AXA Equitable Life Insurance Company MONY Life Insurance Company of America

SECTION C – MEDICAL INFORMATION QUESTIONNAIRE FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

This form is to be completed by the Proposed Insured regarding his/her health for underwriting purposes. The completion is optional if a full Paramedical or Medical Exam is required.

Best practice is to complete this form and answer all medical questions to enable the underwriter to promptly begin the underwriting process. Incomplete information may delay your application.

PROPOSED INSURED

Policy # (if known) _____

1. Name First _____ Middle _____ Last _____
2. Date of Birth _____ (mm/dd/yyyy)
3. Height _____ ft. _____ in. Weight _____ (lbs.)
4. Has the Proposed Insured's weight changed by more than 10 pounds in the last 6 months? ☐ Yes ☐ No
   If "Yes," Pounds Lost _____ Pounds Gained _____ Reason _____

PERSONAL PHYSICIAN

5. Does the Proposed Insured have a personal physician? ☐ Yes ☐ No
6. If "Yes," Physician Name or Name of Practice or Clinic _____
7. Street Address _____ City _____ State _____ Zip _____
8. Phone # _____
9. Date and reason last consulted if within the last 5 years
   a. Date (mm/dd/yyyy) _____
   b. Reason _____
10. What treatment was given or recommended? _____ ☐ None

FAMILY HISTORY

11.

Relationship	Age if Living	Age at Death	Cause of Death if Deceased
Father			
Mother			
Sibling			
Sibling			
Sibling			
Sibling			

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MEDICAL HISTORY

If you check "Yes," to any of the conditions on questions 12-18 please give details in the chart provided on page 3.
On questions 12 and 13 "check all that apply" and provide details.

12. Has the Proposed Insured ever been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for any of the following? ☐ Yes ☐ No

a. ☐ High Blood Pressure	h. ☐ Asthma/Bronchitis	o. ☐ Parkinson's Disease	u. ☐ Arthritis/Neuritis/Gout
b. ☐ Chest Pain	i. ☐ Emphysema	p. ☐ Alzheimer's Disease	v. ☐ Lupus
c. ☐ Heart Attack	j. ☐ Sleep Apnea	q. ☐ Memory Loss	w. ☐ Anemia
d. ☐ Heart Murmur	k. ☐ Eating Disorder	r. ☐ Colitis/Ulcer/Hernia	x. ☐ Paralysis
e. ☐ Diabetes	l. ☐ Stroke/TIA	s. ☐ Cirrhosis	y. ☐ Seizures
f. ☐ High Cholesterol	m. ☐ Depression/Anxiety	t. ☐ Hepatitis	z. ☐ Tuberculosis
g. ☐ Cancer/Tumor/Polyp/Cyst	n. ☐ Multiple Sclerosis		

13. Other than as indicated above, has the Proposed Insured ever been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession any disease or disorder of any of the following? ☐ Yes ☐ No

List the specific organ(s), system(s) and/or impairment(s) in the table if question contains multiple items.

a. ☐ Heart	g. ☐ Reproductive Organs/Breasts	m. ☐ Ears/Nose/Throat
b. ☐ Arteries/Veins	h. ☐ Brain/Nervous System	n. ☐ Lung/Respiratory System
c. ☐ Skin	i. ☐ Liver/Pancreas/Gall Bladder	o. ☐ Muscle/Bones/Joints
d. ☐ Blood	j. ☐ Emotional/Psychological Disorder	p. ☐ Lymph Nodes
e. ☐ Eyes	k. ☐ Immune System	q. ☐ Thyroid/Other Glands
f. ☐ Prostate	l. ☐ Gastrointestinal/Digestive System	r. ☐ Kidney/Bladder

14. Is the Proposed Insured now under medical observation or treatment for any reason not stated above? ☐ Yes ☐ No
15. In the last 10 years, has the Proposed Insured been diagnosed with, or treated for, Acquired Immune Deficiency Syndrome (AIDS) by a member of the medical profession? ☐ Yes ☐ No
16. Other than as stated in answers to Questions 12–15, has Proposed Insured, within the last 5 years:
    a. Been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for dizziness, fainting, shortness of breath, chronic headaches, chronic swelling, palpitation, blood spitting, intestinal bleeding, hemorrhoids, kidney stones, sugar, protein or blood in the urine? ☐ Yes ☐ No
    b. Consulted or been treated by a physician or practitioner, or treated at a hospital, clinic, or other medical facility for any reason? ☐ Yes ☐ No
    c. Been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for any illness, injury or surgery? ☐ Yes ☐ No
    d. Had electrocardiogram, x–ray, or other diagnostic test (including lab tests, but excluding any test related to HIV/AIDS)? ☐ Yes ☐ No
    e. Been advised by a member of the medical profession to have any diagnostic test, treatment or surgery (except as related to HIV/AIDS) which has not been completed? ☐ Yes ☐ No
17. Are there any medications (prescription or non-prescription) not listed in the details section of questions 12–16 that the Proposed Insured is currently taking? ☐ Yes ☐ No
18. In the last 10 years has Proposed Insured:
    a. Used, except as legally prescribed by a physician, marijuana, opiates, cocaine, crack, heroin, morphine, methadone, ecstasy, barbituates, sedatives, benzodiazepines, tranquilizers, amphetamines, methamphetamines, illegal stimulants, hallucinogens, LSD or PCP? ☐ Yes ☐ No
    b. Received counseling or treatment regarding the use of alcohol or drugs including attendance at meetings or membership in any self-help group or program such as Alcoholics Anonymous or Narcotics Anonymous? ☐ Yes ☐ No
19. a. Does the Proposed Insured currently consume alcoholic beverages? ☐ Yes ☐ No

    Type _____ Number of Drinks _____ per ☐ Day ☐ Week

    Type _____ Number of Drinks _____ per ☐ Day ☐ Week

    b. If "No," has the Proposed Insured ever consumed alcoholic beverages? ☐ Yes ☐ No

    c. If "Yes," please provide: Date Last Used _____ (mm/dd/yyyy)

    Reason stopped _____

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DETAILS

List details of all "Yes" answers on pages 1 and 2.

Question No./ Letter	Name, Address and Phone Number of Health Professional or facility consulted or seen (Include City & State)	Date of Diagnosis (mm/dd/yyyy) and Duration of Illness	Diagnosis/Treatment/Medication