Disability Management Services, Inc.

A third party administrator for:

AXA Equitable Life Insurance Company

1350 Main Street, Suite 1600 Springfield, MA 01103-1641 Tel: (413) 747-0990 or (800) 299-6921 Fax: (413) 747-1545

Claimant's Statement

COMPLETE THE FRONT AND THE BACK OF THIS FORM IN FULL AND RETURN IN THE ENVELOPE PROVIDED

1) NAME OF INSURED:		2) SOCIAL SECURITY NO.:
3) POLICY NUMBER(S):	4) DATE OF BIRTH:	5) RESIDENCE TELEPHONE NO.:
6) RESIDENCE (Street, Town/City, State, Zip): ☐ CHECK IF NEW ADDRESS.		
7) NATURE OF ILLNESS OR INJURY:		8) IF ILLNESS, WHEN DID SYMPTOMS FIRST APPEAR?
9) IF ACCIDENT, WORK-RELATED? ____ YES ____ NO	10) DESCRIBE WHEN AND WHERE AND HOW ACCIDENT HAPPENED: HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?	
11) EMPLOYER COMPANY NAME:		12) EMPLOYER TELEPHONE:
13) EMPLOYER ADDRESS:		14) MONTHLY EARNED INCOME: PRIOR TO DISABILITY? _____ CURRENT INCOME? _____
15) WHAT IS YOUR PERCENTAGE OF OWNERSHIP IN THIS BUSINESS?	16) IS THE BUSINESS: ____ SUB CHAPTER "S" CORPORATION ____ SOLE PROPRIETOR ____ PARTNERSHIP ____ "C" CORPORATION	
17) DOES YOUR EMPLOYER PAY ALL OR PART OF THE PREMIUMS FOR YOUR DISABILITY CONTRACT? ____ NO ____ YES IF YES, PERCENTAGE PAID BY THE EMPLOYER: _____%		
18) OCCUPATION:	19) BRIEFLY DESCRIBE YOUR OCCUPATIONAL DUTIES:	
20) DESCRIBE BRIEFLY HOW YOUR MEDICAL CONDITION HAS AFFECTED YOUR ABILITY TO WORK: HOURS WORKING PER WEEK:		
21) DATES OF TOTAL DISABILITY (Completely unable to work): FROM TO		22) DATES OF PARTIAL DISABILITY (Able to perform one or more duties): FROM TO
23) LAST DATE WORKED:		24) DATE YOU EXPECT TO RETURN TO WORK:

Please continue to complete this form on the reverse side.

25) DATE OF FIRST TREATMENT BY A PHYSICIAN FOR THIS CONDITION:			
26) NAME OF TREATING PHYSICIANS	PHYSICIAN'S ADDRESS	TELEPHONE	DATES TREATED. FROM: TO:
			FROM: TO:
			FROM: TO:
			FROM: TO:
			FROM: TO:
27) NAME OF ALL HOSPITALS	HOSPITAL'S ADDRESS	TELEPHONE	DATES CONFINED

28) LIST ALL OTHER COMPANIES WITH WHICH INSURED HAS DISABILITY OR MEDICAL COVERAGE COMPANY	POLICY NUMBER	*(IF NONE, SO STATE)* BENEFIT AMOUNT

29) ARE YOU RECEIVING SOCIAL SECURITY BENEFITS? DISABILITY ____ YES ____ NO RETIREMENT ____ YES ____ NO IF YES, EFFECTIVE DATE _____	30) IS A WORKERS' COMPENSATION OR STATE DISABILITY CLAIM BEING MADE? ____ YES ____ NO IF YES, PLEASE INDICATE CARRIER'S NAME AND ADDRESS

31) OTHER BENEFITS YOU ARE RECEIVING, OR EXPECT TO RECEIVE, INCLUDING SALARY CONTINUATION OR GROUP COVERAGE: (Please Explain)

For your protection, laws in certain jurisdictions require the following to appear on this form:

Any person who knowingly presents a false of fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

I have read the foregoing and above answers are true and complete to the best of my knowledge and belief.

X _____ _____

CLAIMANT SIGNATURE DATE

Disability Management Services, Inc.

A third party administrator for:

AXA Equitable Life Insurance Company

1350 Main Street, Suite 1600 Springfield, MA 01103-1641 Tel: (413) 747-0990 or (800) 299-6921 Fax: (413) 747-1545

Occupational Duties Form

THIS FORM SHOULD BE COMPLETED AS FULLY AS POSSIBLE WITH RESPECT TO YOUR NORMAL WORK:

☐ IMMEDIATELY PRIOR TO DISABILITY ☐ CURRENTLY

NAME OF INSURED	POLICY NUMBER	DATE OF BIRTH
ADDRESS	TELEPHONE NUMBER	SOCIAL SECURITY NUMBER
EMPLOYER NAME		EMPLOYER TELEPHONE NUMBER
EMPLOYER ADDRESS		
WHAT IS YOUR PERCENTAGE OF OWNERSHIP INTEREST IN THIS BUSINESS?	DO YOU ACTIVELY WORK, OR HAVE ANY OWNERSHIP INTEREST IN ANY OTHER BUSINESS? *(IF YES, PLEASE GIVE DETAILS)*	
NUMBER OF HOURS YOU NORMALLY WORK EACH WEEK:	USUAL DAILY HOURS: FROM TO	
NUMBER OF PEOPLE IN YOUR EMPLOY AND/OR UNDER YOUR SUPERVISION:	HOW MANY YEARS HAVE YOU WORKED FOR THIS EMPLOYER?	HOW MANY YEARS HAVE YOU WORKED IN THIS OCCUPATION?

OCCUPATIONAL DUTIES AND ACTIVITIES, LISTING MOST IMPORTANT FIRST AND PERCENTAGE OF TIME SPENT FOR EACH DUTY:

a) _____ ____%

b) _____ ____%

c) _____ ____%

d) _____ ____%

e) _____ ____%

DESCRIBE BRIEFLY WHICH OF THESE DUTIES YOU ARE CURRENTLY UNABLE TO PERFORM AS A RESULT OF YOUR DISABILITY, AND WHY:

Please continue to complete this form on the reverse side.

INSTRUMENTS, TOOLS, OR EQUIPMENT NORMALLY USED IN YOUR OCCUPATION:

a) _____

b) _____

c) _____

d) _____

e) _____

WHERE DO YOU WORK?

____ MOSTLY INDOORS ____ MOSTLY OUTDOORS ____ EQUALLY IN AND OUT

IF YOUR OCCUPATION NORMALLY REQUIRES TRAVEL OTHER THAN BETWEEN RESIDENCE AND PRINCIPAL PLACE OF BUSINESS, DESCRIBE THE USUAL FREQUENCY, DISTANCE, AND MODE OF TRANSPORTATION:

PHYSICAL AND MENTAL REQUIREMENTS OF YOUR OCCUPATION

(CHECK ONE OR MORE OF THE FOLLOWING WHICH BEST DESCRIBE THE PHYSICAL/MENTAL NEEDS REQUIRED BY YOUR OCCUPATION)

ACTIVITY	HOW OFTEN PERFORMED		
	OCCASIONALLY	FREQUENTLY	CONSTANTLY
BENDING			
REACHING			
LIFTING			
CARRYING			
SPEECH-EXPRESSING OR EXCHANGING IDEAS ORALLY			
HEARING-RECOGNIZING SOUNDS			
SIGHT-SHARPNESS OF NEAR VISION			
SIGHT-SHARPNESS OF FAR VISION			
EXACTING MANUAL DEXTERITY			
CAPACITY TO HANDLE STRESS			
PRODUCTION SALES QUOTAS			
TIME DEADLINES			
PERSONAL COMPETITION			

IF YOU CHECKED LIFTING OR CARRYING, PLEASE ANSWER:

WHAT IS THE MAXIMUM WEIGHT YOU LIFT OR CARRY? ___ 10 LBS ___ 25 LBS ___ 50 LBS ___ 100 LBS ___ OVER 100 LBS

WHAT IS THE MOST FREQUENT WEIGHT YOU LIFT OR CARRY? ___ 10 LBS ___ 25 LBS ___ 50 LBS ___ 100 LBS ___ OVER 100 LBS

PLEASE ADD ANY ADDITIONAL INFORMATION ABOUT YOUR JOB WHICH YOU BELIEVE WILL HELP US UNDERSTAND YOUR OCCUPATION:

For your protection, laws in certain jurisdictions require the following to appear on this form:

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

I have read the foregoing and above answers are true and complete to the best of my knowledge and belief.

X _____ _____

SIGNATURE DATE

Disability Management Services, Inc.

A third party administrator for:

AXA Equitable Life Insurance Company

1350 Main Street, Suite 1600 Springfield, MA 01103-1641 Tel: (413) 747-0990 or (800) 299-6921 Fax: (413) 747-1545

Attending Physician's Statement

TO BE COMPLETED BY THE INSURED

1) Insured's Name:	2) Policy Number(s):	3) Claim Number(s):
4) Residence Address:	5) Telephone Number: Home: Work:	6) Date of Birth:
AUTHORIZATION FOR RELEASE OF INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.	SIGNATURE (Patient, or parent if minor):	
	Relationship to insured:	

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

HISTORY

1) When did symptoms first appear,accident occur,or pregnancy commence (LM)?	
2) Has patient ever had same or similar condition? _____YES _____NO If "YES" state when and describe:	
3) Date patient ceased work because of disability:	4) Date patient first consulted with you for this condition:

PRESENT CONDITION

5) Diagnosis:
6) Subjective Symptoms:
7) Objective Findings: *(INCLUDE RESULTS OF CURRENT X-RAYS, E.K.G.'S OR ANY OTHER SPECIAL TESTS):*
8) Is patient still under your care for this condition? _____YES _____NO

TREATMENT

9) Dates of treatment:
10) FREQUENCY OF VISITS: ___WEEKLY ___BIWEEKLY ___MONTHLY ___OTHER: please describe.
11) Hospitalization: Dates: ___/___/___ - ___/___/___ Name of Hospital:_____ Outpatient __ Inpatient __ ER __ Dates: ___/___/___ - ___/___/___ Name of Hospital:_____ Outpatient __ Inpatient __ ER __ Dates: ___/___/___ - ___/___/___ Name of Hospital:_____ Outpatient __ Inpatient __ ER __

Please continue to complete this form on the reverse side.

EXTENT OF DISABILITY

12) Dates patient was continuously totally disabled (completely unable to work): From: ___/___/___ to ___/___/___
13) Dates patient was partially disabled (able to perform any part of his or her job): From: ___/___/___ to ___/___/___
14) When do you expect the patient to be able to return to work?

Additional Comments or Progress:

15)

MEDICAL CONDITION

16) Is this patient competent to manage his or her property unassisted, and to understand the nature and consequence of his or her action, including the ability to endorse checks and direct use of the proceeds? ____YES ____NO

17) Name of Attending Physician:	18) Degree(s):	19) Tax Identification Number:
20) Business Address:	21) Telephone Number:	
22) Physician's Signature:	23) Date:	

Disability Management Services, Inc.

A third party administrator for:

AXA Equitable Life Insurance Company

1350 Main Street, Suite 1600 Springfield, MA 01103-1641
Tel: (413) 747-0990 or (800) 299-6921 Fax:(413) 747-1545

Name of Insured:	Social Security Number:

Authorization To Obtain Information

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, employer, the Social Security Administration, consumer reporting agency, pharmacy benefit manager, or any other person or organization having any information, whether fact or opinion, regarding illness, injury, medical history, diagnosis, treatment, prescription history, and prognosis with respect to the past, present or future physical or mental condition and treatment, including drug and alcohol abuse treatment, of the insured and any other non-medical information of the insured to give AXA Equitable Life Insurance Company, or its authorized representative ("AXA Equitable") any and all such information required by them to determine my eligibility for policy claim benefits.

I authorize AXA Equitable, to request dates of past and present claims and names of insurers, but not medical or personal information, from the Health Claims Index operated for subscriber insurers by the Medical Information Bureau (MIB), and association of life insurance companies. I understand such information may be reported to MIB. MIB, upon request, may disclose such information about you in its file to: another member company with whom you apply for life or health insurance, or to whom you submit a claim for benefits; a governmental agency; a party to a legal or arbitration proceeding as required by law, or for other purposes as required or permitted by applicable law.

Use and Disclosure

I understand the information obtained by use of the Authorization will be used by AXA Equitable to determine eligibility for benefits under an insurance policy. Any information obtained will not be released by AXA Equitable, to any person or organization except to medical professionals who I or AXA Equitable have asked to assess my medical condition, reinsuring companies, third party administrators, claim consultants or other persons or organizations performing business or legal services in connection with this claim or as may be otherwise lawfully required or as I may further authorize.

I understand that information that I disclose to AXA Equitable for the purpose of determining my eligibility for coverage may be appropriately re-disclosed to third parties, as described above, and such third parties' subsequent disclosure of the information may not be limited by applicable state and/or federal privacy laws.

For your protection, laws in certain jurisdictions require the following to appear on this form:

I understand that any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Agreement and Acknowledgment

I know that I may request to receive a copy of this Authorization.
I agree that a photocopy of this Authorization shall be as valid as the original.
I agree that this Authorization shall be valid for the duration of my current claim or twenty-four (24) months, whichever is shorter, unless I revoke this Authorization in writing by sending a letter to the claims representative assigned to my claim. If I revoke this Authorization, I recognize that AXA Equitable may continue to consider any information that it has already obtained to evaluate my claim and may continue to gather additional information to the extent that this Authorization is not needed to gather such information. However, I understand that as a result of my revocation of this Authorization, AXA Equitable may be unable to gather sufficient proof to support my claim and therefore may not provide benefits.

Claimant's Signature:_____ **Date**:_____
(Claimant or claimant's authorized representative)

_____ _____
(Relationship to claimant if authorized representative) (Claimant's Social Security No.)