Policy Number

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AXA Equitable Life Insurance Company*
For Assistance Call (866) 274-9887; Fax (469) 417-1973

DATE: ____________

Group Insurance Beneficiary Designation/Change

1. EMPLOYEE INFORMATION (please print)

Last Name	First Name	MI	Employee ID# (if applicable)	Marital Status (check one) Married ___Widow Single ___Divorced	Gender (check one) ___Male ___Female	Has this insurance been assigned? ___Yes___ No
Address	City	State	Zip Code	Daytime Phone	Home Phone	Date of Birth	Date of Hire	Date of Retirement (if applicable)

Unless otherwise indicated below this Beneficiary Designation/Change form applies to ALL coverages offered under my employer's group plan.
This form applies only to ___Basic Life ___Basic AD&D ___Supplemental/Voluntary Life ___Supplemental/Voluntary Life AD&D ___Dependent Life ___Dependent Life AD&D

2. BENEFICIARY DESIGNATION: I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies), if any in the event of my death, designate the following:

A. Primary Beneficiaries

Beneficiary Description	First Name	MI	Last Name	Address (include city, state, Zip)	Relationship	Date of Birth	SSN/Tax ID Number	Phone	% Share
__Individual __Other ______ __Trust __Corporation/Organization									
__Individual __Other ______ __Trust __Corporation/Organization									
__Individual __Other ______ __Trust __Corporation/Organization									
__Individual __Other ______ __Trust __Corporation/Organization									
							Total: (Must equal 100%)		

B. Contingent Beneficiaries

Beneficiary Description	First Name	MI	Last Name	Address (include city, state, Zip)	Relationship	Date of Birth	SSN/Tax ID Number	Phone	% Share
__Individual __Other ______ __Trust __Corporation/Organization									
__Individual __Other ______ __Trust __Corporation/Organization									
__Individual __Other ______ __Trust __Corporation/Organization									
__Individual __Other ______ __Trust __Corporation/Organization									
							Total: (Must equal 100%)		

3. TRUST DESIGNATION – COMPLETE IF A TRUST HAS BEEN NAMED AS A BENEFICIARY IN SECTION 2

Trustee's Name (First, MI, Last)	Address (Include city, state, zip)

And successor(s) in trust, as Trustee(s) under ______________ dated ______________ as amended and executed by me and said Trustee.

AXA is the brand name of AXA Equitable Financial Service, LLC and its family of companies, including AXA Equitable Life Insurance Company (NY,NY), MONY Life Insurance Company of America (AZ stock company, administrative office: Jersey City, NJ).

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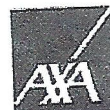
redefining / standards® 

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4. AUTHORIZATION/SIGNATURE I authorize my plan administrator to record and consider the individuals/institutions that I have named on this form as beneficiaries for benefits under the applicable employee benefit plans. If designating a trust as a beneficiary, I understand AXA assumes no obligation as to the validity or sufficiency of any executed Trust Agreement and does not pass on its legality in making payment to any Trustee(s). AXA has the right to assume that the Trustee(s) is acting in a fiduciary capacity until notice to the contrary is received by AXA at its Group Life Claim office. I agree that if AXA makes any payment(s) to the Trustee(s) before notice is received, AXA will not make payment(s) again.

Employee's Signature ______________________ Date Signed ______________________

The employee must sign and date this form. The signature date must be the date the employee actually signed the form.

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