Group Term Life Evidence of Insurability Form

Regular Mail: AXA's Employee Benefits Group
PO Box 1507, Secaucus, NJ 07096

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AXA Equitable Life Insurance Company
For Assistance Call (866) 274-9887; Fax 816-502-9118
email: EOIProcessing@AXA.US.com

Please complete the AXA Equitable Life Insurance Company ("AXA") Statement 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 the address listed above. Please note that missing information will cause a delay in processing your application.

During the evaluation process AXA may request the completion of a supplemental form.

Reason for Applying:

☐ **Applying for coverage over guaranteed issue limit** ☐ **New Hire** ☐ **Late Enrollee** ☐ **Increasing Coverage**

☐ **Other:** _____ **Date of Hire:** _____

Employer Name							**Group Plan #**
Insured Last Name (Employee)	**First Name**	**Int**	Sex (Circle one) M F	Birthdate	HT	WT	SS#
Home Address							Telephone #
Cell Phone	Email Address						Annual Earnings
Insured Last Name (Spouse)	**First Name**	**Int**	Sex (Circle one) M F	Birthdate	HT	WT	SS#

Employee Amount of Basic Life Insurance Currently Inforce	Spouse Amount of Basic Life Insurance Currently Inforce
Employee Basic Life Insurance Amount Elected	Spouse Basic Life Insurance Amount Elected
Employee Amount of Supplemental/Voluntary Life Insurance Currently Inforce	Spouse Amount of Supplemental/Voluntary Life Insurance Currently Inforce
Employee Supplemental/Voluntary Life Insurance Amount Elected	Spouse Supplemental/Voluntary Life Insurance Amount Elected

IF APPLYING FOR LIFE INSURANCE, questions 1-4 must be answered by each person applying for coverage.	
1. Have you ever been diagnosed by a member of the medical profession as having Acquired Immunodeficiency Syndrome (AIDS) or any immune deficiency disorder other than HIV?	Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No
2. In the past 7 years, you (proposed insured) been treated for or diagnosed as having any of the following: a) any disorder or condition of the heart, liver, kidney(s); lung or respiratory system; b) any disorder or condition of your digestive system including your esophagus, stomach, or intestines; c) any mental, nervous, emotional or neurological disorder or condition; d) auto immune disorder; e) diabetes; f) cancer; or g) a stroke?	Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No
3. In the past 2 years, have you (proposed insured) received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue the use of alcohol or prescribed or non-prescribed drugs?	Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No
4. In the past 5 years, have you (proposed insured); (a) consulted or been examined by or treated by a physician, practitioner or specialist for any illness or injury, disease or disorder NOT listed in the questions above (including routine physicals only when there is an existing or newly diagnosed medical condition); or (b) sought treatment or a consultation in a hospital or other health care facility for observation, diagnosis, treatment or an operation; undergone any diagnostic testing including but not limited to X-ray, blood work, ultrasound, an MRI, a CT scan, or PET scan with abnormal findings,; or been prescribed medication(s) – (other than for cold, flu or allergies)?	Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No

Group Plan #

Employer Name

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For each "yes" answer to question 4 give details below. (Continue on reverse side if additional space is needed.)					
Question #	**Proposed Insured**	**Test, Injury, Illness, Disease, Operation or Complication**	**Date Of Onset**	**/ Recovery**	**Full Details (including Doctor's Names and Addresses)**

In order to complete the evaluation of this application, AXA Equitable Life Insurance Company may contact you, through the mail or over the telephone to:

1. clarify any information contained on this form;
2. obtain any information missing from this form;
3. ask additional questions of you by providing a supplemental form

Group Plan # _____

Employer Name _____

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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 AXA Equitable Life Insurance Company to determine insurability. I understand that any misstatements which is material to the issuance of coverage may be used as a basis for denial of payment of a claim. I agree that if my enrollment is approved by AXA Equitable Life Insurance Company, 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 AXA Equitable Life Insurance Company, can modify, waive or change this form, nor bind coverage or guarantee approval of this form.
I authorize AXA Equitable Life Insurance Company, 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.

FOR ACCIDENTAL DEATH & DISMEMBERMENT COVERAGE ONLY: Any person who knowingly and with intent to defraud any insurance company or other person files and 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 $5,000 and the stated value of the claim for each such violation.

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.

Signed at _____
City, State

_____ _____
Proposed Insured (Employee) **Date**

_____ _____
Proposed Insured (Spouse, if applicable) **Date**

_____ _____
Employee Signature (Required for all Proposed Insureds) **Date**

Group Plan # _____

Employer Name _____

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This authorization is valid for AXA Equitable Life Insurance Company

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 Company listed above and their authorized representatives (collectively hereinafter "the Company 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. Psychotherapy notes, along with drug and alcohol treatment information is specifically excluded from this disclosure.

RE-DISCLOSURE OF HEALTH INFORMATION I (We) understand that any disclosure of information to the Company 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 Company 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 Company 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 Company 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 Company named above may request additional authorizations in order to obtain the information the Company 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 Company 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 Company named above has/have taken in reliance on this authorization or (2) any right granted the Company 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, 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 (Employee) or Authorized Representative **Date**

_____ _____
Signature of Proposed Insured (Spouse, if applicable) or Authorized Representative **Date**

_____ _____
Print name of Proposed Insured (Employee) or Authorized Representative **Date**

_____ _____
Print name of Proposed Insured (Spouse, if applicable) or Authorized Representative **Date**

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

Dated at _____ **on** _____**.**
City, State **(MM/DD/YYYY)**