AXA Employee Benefits

Evidence of Insurability (EOI)

REGULAR MAIL ADDRESS:
AXA EMPLOYEE BENEFITS
PO BOX 1507
SECAUCUS, NJ 07096

OVERNIGHT ADDRESS:
AXA EMPLOYEE BENEFITS
500 PLAZA DRIVE, 6th FLOOR
SECAUCUS, NJ 07094

Return this form to AXA within 30 days of enrollment in coverage

Employer Section

Please complete the information in the Employer Section before providing the Evidence of Insurability application to the employee. The employee or dependent requesting coverage subject to Evidence of Insurability must complete the Applicant Section in entirety and return the application to AXA Employee Benefits for processing.

Employer Name _____ Group Number _____

Employee First Name _____ M.I. _____ Last Name _____

Employee Annual Earnings (please refer to the definition of earnings in your plan documents) _____

Employee Supplemental / Voluntary Life - Current Inforce Coverage Amount Dependent _____

Spouse Supplemental / Voluntary Life - Current Inforce Coverage Amount Dependent _____

Applicant Section

Please complete the AXA Evidence of Insurability form in its entirety for each applicant requesting coverage. If your employer has not completed the Employer Section of this document, please complete the section on their behalf and contact them with any questions regarding the required information. Once complete, mail the form to AXA at the address listed above. Please note that missing information will cause a delay in processing your application.

Applicant is: ☐ Employee ☐ Spouse

Applicant First Name _____ M.I. _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Primary Phone Number _____ Email _____

Total Supplemental / Voluntary Life Coverage Amount Requested _____

Employee SSN (required if Applicant is Dependent) _____

Group Term Life Statement of Insurability

MONY LIFE INSURANCE COMPANY OF AMERICA
Regular Mail: PO Box 1507, Secaucus, NJ 07096
Overnight Mail: 500 Plaza Drive, 6th Floor, Secaucus, NJ 07094
Phone: (866) 274-9887
Fax: (816) 502-9118
https://us.axa.com/customer-service/mony-life-insurance.html

(A separate form must be completed for each person seeking coverage)

Reason for Applying:
☐Applying for coverage over guaranteed issue limit ☐New Hire ☐Late Enrollee
☐Increasing Coverage ☐Adding Dependent(s) ☐Other: _____

Applicant Information

Applicant's Name: Last, First, MI			Date of Birth: (Month/Date/Year)
Sex: ☐ Male ☐Female	Age:	Height: (ft. in.)	Weight: (lb.)
Driver's License Number and State:		Social Security No. - -	Already Enrolled: ☐ Yes ☐No
Are you a U.S. Citizen or Permanent Resident? ☐U.S. Citizen ☐Permanent Resident ☐Neither			If Permanent Resident, give Alien Registration number:
Physician's Address: (Street, City, State, Zip)			Physician's Phone No. ( ) -
Employee Member Name: (if different than Applicant)			Employee's Job Title:
Employer Name:			Group Number:

Medical Questions

(1) Have you, in the past 5 years, been treated for, diagnosed with, tested positive for, or been given advice by a medical professional, or been hospitalized with or taken medication for any of the following:

☐ heart disease or disorder (including rheumatic fever)	☐ Digestive system disease or disorder	☐ Stroke/transient ischemic attack
☐ disease of the circulatory system	☐ Lung disease or disorder (including allergies or sleep apnea)	☐ Epilepsy/seizure; including dizziness or fainting
☐ Diabetes/endocrine/thyroid	☐ Any mental or nervous system disorders including depression or anxiety	☐ Arthritis
☐ Blood disease or disorder (other than HIV)	☐ Muscular spinal, joint, or bone disorders or injuries including concussions	☐ Congenital defects or physical impairments
☐ Kidney disease	☐ High blood pressure	
☐ Liver disease or disorder	☐ Cancer	

(2) Have you, in the past 12 months, been treated, examined or advised by a medical professional or been hospitalized for more than 24 hours for any accident, illness or medical conditions resulting in you scheduling or being advised to schedule surgery, a diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS Virus), or evaluation of any kind that has not been completed?	☐ Yes ☐No
(3) Have you ever tested positive for or been diagnosed by a member of the medical profession as having Human Immunodeficiency Virus (AIDS Virus) or Acquired Immunodeficiency Syndrome (AIDS) or any immune deficiency disorder?	☐ Yes ☐No
(4) Have you, in the past 5 years, used narcotics, barbiturates, amphetamines other than as prescribed by a doctor, or hallucinogens, heroin, cocaine, or received medical treatment or counseling for, or been advised by a medical professional to discontinue the use of alcohol or prescribed or non-prescribed drugs?	☐ Yes ☐No
(5) Have you, in the past 10 years, pled guilty or no contest to or been convicted of a felony offense, or are matters concerning felony convictions outstanding against you?	☐ Yes ☐No
(6) Do you anticipate travel or change of residence outside the United States (including military deployment) during the next 2 years?	☐ Yes ☐No
(7) Have you, in the past 3 years, participated in or do you plan in the next 2 years to participate in any of the following activities: aeronautics, including hang gliding, sky diving, parachuting, or ballooning; racing, including car, motorcycle, or boat; scuba/skin diving; hiking, including mountain/trail climbing or rock climbing; or any similar hazardous activities?	☐ Yes ☐No
(8) Have you, in the past 3 years, piloted an aircraft, or do you have any intention in the next 2 years of flying other than as a passenger on a scheduled airline?	☐ Yes ☐No

(9) Have you had your driver's license suspended or revoked, pled guilty to or been convicted of three or more moving violations in the past 3 years, or pled guilty to or been convicted of driving while impaired, intoxicated or under the influence of any drug in the past 5 years?	☐ Yes ☐No

If you answered "Yes" to any Health Questions in this form, please explain below. (Please use another sheet of paper if necessary.)

Date	Condition	Doctor Names and Addresses	Results

Agreements, Authorizations & Signature

I have read this Statement of Insurability and all statements and answers as they pertain to the applicant. These statements are true and complete to the best of my knowledge and belief, and I understand all statements and answers I have given will be used by MONY Life Insurance Company of America to determine insurability. I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify MONY Life Insurance Company of America of any change in my medical condition while my enrollment is pending. I agree that if my enrollment is approved by MONY Life Insurance Company of America, the effective date of any coverage will be determined in accordance with the terms of the group policy, including any actively at work requirement. I acknowledge this Statement of Insurability form (when approved), the group policy, certificate of insurance, and any endorsement, amendment or rider hereto, are part of the insurance coverage(s) applied for. I understand that no insurance agent or broker, or persons other than officers of MONY Life Insurance Company of America, can modify, waive or change this form, nor bind coverage or guarantee approval of this form.

[I authorize MONY Life Insurance Company of America, or its reinsurers, to make a brief report of my personal health information to MIB.] [I have read the separate notice enclosed with this form pertaining to the Medical Information Bureau as required by the Fair Credit Reporting Act.]

Any person who knowingly presents a false statement in a statement of insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at _____
City, State

_____ _____
Applicant Signature **Date**

_____ _____
Parent/Guardian Signature **Date**
(For dependent enrollees under age 18)

This authorization is valid for AXA Equitable Life Insurance Company and MONY Life Insurance Company of America

Proposed Insured's Name _____ Date of Birth_____

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

TO OBTAIN HEALTH INFORMATION In this authorization, "I" "we" "our" "me" and "us" means the Proposed Insured or Authorized Representative. I (We) authorize any physician, hospital, clinic, medical practitioner, medical testing laboratory, pharmacy, pharmacy benefit manager, medically related facility or other health care provider, health plan or insurance company (including those listed above, with respect to their coverages) and the Medical Information Bureau to disclose to the Companies listed above and their authorized representatives (collectively hereinafter "the Companies named above") any and all information, including medical reports, pharmaceutical records or prescription history, whether fact or opinion, they may have about any diagnosis, treatment, medication or drug history, and prognosis regarding my past, present or future physical or mental condition.

RE-DISCLOSURE OF HEALTH INFORMATION I (We) understand that any disclosure of information to the Companies named above for the purpose of determining my (our) eligibility for coverage carries with it the potential for re-disclosure, meaning the information may no longer be protected by HIPAA. However, please note that such information may be protected by other state and federal privacy laws such as the Gramm-Leach-Bliley Act.

PURPOSE OF AUTHORIZATIONS I understand the following parties may need to collect information on me in regard to the proposed coverage: The Companies named above and their reinsurers; any insurance support organization; any consumer reporting agency; and all persons authorized to represent these organizations for this purpose. I (We) understand that the information obtained will be used by the Companies named above to determine my (our) eligibility for life insurance coverage and any associated risk rating classification, and to obtain reinsurance. If a policy is issued to me (us), this information may also be used in the future to administer my (our) policy and process claims made under the policy. In addition, information may be disclosed to the Medical Information Bureau (MIB) who, upon request, may disclose such information about me (us) in its file to another member company with whom I (we) apply for life or health insurance or to whom a claim for benefits may be submitted; when requested by a government agency; in connection with a legal or arbitration proceeding; or for other purposes as required or permitted by applicable law.

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

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

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

Life Insurance Company, or MONY Life Insurance Company of America, [1290 Avenue of the Americas, New York, New York 10104].

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

_____

Signature of Proposed Insured or Authorized Representative

_____

Print Name of Proposed Insured or Authorized Representative

_____

Description of Personal Representative's Authority or Relationship to Proposed Insured

Dated at _____ **on** _____**.**
City, State **(mm/dd/yyyy)**

Fraud Warnings

Residents of all states unless listed below: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.