

**Application Part 2 To:**  AXA Equitable Life Insurance Company

AXA Life and Annuity Company

**PARAMEDICAL**

Reason for submission of this form:  New Policy  Policy Change  Reinstatement

1. a. Proposed Insured (Please Print) First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_  
 b. Height: \_\_\_ ft. \_\_\_ in. c. Weight: \_\_\_\_\_ lbs.  
 d. Birth Date: \_\_\_\_\_  
 e.  Male  Female

2. a. Name and address of personal physician (or medical facility used instead): (If none, so state) \_\_\_\_\_  
 b. Date and reason last consulted if within the last 5 years: \_\_\_\_\_  
 c. What treatment was given or recommended? (If none, so state) \_\_\_\_\_

(For all "Yes" answers to Questions 3-9, circle items that apply.)

3. Has Proposed Insured ever had or been treated for: **Yes No**
- a. Disease or disorder of eyes, ears, nose or throat?
  - b. Dizziness, fainting, convulsions; paralysis or stroke; psychiatric, psychological or emotional disturbance; mental or nervous disease or disorder?
  - c. Shortness of breath; blood spitting; bronchitis, asthma, emphysema, tuberculosis and other chronic respiratory disease or disorder?
  - d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disease or disorder of the heart or blood vessels?
  - e. Ulcer, hernia, colitis, intestinal bleeding; jaundice, hemorrhoids, or other disease or disorder of the stomach, intestines, liver or gallbladder?
  - f. Sugar, albumin, blood or pus in urine; stone or other disease or disorder of kidney or bladder?
  - g. Diabetes; cyst, tumor, or cancer; thyroid or glandular disorder; skin disease or disorder?
  - h. Neuritis, arthritis, gout, or disease or disorder of the muscles or bones, including the back, or joints?
  - i. Deformity, lameness or amputation?
  - j. Allergies; anemia; other blood or lymph disease or disorder?
  - k. Disorder of prostate, reproductive organs, breasts, menstruation or pregnancy?

4. Is Proposed Insured now under observation or taking treatment?

5. Has Proposed Insured, within the last 10 years, been:  
 a. Diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?    
 b. Treated by a member of the medical profession for AIDS or ARC?

6. Has Proposed Insured, within the last 10 years:  
 a. Used, except as legally prescribed by a physician, tranquilizers; barbiturates or other sedatives; marijuana, cocaine, hallucinogens or other mood-altering drugs; heroin, methadone or other narcotics; amphetamines or other stimulants; or any other illegal or controlled substances?    
 b. Received counseling or treatment regarding the use of alcohol or drugs?

7. Has Proposed Insured's weight changed by more than 10 pounds in the last 6 months?

8. Other than as stated in answers to Questions 2-6, has Proposed Insured, within the last 5 years: **Yes No**
- a. Consulted or been examined or treated by any physician or practitioner?
  - b. Had any illness, injury, or surgery?
  - c. Been a patient in or been examined or treated at a hospital, clinic, sanatorium, or other medical facility?
  - d. Had electrocardiogram, X-ray, other diagnostic test?
  - e. Been advised to have any diagnostic test, hospitalization, treatment or surgery which was not completed?
9. a. Has Proposed Insured, within the last 12 months:  
 (i) Smoked Cigarettes?    
 (ii) Used any other form of tobacco?    
 (Give full details)  
 b. Has Proposed Insured, within the last 5 years:  
 (i) Smoked Cigarettes?    
 (ii) Used any other form of tobacco?    
 (Give full details)

10. Family History	Age if Living	Cause of Death	Age at Death
Father			
Mother			
Brothers/Sisters			

DETAILS FOR "YES" ANSWERS. Include: i. Question Number. ii. Diagnosis and Treatment. iii. Results. iv. Dates and Duration. v. Names and Addresses of all attending physicians and medical facilities. (If additional space is needed, please attach a separate sheet, dated, signed and witnessed as below.)

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application for insurance or request for policy change or reinstatement, as the case may be. The Insurer may rely on them in acting on the application or making the policy change or reinstatement.

Dated at \_\_\_\_\_ on \_\_\_\_\_ **X** \_\_\_\_\_  
 City State Mo. Day Yr. Signature of Proposed Insured  
 Witness (Must be Examiner): \_\_\_\_\_

**PARAMEDICAL REPORT**  
**AXA Equitable Life Insurance Company**  
**AXA Life and Annuity Company**

11a. Height (Without shoes) \_\_\_\_\_ ft. \_\_\_\_\_ in.      11b. Weight (Clothed) \_\_\_\_\_ lbs.  
 11c. Chest \_\_ Full Inspiration \_\_\_\_\_ in.  
 11d. Chest \_\_ Forced Expiration \_\_\_\_\_ in.  
 11e. Abdomen at Umbilicus \_\_\_\_\_ in.

11f. Did you weigh?  Yes  No      11g. Did you measure?  Yes  No

12. Blood Pressure—Record 1st Reading. If Reading exceeds 140 systolic and/or 90 diastolic, obtain and record 2nd and 3rd Readings at 5 min. intervals.

	1st Reading	2nd Reading	3rd Reading
Systolic			
Diastolic—(5th phase)			

13. Pulse Rate \_\_\_\_\_ per min.

Is it regular?  Yes  No

If "No," describe \_\_\_\_\_  
 \_\_\_\_\_

14. Did you observe any physical defects (including scars, deformities, amputation, paralysis, sight or hearing impairment, etc.)?

Yes  No

If "Yes," describe \_\_\_\_\_  
 \_\_\_\_\_

15. Urinalysis

	Neg.	Pos.	Amt.
Protein	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood	<input type="checkbox"/>	<input type="checkbox"/>	_____

*In all cases, send specimen to the laboratory with completed identification slip.*

16. Is blood being sent to the laboratory?  Yes  No

I made the examination reported above

at \_\_\_\_\_ A.M. on \_\_\_\_\_  
Mo. Day Yr.

**X** \_\_\_\_\_ (Examiner's Signature)

\_\_\_\_\_ P.M.  
 at \_\_\_\_\_  
(No.) (Street) (City or Town) (State)

Name of Facility (STAMP or PRINT)		
No.	Street	
City	State	Zip Code

What proof (photo-proof preferred) of Applicant's identity did you review?  Driver's License  Other (Specify: \_\_\_\_\_)

Did this proof include a photograph?  Yes  No  
 Are you related to the Applicant or Financial Professional?  Yes  No

Name of Financial Professional \_\_\_\_\_

**IMPORTANT: This report is the property of AXA Equitable and must be mailed immediately to the Branch Operations Manager. It should not be given to any other person. Before mailing, please review entire report to make certain that every question is answered completely.**

# PARAMEDICAL FEE AUTHORIZATIONS

(To be detached only by AXA Equitable)

\_\_\_\_\_  
Name of Examination Facility (Print or Stamp)

\_\_\_\_\_  
Name of Person Examined (Print)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
City or Town                      State                      Zip Code

-   -       SSN      -         EIN  
 Examiner's Social Security No. or Employer's Tax Identification No.  
 whichever is applicable. (The fee cannot be paid without your Social Security  
 Number or Employer Identification Number, whichever is applicable. Your S.S.N. or  
 E.I.N. is required for tax reporting purposes under the Internal Revenue Code. If you do  
 not furnish this number, you may be subject to a fine imposed by the IRS.)

Insurance Examination (20)                      Fee \$ \_\_\_\_\_  
 If other tests were done, which were requested and  
 authorized by AXA Equitable, list below:  
 \_\_\_\_\_ Fee \$ \_\_\_\_\_  
 \_\_\_\_\_ Fee \$ \_\_\_\_\_  
 \_\_\_\_\_ Fee \$ \_\_\_\_\_

**AXA EQUITABLE WILL PAY UP TO \$40.00 FOR THIS EXAM. PLEASE INDICATE YOUR FEE ABOVE.**

AXA Equitable Use Only		Account	X	Code
LIC at		Individual Life		01
ASU at				
		Individual Health		03
		Individual Annuity		05
		Life Account (ELA)		06
APP #		Medical		07
	or	DI		08
Pol. #		Regular Group		10
		AXAL&A		20

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

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

**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 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 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 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.

The urine HIV test is a screening test and any positive test result should be confirmed by a blood test. Final underwriting action will not be taken on a positive urine HIV screening test. In the event of a positive urine HIV screening test, the Insurer will request a blood test for further HIV testing. A blood test may also be requested for certain other abnormalities in the urine.

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. No report of a positive urine HIV screening test will be made to the MIB, Inc. If the test results for blood HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific 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 HIV 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 blood 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 and/or Blood Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the collection of urine and/or withdrawal of blood from me by needle, the testing of that urine 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 Date State of Residence  
or Parent/Guardian

\_\_\_\_\_  
Witness