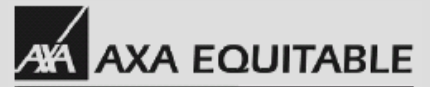


Momentum Series

Request for Distribution Form
Basic Service



PLEASE PRINT

1. Background Information

Participant's First Name, Middle Initial _____ Last Name _____ Social Security Number _____

Employer's Name _____ Contract ID Number _____

The participant is: Still Employed Terminated _____

Termination Date (mm/dd/yyyy) _____ Employer Contact Telephone Number _____

2. Type of Disbursement

This withdrawal is due to (check one):

Certain disbursements may result in a Contingent Withdrawal Charge being assessed against amounts withdrawn. Refer to the appropriate disclosure brochure or speak to your Employer for details.

Retirement

Death

Still employed, 100% vested and between age 59 ½ and Normal Retirement Age (*Profit Sharing Only*)

In-service Withdrawal

Separation from Service (*As described in Section 402(d)(4)(A) of the Code as in effect prior to the Tax Reform Act of 1996 "Same Desk" rule*)

Disability (*Disability as determined by the Plan Administrator on the basis of either (A) a written determination by the Social Security Administration that disability payments under the Social Security Act have been approved; or (B) other evidence satisfactory to the Plan Administrator of such condition.*)

Hardship (*The exact hardship withdrawal amount must be provided by Plan Administrator in conjunction with Plan rules.*) NOTE: This type of withdrawal cannot be rolled over to an IRA or other qualified plan.

3. Amount of Disbursement

The following withdrawal is requested (**check one**) : Please ensure that the final contribution for the Participant has been received by AXA Equitable prior to submitting a request for a total payout.

PAY OUT ALL ACCOUNTS. The Vesting Percentage indicated below will be applied to the respective contributions. Any unvested portion will be transferred to the plan's forfeiture account. All employee contributions are 100% vested. The following vesting percentages will be applied:

Employer Matching Contributions _____%

Employer Contributions _____%

Other Contributions _____% (E.g.: Direct Transfer from a Prior Pension Plan of the same employer.)

PARTIAL PAYMENT. Funds are withdrawn on a pro-rata basis from each Investment Option. Specify the contribution source(s) from which you wish to request your withdrawal (e.g., Salary Deferral, Employer Matching, etc.).

Indicate a dollar amount or write "total" on the amount line for that Investment Option. (If you need additional space, attach a separate sheet showing the following information.)

Source	Investment Option	Amount
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

4. Direct Rollover Information

The Participant elects to directly rollover assets: IRA Qualified Plan

Check Made payable To (Bank, Financial Institution, Trustees, etc.)

Account Number (if available)

Street Address of Above Payee (where check is to be mailed - Bank, Financial Institution, Trustees, etc.)

City

State

Zip Code

5. Statement of Understanding and Representations

We, the signatories of this Request for Distribution form, hereby certify and/or acknowledge that:

1. this distribution is being requested in accordance with the terms of the Plan;
2. the information contained in this form is complete and correct to the best of our knowledge;
3. the Plan Administrator has provided the Participant the Special Tax Notice Regarding Plan Payments explaining the federal income tax rules and options which apply to eligible rollover distributions, and acknowledge whether or not you are affirmatively electing to make a direct rollover;
4. if applicable, the Plan Administrator has provided the Participant and/or the Participant's spouse a notice of the right of the Participant and/or spouse to receive the benefits under the plan in the form of a Qualified Joint and Survivor Annuity or Qualified Pre-Retirement Survivor Annuity (in the case of the death of the Participant);
5. distribution checks for Participants will be mailed to the Employer unless you request a Rollover in which case the check is sent to the address provided above. It is the responsibility of the Employer to ensure that all addresses are correct and valid. State tax withholding is based on, as our records indicate, the state of the address of the Participant. It is the Employer's responsibility to ensure that the address to which the check will be mailed is the State residence of the payee;
6. there is a \$25.00 fee per check issued; and
7. AXA Equitable will not be held liable for the validity of this request and any tax or legal consequences that may occur to the Participant or beneficiary, the Plan Administrator, Plan Trustee(s) and Employer as a result of this distribution.
8. **All Other States Except Virginia:** 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. For your protection Arizona 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 subject to criminal and civil penalties.

Income Tax Withholding (to be completed by participant)

I understand that this distribution will be reported to the Internal Revenue Service and the state of my residence, if applicable, as taxable income as appropriate. The address on this form will determine my state of residence for state withholding purposes. I also understand that the distribution will be subject to income taxes, and that any distribution that is greater than \$200 is subject to 20% mandatory federal income tax withholding unless I rollover the distribution amount to another retirement account. I further understand that if I receive this distribution prior to age 59 1/2 the distribution may be subject to a 10% early withdrawal penalty.

I have read the "Special Tax Notice" provided to me by the Plan Administrator. I request payment from the Plan designated above as indicated.

By checking this box, I am indicating that I wish to waive the 30-day notice period in order for my distribution to be processed immediately.

X

Trustee/Authorized Individual for the Plan

Date

X

Signature of Participant

Date

FAILURE TO PROPERLY COMPLETE THIS FORM MAY RESULT IN A DELAY OF YOUR WITHDRAWAL

AXA EQUITABLE LIFE INSURANCE COMPANY

PO Box 8095, Boston, MA 02266-8095 - (800) 821-7777 - www.AXAonline.com.