

PHL Variable Insurance Company (Phoenix)

Regular Mail: PO Box 8027, Boston MA 02266-8027
Express Mail: 30 Dan Road, Suite 8027, Canton MA 02021-2809

Email: pnx.newbusiness@phoenixwm.com
Fax: 816-527-0053

**DO NOT complete if Proposed Insured has completed, or will complete, a phone interview.
For Phone Interview, Call 1-844-805-LIFE (5433).**

1. Proposed Insured				
First Name	Middle Name	Last Name	Gender	Date of Birth
			M <input type="checkbox"/> F <input type="checkbox"/>	

2. Medical Questions

Section A:	
1. Name of Physician / Health Care Provider:	Date of Last Visit: (mm/yyyy)
2. What is your current height and weight?	Height: ft. in. Weight: lbs.
3. In the past 12 months, have you used tobacco or nicotine in any form (excluding occasional cigar or pipe use)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. In the past 10 years, have you been diagnosed, treated, or been prescribed medication by a licensed member of the medical profession for:	
a. High blood pressure, high cholesterol, heart murmur, or irregular heart beat?	Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Angina (chest pain), heart attack, heart surgery (including bypass, angioplasty, or heart valve replacement), aneurysm, stroke, carotid disease, or peripheral vascular disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. In the past 5 years, have you been diagnosed, treated, or been prescribed medication by a licensed member of the medical profession for:	
a. Cancer of any type, tumor, malignancy, polyp, leukemia, multiple myeloma, swelling or lump?	Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Diabetes, or a disorder or a disease of the thyroid, pituitary, pancreas, or endocrine system?	Yes <input type="checkbox"/> No <input type="checkbox"/>
c. Asthma, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, pulmonary fibrosis, sleep apnea, disease or disorder of the lung or respiratory system?	Yes <input type="checkbox"/> No <input type="checkbox"/>
d. Anxiety, bipolar disorder, depression, or other mental or nervous disease or disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>
e. Anemia, bleeding or clotting disorder, other disease or disorder of the blood or lymphatic system?	Yes <input type="checkbox"/> No <input type="checkbox"/>
f. Convulsion, epilepsy, seizure, multiple sclerosis, Parkinson's disease, or disease or disorder of the brain or neurological system?	Yes <input type="checkbox"/> No <input type="checkbox"/>
g. Ulcer, colitis, crohn's disease, liver disease, hepatitis, pancreatitis, or gastrointestinal disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>
h. Blood, protein, albumin, or sugar in the urine, disease or disorder of the prostate, bladder, kidneys or genitourinary organs?	Yes <input type="checkbox"/> No <input type="checkbox"/>
i. Connective tissue disease, rheumatoid arthritis, psoriatic arthritis, paralysis, disorder of the back, neck or musculoskeletal?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Within the past 3 years, have you been unable to work at your regular job for more than 30 consecutive days, or perform the normal activities of like age and gender, or been confined at home, or are you currently unable to work at your regular job?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. In the past 3 years, have you been convicted of any misdemeanor, of two or more moving violations or driving under the influence of alcohol or drugs or had a driver's license suspended or revoked?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Continued on next page

Section B: Provide details to all "Yes" answers in Section A.

Question #	Medical Condition	Date Diagnosed

Section B continued: Provide details to all "Yes" answers in Section A.

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3. Signatures

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I, the Proposed Insured, attest that all answers and statements provided are full, complete and true as of this date.

Proposed Insured's Signature	State Signed In	Date (mm/dd/yyyy)
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I certify that the information provided by the Proposed Insured is accurately recorded on the application and I am not aware of any discrepancies or misrepresentation in the recorded information. I am qualified and authorized to discuss the contract herein applied for.

Producer's Signature	Date (mm/dd/yyyy)
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If the Part 2 was completed by a phone interview, the information collected is printed above.