

LIFE INSURANCE

AUTHORIZATION TO RELEASE INFORMATION (HIPAA)

Express Mail:
 AXA Equitable Life Insurance Company
 National Operations Center
 10840 Ballantyne Commons Parkway
 Charlotte, NC 28277

Regular Mail:
 AXA Equitable Life Insurance Company
 National Operations Center
 P.O. Box 1047
 Charlotte, NC 28201-1047

Fax Number:
 (704) 540-2203



AXA Equitable Life Insurance Company (AXA Equitable)
MONY Life Insurance Company (MONY)
MONY Life Insurance Company of America (MLOA)

For Assistance: Call (800) 777-6510
Monday–Friday, 8:00 a.m. – 7:00 p.m. EST

AUTHORIZATION TO RELEASE INFORMATION PROTECTED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) IN CONNECTION WITH A CLAIM FOR LIFE INSURANCE BENEFITS

I am the next of kin or executor/administrator of the estate of _____
 (PLEASE PRINT INSURED'S NAME)

TO OBTAIN HEALTH INFORMATION. Pursuant to HIPAA, as the personal representative of the individual named above, I authorize any physician, hospital, clinic, medical practitioner, medical testing laboratory, pharmacy, pharmacy benefits manager, or other health care provider, health plan or insurance company (including AXA Equitable/MLOA/MONY; with respect to other AXA Equitable/ MLOA/MONY coverages) and the Medical Information Bureau to disclose to AXA Equitable/MLOA/MONY and its authorized representatives (collectively hereinafter the "Companies") any and all information, whether fact or opinion, they may have about any diagnosis, treatment, medication or drug history, and prognosis regarding physical or mental conditions of the individual listed above.

RE-DISCLOSURE OF HEALTH INFORMATION. I understand that any disclosure of information to the Companies for the purpose of determining eligibility for benefits 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 that the information obtained will be used by the Companies to determine eligibility for life insurance benefits and in connection with reinsurance. In addition, information may be disclosed when requested by a government agency; in connection with a legal or arbitration proceeding; or for other purposes as required or permitted by applicable laws.

COVERAGE CONDITIONS. I understand that the Companies are conditioning the possible payment of benefits on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in the denial of a claim for benefits.

DURATION. Unless otherwise revoked, I agree that this authorization will expire 24 months from the date below. I understand that I may revoke my authorization at any time. No termination or revocation shall affect (1) any action that the Companies have taken in reliance on this authorization or (2) any right granted by law to contest a claim under the policy or the policy items. If I choose to revoke any authorization, any claim made under the policy may be denied. My revocation must be submitted in writing to: Chief Underwriter, AXA Equitable Life Insurance Company/ MONY Life Insurance Company of America, 1290 Avenue of the Americas, New York, New York, 10104.

COPY OF AUTHORIZATIONS. I have a right to ask for and receive true copies of this Authorization Form and all other authorizations signed by me. I agree that reproduced copies will be as valid as the original.

x _____
 Signature of Authorized Personal Representative

x _____
 Print Name of Authorized Personal Representative

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

Dated at City, State _____ on _____