME
(score 50), MA (score 50), MI, MN, MT, NE, NV, NJ, NM, ND, OH, OK, SC, SD, TN, VA, WV, WI
Creation Date: 06/09/2010 3:02:00 PM
Change Number: 3
Last Saved On: 10/24/2011 10:56:00 AM
Last Saved By: aarold
Total Editing Time: 4 Minutes
Last Printed On: 10/24/2011 10:56:00 AM
As of Last Complete Printing
Number of Pages: 1
Number of Words: 71 (approx.)
Number of Characters: 405 (approx.)

[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.

SECTION A-PROPOSED INSURED INFORMATION

PROPOSED INSURED	Plan Name _____	Face Amount _____	
	1. Name First _____ Middle _____ Last _____		
	2. SSN _____	3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
	4. Is the Proposed Insured the Owner? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," complete Owner Questionnaire or see Survivorship Product Questionnaire if applicable)		
	5. Primary residential address _____		Bldg/Apt/Suite _____
	City/Municipality _____	County/Parish* _____	State _____ Zip _____
	<small>* County/Parish required only in AL, FL, GA, KY, LA, SC</small>		
	6. Are you a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," complete Foreign Residence and Travel Questionnaire)		
	7a. Phone # _____	<input type="checkbox"/> Daytime <input type="checkbox"/> Cell <input type="checkbox"/> Evening	b. Best time to call _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
	8. Date of birth _____ (mm/dd/yyyy)	9. Place of birth _____ (Country/State)	
	10. Email address _____		
11. Do you have a driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes," to government issued ID, type of ID _____		Government ID number _____	

EMPLOYMENT	12. Currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Retired <input type="checkbox"/> Other _____		
	<i>If "Yes," to question 12, complete questions 13-15</i>		
	13. Occupation(s) a. Title _____	b. Years at current job** _____	
	<small>**If less than one year at current job, give previous occupation information in remarks section</small>		
	c. Duties _____		
14. Employer name _____			
15. Work site address _____			
City _____		State _____ Zip Code _____	

FINANCIAL DETAILS	16. Income (If minor, complete for Parent/Guardian)			
	Gross Earned Annual Income <small>(salary, commissions, bonuses)</small>	Gross Unearned Annual Income <small>(dividends, pensions, interest, real estate income, etc)</small>	Gross Annual Income <small>(Household)</small>	Total Net Worth <small>(Household)</small>
	\$ _____	\$ _____	\$ _____	\$ _____
17. In the last 5 years, have you filed for bankruptcy? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If "Yes," Chapter _____		Date opened _____ (mm/dd/yyyy)	Date Closed _____ (mm/dd/yyyy)	

BENEFICIARY	18. If no contingent beneficiary is named, the contingent beneficiary will be: (1) the Proposed Insured's surviving children, if any, in equal shares; or (2) if the Proposed Insured has no surviving children, the contingent beneficiary will be the Proposed Insured's estate. Total percentage must equal 100% for each category of beneficiary. If percentage shares are left blank, the shares will be deemed equal. If beneficiary is a Trust other than Owner, include full name and date of Trust.			
	Full Name	Relationship to Insured	Beneficiary Type	(%) Percentage
			<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
			<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
			<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	

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

19. Complete for Personal Insurance

Income Replacement Mortgage/Debt Repayment Estate Planning Charitable/Gifting Other _____

20. Complete for Business Insurance

Key Person Buy-Sell Deferred Comp Other (please specify) _____

Loan indemnification (Security for Loan) Amount of loan \$ _____ Duration _____
Interest charged on loan _____ Collateral pledged to secure loan _____

- a. Type Sole Proprietorship Partnership Corporation Limited Liability Corp.
- b. Name of business _____ Nature of business _____
- c. How long has the business been in operation? _____ Years
- d. % of business owned by Proposed Insured _____ %
- e. Fair market value of the business: \$ _____
- f. Are all members of the business being similarly insured? Yes No
If "Yes," provide details of business coverage issued or applied for on other members. (Use remarks section if additional space is needed)

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

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

If "Yes," explain _____

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

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

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

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

- a. Do you have any life insurance / annuities currently in force, including any policy that has been sold, settled or assigned to or with a settlement or viatical company or any other person or entity? Yes No
- b. Will the coverage applied for replace, change, or affect any existing policy(ies) or contract(s)? Yes No
- c. Do you have any other formal life insurance applications pending? Yes No
- d. Including this application, what is the total amount of life insurance coverage pending (base policy face amount plus amounts attributable to additional benefits and riders) that you plan to accept on the Proposed Insured? _____

Chart for questions 21a and b

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

Chart for question 21c

Name of Company	Total Amount (Face Plus Riders)	Competitive or Additional
	\$ _____	<input type="checkbox"/> Competitive <input type="checkbox"/> Additional
	\$ _____	<input type="checkbox"/> Competitive <input type="checkbox"/> Additional

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

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

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

25. Do you engage in regular exercise? (For example, running, walking, strength training, tennis) Yes No
 If "Yes," give details of type, frequency and length of time _____
26. Have you ever had an application for life or health insurance declined, postponed, required an extra premium, offered with a reduced face amount or other modification or had a life or health policy or contract that was cancelled, recalled or denied renewal? *(If "Yes," please state companies and provide full details in remarks section)* Yes No
27. Have you in the last 10 years, been convicted of, or pled guilty or no contest to a felony, or are current felony charges pending? Yes No
(If "Yes," state offense and penalty, date of probation, duration of probation and end date in remarks section)
28. Do you expect to travel outside of the U.S. or Canada, or change your country of residence in the next 2 years? Yes No
(If "Yes," complete Foreign Travel Questionnaire)
29. In the last 2 years have you:
- a. Flown other than as a passenger or do you plan to do so? *(If "Yes," complete Aviation Questionnaire)* Yes No
- b. 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? *(If "Yes," complete Avocation Questionnaire)* Yes No
30. Are you a member of the armed forces, including the reserves? Yes No
(If "Yes," you must also submit a completed and signed Life Insurance/Annuity Disclosure to Active Duty Members of the Armed Forces)

31. Have you ever received medical treatment or counseling for, or been advised by a physician to reduce or discontinue, the use of alcohol or prescribed or non-prescribed drugs? *(If "Yes," complete Substance Usage Questionnaire)* Yes No
- Do not complete if Proposed Insured is age 0-17
32. Do you currently use or have you ever used tobacco or nicotine products? Yes No
(If "Yes," provide details in chart below)

Product Type(s)	Amount and Frequency Indicate amount and frequency of use	Indicate date last used (mm/yyyy)
<input type="checkbox"/> Cigarettes	# ___ per <input type="checkbox"/> Day <input type="checkbox"/> Month <input type="checkbox"/> Year	
<input type="checkbox"/> Cigars <input type="checkbox"/> Cigarillos	# ___ per <input type="checkbox"/> Day <input type="checkbox"/> Month <input type="checkbox"/> Year	
<input type="checkbox"/> Pipe <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Nicotine Patch or Gum	Not Applicable	
<input type="checkbox"/> Other (please specify) _____		

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

If "Yes" to questions 34 or 35, complete a Medical Information Questionnaire

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

SECTION D-AUTHORIZATION/AGREEMENT SIGNATURE

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

ACKNOWLEDGEMENT
OF OUR UNDERWRITING
PROCESS

I (We) acknowledge that I (we) have reviewed the statement of the Underwriting Process of the Company(ies) (the "Statement") which describes from whom and why the Company(ies) obtains information about me (us), to whom such information may be reported and how I (we) may obtain a copy of it. The Statement contains the notice required by the Fair Credit Reporting Act.

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

AUTHORIZATION TO
OBTAIN NON-HEALTH
INFORMATION

I (We) authorize any employer, business associate, government unit, financial institution, consumer reporting agency, the Medical Information Bureau, my (our) insurance agency and my (our) financial professional to disclose to the Company(ies) and its authorized representatives any information they may have about my (our) occupation, avocations, insurance activities, finances, driving record, character and general reputation(s). 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 the Statement attached to this application. In addition, information may be disclosed to the Medical Information Bureau (MIB).

COVERAGE
CONDITIONS

I (We) understand that the Company(ies) may not issue coverage unless I (we) provide this authorization, and that, while I (we) may refuse to sign this authorization, my (our) refusal to do so could result in coverage not being issued.

ADDITIONAL
AUTHORIZATIONS

I (We) understand that the Company(ies) may request additional authorizations in order to obtain the information the Company(ies) needs to complete its review of my (our) application and, if the policy is issued, in connection with any claim asserted under the policy, I (we) understand that I (we) am (are) not required to provide these authorizations but that, if I (we) choose not to provide them, this application and any claim made under the policy, if issued, may be rejected.

DURATION

Unless otherwise revoked, I (we) agree that this authorization will expire on the earlier of the date that the Company(ies) declines my application for coverage or, if a policy is issued, 24 months from the date of my (our) application. I (We) understand that I (we) may revoke my (our) authorizations at any time, except to the extent that the Company(ies) has (have) taken action in reliance on this authorization, and that this application and any claim made under the policy, if issued, may be rejected. My (Our) revocation must be submitted in writing to: Corporate Chief Underwriter, [1290 Avenue of the Americas, New York, New York 10104.]

SECTION D-AUTHORIZATION/AGREEMENT SIGNATURE

AUTHORIZATION IF BANK DRAFT IS ELECTED

I (We) request and authorize my (our) Bank to charge monthly or quarterly my (our) checking account to pay premiums due under the policy(ies). It is understood that debits will be made automatically after the effective date determined by the Company checked on page 1 above section A of the Application and/or any other affiliated companies and if charges are overlooked or inadvertently not made, the Company checked on page 1 above section A of the Application and/or any other affiliated companies may charge my (our) account at a later date provided the policy(ies) is (are) active.

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

I (We) understand this authorization is to remain in full force and in effect, unless terminated. I (We) understand this Plan may be terminated by the depositor, the Owner or the Company checked on page 1 above section A of the Application and/or any other affiliated companies. upon 30 days written notice to the other parties or if any charge due is not paid or is reversed by the Bank. I (We) understand this Plan may be terminated upon closing of my account.

I (We) understand if this Plan is terminated, premiums for regular or scheduled premium policies will be payable directly to the Company checked on the page 1 of section A of the Application.

I (We) agree that this Plan may be terminated if any debit is not honored by my (our) Bank or Depository for any reason. I (We) further agree that if any such charge is dishonored, whether with or without cause and whether intentionally or inadvertently, Company checked on page 1 above section A of the Application and/or any other affiliated companies shall be under no liability whatsoever, even if such dishonor results in the forfeiture of insurance.

AGREEMENT

Each signer of this Application agrees that:

1) Except when the required money is paid with this Application and as stated in any Temporary Insurance Agreement/Receipt, no insurance shall take effect on this Application: (a) until the date the policy and all amendments are delivered to the Owner(s) and all delivery requirements have been completed; (b) before any Register Date of the policy; and (c) unless the statements and answers in all parts of this Application and any applicable supplements continue to be true and complete to the best of my (our) knowledge and belief, without material change, as of the latest of the date: (i) the policy and all amendments are delivered to the Owner(s); (ii) all delivery requirements have been completed; and (iii) the full initial premium is paid while the person(s) proposed for insurance is (are) living.

2) If temporary insurance is to be provided, the full initial premium must accompany this Application; the Proposed Insured(s) and Owner(s) understand and agree to the terms of the Temporary Insurance Agreement/Receipt and have executed and the Owner(s) has received a copy of the Temporary Insurance Agreement/Receipt.

3) The Temporary Insurance Agreement/Receipt states the conditions that must be met before any insurance takes effect if the full initial premium is paid with this Application. Temporary insurance is not provided for a policy or benefit applied for under the terms of a guaranteed insurability option or a conversion privilege.

4) No financial professional or medical examiner has authority to modify this Application and/or its supplements or questionnaires, the Temporary Insurance Agreement/Receipt (if applicable), and/or to waive any of our rights or requirements.

5) We shall not be bound by any information unless it is stated in Application Part 1, Application Part 2 or any of its supplements or questionnaires.

6) I (We) acknowledge receipt of the Living Benefits Brochure (Accelerated Death Benefit Rider Brochure), where applicable.

7) I (We) acknowledge that no representation is made that a particular rate or risk classification is being offered based on the information provided in response to the policy Application questions.

8) If applicable, the Trustee(s) represent(s) that the Trust named as Owner is allowed to purchase life insurance and securities under the trust document. I (We) further represent that beneficial interests in the Trust are at this time, and currently intend to be, only for parties who are related closely by blood or law, and have a substantial interest in the Proposed Insured(s) engendered by love and affection, or those who have a lawful and substantial economic interest in the continued life of the Proposed Insured(s).

9) I/We represent and certify to the Company checked on page 1 above section A of the Application and/or any other affiliated companies that none of the monies utilized to fund this policy derived directly or indirectly from illegal activities or sources and/or tax evasion

TAXPAYER IDENTIFICATION
NUMBER CERTIFICATION

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

SECTION D-AUTHORIZATION/AGREEMENT SIGNATURE

STATE FRAUD DISCLOSURES

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

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.

ACKNOWLEDGMENTS

I (We) have a right to ask for and receive 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.
PLEASE INDICATE YOU HAVE REVIEWED THE APPLICATION AND QUESTIONNAIRES AS THEY HAVE BEEN COMPLETED BY CHECKING THE APPROPRIATE BOX(ES) BELOW. FAILURE TO CHECK THE APPROPRIATE BOX(ES) WILL REQUIRE YOU TO SIGN AN APPLICATION AMENDMENT.

Section A –Proposed Insured Information

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

- Term Life
- Universal Life (Athena UL)
- Indexed Universal Life (Athena IUL) (I have received a copy of the Client Brochure for the policy)
- Variable Universal Life (IL Optimizer II)
- Variable Universal Life (IL Legacy II)
- Survivorship Universal Life (ASUL III)
- Survivorship Variable Universal Life (SIL Legacy)
- Interest Sensitive Whole Life (ISWL)
- Employer Sponsored Life Insurance (ESLI)
- Corporate Owned IL (COIL)

Section C-Additional Underwriting Requirements

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

SIGNATURES

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

X _____

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

X _____

Signature of Proposed Insured 2

X _____

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

Signed by Owner at City, State

Dated on (mm/dd/yyyy)

FINANCIAL PROFESSIONAL TO COMPLETE THIS SECTION

Will any existing insurance be replaced, changed or affected (or has it been) assuming the insurance applied for will be issued? Yes No
If "Yes," is the information provided in question 21 on Part 1 of the Application for Proposed Insured 1, and question 21 of the Survivorship Product Questionnaire for Proposed Insured 2, if applicable, complete and accurate? Yes No
If "No," provide details _____

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

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

For VUL Policies Only:

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

X _____

Signature of Licensed Financial Professional/Insurance Broker

Dated on (mm/dd/yyyy)

Print Licensed Financial Professional's Name

License Number

**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

AXA-Life-2011AR (rev. 11/11)

Form Description

Individual Life Insurance Application

1. **Company Address (page A1 and D1):** We have bracketed the Home Office address, as it may change in the future.
2. **Product Information (page D3):** We have bracketed the list of Product Information questionnaires to account for future changes in our portfolio. We will always get State Department of Insurance (or Interstate Insurance Product Regulation Commission "IIPRC," if applicable in the future) approval for the product types that require approval before we offer them to the public.
3. **Additional Underwriting Requirements (page D3):** We have bracketed the list of Additional Underwriting Requirements questionnaires to account for future underwriting changes. We will always get State Department of Insurance (or IIPRC, if applicable in the future) approval for the specific type of underwriting change.

Form Number

AXA-FIN-2011 (rev. 11/11)

Form Description

Financial Questionnaire

1. **Age and Amount Limitations:** We have bracketed age and amount of insurance limitations, as we reserve the right to change them in the future to allow for changes to underwriting requirements.