PHOENIX®

Phoenix Safe Harbor Term Life Application for Individual Term Life Insurance Part 2

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

Name – First	Middle	Last	Gender	Date of Birth
			M ☐ F ☐	

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 2 years, have you used tobacco or nicotine in any form (excluding occasional cigar or pipe use)? Yes ☐ No ☐

If "Yes", please provide additional information:

Type:	Frequency:	Date Stopped

4. What medications are you currently taking? (Please list all medications below)

a. _____ b. _____ c. _____

d. _____ e. _____ f. _____

5. 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 ☐ No ☐

b. Angina (chest pain), heart attack, heart surgery (including bypass, angioplasty, or heart valve replacement), aneurysm, stroke, carotid disease, or peripheral vascular disease? Yes ☐ No ☐

6. 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 ☐ No ☐

b. Diabetes, or a disorder or a disease of the thyroid, pituitary, pancreas, or endocrine system? Yes ☐ No ☐

c. Asthma, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, pulmonary fibrosis, sleep apnea, disease or disorder of the lung or respiratory system? Yes ☐ No ☐

d. Anxiety, bipolar disorder, depression, or other mental or nervous disease or disorder? Yes ☐ No ☐

e. Anemia, bleeding or clotting disorder, other disease or disorder of the blood or lymphatic system? Yes ☐ No ☐

f. Convulsion, epilepsy, seizure, multiple sclerosis, Parkinson's disease, or disease or disorder of the brain or neurological system? Yes ☐ No ☐

g. Ulcer, colitis, crohn's disease, liver disease, hepatitis, pancreatitis, or gastrointestinal disease? Yes ☐ No ☐

h. Blood, protein, albumin, or sugar in the urine, disease or disorder of the prostate, bladder, kidneys or genitourinary organs? Yes ☐ No ☐

i. Connective tissue disease, rheumatoid arthritis, psoriatic arthritis, paralysis, disorder of the back, neck or musculoskeletal? Yes ☐ No ☐

7. 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 ☐ No ☐

8. 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 ☐ No ☐

9. In the past 2 years, have you flown in an aircraft as a pilot, student pilot or crew member, or plan such activity in the next 2 years? (If "Yes," complete Aviation Supplement Form) Yes ☐ No ☐

10. In the past 2 years, have you engaged in skydiving, motor vehicle racing, motor boat racing, mountain or rock climbing, cave exploration, base jumping, scuba diving, or ultra light flying, or do you plan such activity in the next 2 years? (If "Yes," complete Avocation Supplement Form) Yes ☐ No ☐

11. Has a parent or sibling been diagnosed or treated by a member of the medical profession for cancer, heart disease, stroke, Alzheimer's disease, polycystic kidney disease, Huntington's chorea prior to age 60? Yes ☐ No ☐

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.

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)

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)

If the Part 2 was completed by a phone interview, the information collected is printed above.