

GROUP EMPLOYEE BENEFITS

Enrollment Form / Change Form

redefining / standards®



BASIC LIFE / AD&D

BASIC DEPENDENT LIFE / AD&D

LONG-TERM DISABILITY

; 9B9F 5@GMBC 8`C: `H< 9`5GGC 7 5H9`F 9: C F A 98`
DF 9G6MH9F 5B`7<I F 7<`''''

DC@7MD9F €B.`>| B9`%&\$\$%+`!>| B9`%&\$\$%

MONY Life Insurance Company of America

SECTION 1. EMPLOYEE'S INFORMATION - PLEASE PRINT USING DARK INK & PROVIDE ALL REQUESTED INFORMATION

Employee Name and Address (where you work)							
Group Number # 000569		Classification: 1-Salary 2- Hourly 3-Erskine			Hire Date / Effective Date		
Employee Name (First, MI, Last)			Social Security Number (SSN)		<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Single <input type="radio"/> Married**	Date of Birth (DOB) (mm/dd/yyyy)
Home Address			City	State (US)	Zip	County	Phone Number
Job Title		Annual Salary		Hours Per Week	<input type="radio"/> Salaried <input type="radio"/> Hourly	E-mail address	
Status Change - reason form is being completed <input type="radio"/> Open Enrollment <input type="radio"/> New Hire <input type="radio"/> Change in Marital Status <input type="radio"/> Date ____ / ____ / ____							
<input type="radio"/> New Retiree <input type="radio"/> Add/Remove Dependent(s) Date ____ / ____ / ____ <input type="radio"/> Other _____ Date ____ / ____ / ____							

COVERAGES ELECTED

SECTION 2. COMPLETE THIS SECTION IF APPLYING FOR LIFE PLAN DESIGN COVERAGE OPTIONS

<input type="checkbox"/> Basic Life/AD&D <input type="checkbox"/> Basic Dependent Life/AD&D (select if you have dependents)	_____ _____ _____
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SECTION 3. DISABILITY INSURANCE

<input type="checkbox"/> Long-Term Disability Amount \$ _____ (amount to be completed by Central Services)	
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**AXA" is the brand name of AXA Equitable Financial Services, LLC and its family of companies, including AXA Equitable Life Insurance Company (AXA Equitable) located at 1290 Avenue of the Americas, New York, NY 10104 and MONY Life Insurance Company of America (MONY America) located at 2999 North 44th Street, Suite 250, Phoenix, Arizona 85018.

¹ References herein to the "Company" refer to either AXA Equitable or MONY America as the applicable issuing company.

SECTION 4. SPOUSE AND DEPENDENT CHILDREN INFORMATION

<i>(first, middle and last name)</i>	Gender	Date of Birth (mm/dd/yyyy)	Social Security Number	Life
Spouse**	<input type="radio"/> Male <input type="radio"/> Female			<input type="checkbox"/>
Child	<input type="radio"/> Female <input type="radio"/> Male			<input type="checkbox"/>
Child	<input type="radio"/> Female <input type="radio"/> Male			<input type="checkbox"/>
Child	<input type="radio"/> Female <input type="radio"/> Male			<input type="checkbox"/>
Child	<input type="radio"/> Female <input type="radio"/> Male			<input type="checkbox"/>
Child	<input type="radio"/> Female <input type="radio"/> Male			<input type="checkbox"/>

SECTION 5. BENEFICIARIES

Indicate your beneficiary designation in the space below. If you need more space, please use another sheet.

(1) You may designate more than one primary or secondary beneficiary. Indicate the % share each beneficiary should receive. Each class (primary & secondary) should equal 100%

PRIMARY BENEFICIARY(IES) Basic Life / Basic AD&D

Name (Last, First, MI)	Address (Street, City, State, Zip)	Social Security Number	Relationship	% of Benefit

SECONDARY/CONTINGENT BENEFICIARY(IES) Basic Life / Basic AD&D

Name (Last, First, MI)	Address (Street, City, State, Zip)	Social Security Number	Relationship	% of Benefit

PLEASE NOTE: AXA does not act or serve as a record keeper or a third party administrator in any capacity in connection with an employee's designation of beneficiaries under any group life insurance policy. AXA assumes no responsibility for an employee's designation of beneficiaries or the transmission, maintenance or use of such information by the Benefits Administrator, Plan Sponsor or the employee. The Benefits Administrator and Plan Sponsor remain solely responsible for maintaining the Plan's official record of such designation and the accuracy of the information.

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SECTION 6. ACKNOWLEDGEMENTS

By signing this Enrollment form, I understand and agree that:

- (1) All statements and answers I have given are complete and true to the best of my knowledge and belief.
- (2) Coverage is not in effect until final approval is given by the Company¹.
- (3) No person, except an officer of the Company, is authorized to vary or modify a contract.
- (4) I have read and acknowledge the applicable fraud warning attached.
- (5) I, the undersigned agree that statements and answers in all parts of the enrollment form are true and complete to the best of my knowledge and belief.

Sign Here 

Signature

Date

Employee/Applicant

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FRAUD WARNINGS

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas, Louisiana, New Mexico, Rhode Island, and West Virginia: 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.

California: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: 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.

Maine, Tennessee, Virginia and Washington: WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Florida: Any person who knowingly and with an 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.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York: Note: Does not apply to Life Insurance. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement that is material to the interests of an insurer may be guilty of insurance fraud.

Pennsylvania: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

All Other States: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

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