



AXA EQUITABLE

AXA Equitable
Benefit Payment Services Group
PO Box 4993
Syracuse, NY 13221
(800) 245-1230

AB CLAIMANTS STATEMENT

IMPORTANT— SUBMIT REQUIREMENTS PROMPTLY

PLEASE PRINT OR TYPE

Claim is made by the undersigned for the benefits payable under the following contract(s). Each beneficiary must complete and sign a Claimants Statement. Photocopies of forms are permitted; however, original signatures are required in this section.

Contract Number: _____

1. Deceased's name in full _____ Date of Birth _____

2. Residence _____
STREET CITY OR TOWN COUNTY STATE

3. Date of death _____ Place of Death _____

4. Print your name _____

5. Telephone Number _____

6. State YOUR Date of Birth _____ Relationship to the Deceased _____

7. State whether you make claim as Beneficiary, Assignee or Otherwise _____

Please Read

Please check your state of residence on the list below:

- | | |
|---|--|
| <input type="checkbox"/> Alaska | <input type="checkbox"/> New Hampshire |
| <input type="checkbox"/> Arizona | <input type="checkbox"/> New Jersey |
| <input type="checkbox"/> Arkansas | <input type="checkbox"/> New Mexico |
| <input type="checkbox"/> California | <input type="checkbox"/> New York |
| <input type="checkbox"/> Colorado | <input type="checkbox"/> Ohio |
| <input type="checkbox"/> Delaware | <input type="checkbox"/> Oklahoma |
| <input type="checkbox"/> District of Columbia | <input type="checkbox"/> Oregon |
| <input type="checkbox"/> Florida | <input type="checkbox"/> Pennsylvania |
| <input type="checkbox"/> Idaho | <input type="checkbox"/> Puerto Rico |
| <input type="checkbox"/> Indiana | <input type="checkbox"/> Tennessee |
| <input type="checkbox"/> Kentucky | <input type="checkbox"/> Texas |
| <input type="checkbox"/> Louisiana | <input type="checkbox"/> Virginia |
| <input type="checkbox"/> Maine | <input type="checkbox"/> Washington |
| <input type="checkbox"/> Maryland | <input type="checkbox"/> West Virginia |
| <input type="checkbox"/> Minnesota | |
| <input type="checkbox"/> Other (please indicate): _____ | |

By signing below, I affirm that I have read the appropriate disclosure language found in the Special State Disclosures section, if any, for my state of residence and that I have provided my correct Taxpayer ID Number. If you are a New York State Resident do not sign here. Instead, please sign affidavit found on the following page for New York State Residents only.

Your Signature

Date

Special State Disclosures

The following states require us to notify you of the serious consequences of filing a false or fraudulent insurance claim. Please read this section carefully.

Alaska:

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona and California:

For your protection, Arizona and California law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Arkansas, District of Columbia, Louisiana, Maryland, Texas and West Virginia:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana and Oklahoma:

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Florida:

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky:

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota:

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire:

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey and New Mexico:

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

New York State Residents Only: Read & Sign Below

I have read and understand the New York State fraud warning. (Each beneficiary must complete and sign a Claim to Annuity Benefits Form. Photocopies of forms are permitted; however, original signatures are required in this section (for New York state residents).)

X

Beneficiary's Signature

Date

Ohio:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oregon:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement that is material to the interests of an insurer may be guilty of insurance fraud.

Pennsylvania:

Any person who knowingly and with intent to defraud any Insurance Company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

Special State Disclosures (continued)**Puerto Rico:**

Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

All Other States:

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may be subject to penalties, fines and imprisonment.

Under penalties of perjury, I certify that the number shown is my correct taxpayer identification number.

Under penalty of perjury, I certify that the information provided on this form is true, correct and complete. (Laws in your state may make it a crime to fill out an insurance or annuity application or claim form with information you know is false or leave out material facts).

Date _____

(Signature of Claimant — See 2 Below)

CLAIMANT'S SOCIAL SECURITY NUMBER
OR TAXPAYER IDENTIFICATION NUMBER

(STREET ADDRESS)

(CITY)

(STATE)

(ZIP CODE)

IMPORTANT NOTICE

Under the Federal Income Tax Law, you are subject to certain penalties as well as Backup Withholding tax at 20% of any taxable income you may receive, if you have not provided us with your correct Social Security Number or Taxpayer Identification Number.

INSTRUCTIONS AND CHECKLIST

1. Be sure the Claimant's complete address, including city and state, is shown and that it is legible.
2. If the Claimant's name differs from that shown in the Contract, explain on a separate statement or on the reverse side of this sheet.
3. When benefits are payable to a minor or to an Executor or Administrator of the Estate of the deceased, an official Court Certificate should be furnished, showing the Appointment and qualifications of the Legal Guardian for the minor, or the Executor or Administrator.
4. If the indicated beneficiary is deceased and the benefits become payable to another beneficiary, the surviving beneficiary may complete this Claimant's Statement, but proof of the death of the deceased beneficiary must be furnished by the surviving beneficiary in the form of an Affidavit, setting forth the date of the death.