☐ **AXA Equitable Life Insurance Company**, 1290 Avenue of the Americas, New York, NY 10104

☐ **AXA Equitable Life and Annuity Company,** Home Office: 370 17th Street, Suite 4950, Denver, CO 80202

☐ **MONY Life Insurance Company of America (MLOA),** 2999 North 44th Street, Suite 250, Phoenix, AZ 85018

Instructions: Proposed Insured must complete and sign the bottom portion of this form. The Agent should enter the Examiner's Name and Address, if known. This form must be submitted with the Application.

Name of Examiner _____

Examiner's Address _____

NOTICE AND CONSENT FOR URINE, ORAL FLUID, AND/OR BLOOD TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your urine, oral fluid, and/or blood for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes the Insurer to collect urine, oral fluid, and/or withdraw blood and order laboratory tests only in regard to your present application for insurance.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, immune disorders, nicotine, drugs and certain prescribed medications.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if your HIV test is normal, no report is made about it to the MIB, Inc. If the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MlB, Inc. a generic code which signifies only a non-specific urine, oral fluid, and/or blood test abnormality. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HlV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer asks that you name and authorize disclosure to a physician or other health care provider with whom you can discuss the test results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS Virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

CONSENT AND DISCLOSURE

I have read and I understand this Notice and Consent For Urine, Oral Fluid, and/or Blood Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the collection of urine and/or oral fluid and/or withdrawal of blood from me by needle, the testing of that urine, oral fluid, and/or blood, and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

In the event of positive test results, I authorize disclosure to the following physician or health care provider:

Name: _____

Address: _____

_____ _____

Print Name of Proposed Insured | Date of Birth

_____ _____ _____

Signature of Proposed Insured or Parent/Guardian | Date | State of Residence

_____

Witness