



CHANGE OF ADDRESS REQUEST

PLEASE BE SURE TO INCLUDE POLICY IDENTIFICATION NUMBER THAT APPEARS ON YOUR CONTRACT OR CHECK. SEND ALL COMMUNICATIONS TO:

**AXA EQUITABLE
BENEFIT PAYMENT SERVICES GROUP
PO BOX 4993
SYRACUSE, NY 13221**

Contract Number(s): _____

Effective Date of Change: _____

(Number and Street)

(City and State)

(Zip Code)

()

(Area Code & Telephone #)

(Signature of Payee)

(Date)

(Signature of Joint Payee, if any)

(Date)