

(Select One)

AXA Equitable Life Insurance Company

MONY Life Insurance Company of America

AXA Equitable Life and Annuity Company

MONY Life Insurance Company

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

TO OBTAIN HEALTH INFORMATION In this authorization, "we" "our" and "us" mean AXA Equitable Life Insurance Company, or the insurance company selected above. I (we) authorize any physician, hospital, clinic, medical practitioner, medical testing laboratory, pharmacy or other health care provider, health plan or insurance company (including the Company checked above, with respect to other the Company checked above coverages) and the Medical Information Bureau to disclose to the Company checked above and its authorized representatives (collectively hereinafter "the Company checked above") any and all information, whether fact or opinion, they may have about any diagnosis, treatment 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 Company checked 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 (we) understand that the information obtained will be used by the Company checked above to determine my (our) eligibility for life insurance coverage, 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 you in its file to another member company with whom you 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 checked above is conditioning the issuance of coverage on the provision of this authorization, and that, while I (we) may refuse to sign this authorization, my (our) refusal to do so could result in coverage not being issued.

ADDITIONAL AUTHORIZATIONS You have advised me (us) that the Company checked above may request additional authorizations in order to obtain the information the Company checked above 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 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 otherwise revoked, I (we) agree that this authorization will expire on the earlier of the date that the Company checked above declines 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 that the Company checked above has taken action in reliance on this authorization or (2) any right granted the Company checked 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/AXA Equitable Life and Annuity Company/MONY Life Insurance Company of America/MONY 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.

X _____
Signature of Proposed Insured/Patient or Authorized Representative

Print Name of Proposed Insured/Patient or Authorized Representative

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

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