CONFIDENTIAL COMMUNICATION REQUEST FORM

This form is for use by a person who is covered by health insurance and wishes to make a reasonable request to receive communications of insurance claim-related information from AXA Equitable Life Insurance Company by alternative means or at alternative locations if disclosing claim-related information could endanger the person.

SECTION A: Covered individual requesting confidential communication:

Name: ____ Member I.D.: ______________________

Birth Date: ____________________ Relationship to Primary Insured or Subscriber: ____________________

Current Address: ____

SECTION B: To the covered individual – please read the following and complete the information requested.

You have the right to make a reasonable request that you receive communications of claim-related information from us by alternative means or at alternative locations if disclosing the claim-related information could endanger you. "Claim-related information" means all claim or billing information relating specifically to you, including your name, address, any services received, and the name and address of the provider of any services (such as your doctor). Your request will remain in effect until you revoke the request.

I, the covered individual, request that AXA Equitable Life Insurance Company send communications of claim related information to me by the following alternative means or at the following alternative locations because disclosing the claim-related information could endanger me:

In care of: ____
(If you are using someone else's address, then enter his or her name here.)

Alternative Address: ____

Alternative Phone Number: __________________ Alternative Email Address: ___________________________

Signature: ________________________________ Date: _______________

SECTION C: Parents, Guardians, or Legal Representatives

If the covered individual is a child younger than 18-years-old and the person making this request is the child's parent or guardian, then please provide:

Parent or Guardian's Name: ______________________ Relationship to Covered Individual: __________________

If a legal representative, such as an attorney, is making this request on behalf of the covered individual, then please provide:

Legal Representative's Name: ____________________ Relationship to Covered Individual: __________________

Organization or Firm Name: ____

Business Address: ____

Business Phone Number: ________________________ Business E-mail Address: _________________________

Please mail the completed form to:	**Or fax to:**
AXA Equitable	
P.O. Box 10374	515-365-1520
Des Moines, Iowa 50306-0374	