

PHL Variable Insurance Company (Phoenix)
Regular Mail: PO Box 8027, Boston MA 02266-8027

Email: pnx.newbusiness@phoenixwm.com

Express Mail: 30 Dan Road, Suite 8027, Canton MA 02021-2809

Fax: (816) 527-0053

Please print and use black ink. Any changes should be initialed by the Proposed Insured and Owner.

1. Proposed Insured							
First Name	Middle Name	Last Name	Gender	Date of Birth	SSN/Tax ID		
			M <input type="checkbox"/> F <input type="checkbox"/>				
Residence Street Address/Apt #		City	State	ZIP Code	Current/Former (if retired) Occupation		
Email Address		Preferred Phone	Driver's License/ID #	State or Country	Expiration Date		
U.S. Citizen Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If "No", please complete the questions below.</i>							
Permanent Resident Card Holder	If "Yes", Permanent Resident/Green Card No.	Issue Date	Expiration Date	Country of Birth	Country of Citizenship	Years in U. S.	
Yes <input type="checkbox"/> No <input type="checkbox"/>		If "No", do not proceed.					

2. Coverage Applied For							
Face Amount	Level Term Period			Accidental DB (Optional)			
\$	10 year <input type="checkbox"/>	15 year <input type="checkbox"/>	20 year <input type="checkbox"/>	30 year <input type="checkbox"/>	\$		
Amount Paid or Amount For Initial Draft				Pay Mode (If Monthly Bank Draft complete Section 8)			
\$				Monthly Bank Draft <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual <input type="checkbox"/> Quarterly <input type="checkbox"/>			

3. Screening Questions	
IF ANY OF THE FOLLOWING ARE ANSWERED "YES" THE APPLICATION SHOULD NOT BE COMPLETED OR SUBMITTED	
1. Do you require the assistance of another person in performing activities of daily living, such as bathing, dressing, toileting, eating, or taking medications?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Are you currently hospitalized, confined to a nursing facility or receiving hospice care, or using oxygen equipment to assist in breathing?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Have you been diagnosed by a licensed member of the medical profession as having a terminal illness or life expectancy of 12 months or less?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Have you ever been diagnosed, treated, or prescribed medication by a licensed member of the medical profession for:	
a. Acquired Immune Deficiency Syndrome (AIDS), or any immune deficiency related disorder or tested positive for Human Immunodeficiency Virus (AIDS Virus)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Alzheimer's, dementia, Lou Gehrig's disease (ALS), Huntington's Disease, leukemia, multiple myeloma, congestive heart failure (CHF), or cardiomyopathy, or non-Hodgkin's lymphoma?	Yes <input type="checkbox"/> No <input type="checkbox"/>
c. More than one occurrence or metastasis (spreading) of cancer (excluding basal cell or squamous cell skin cancer)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. In the past 2 years, have you been diagnosed, treated, or prescribed medication by a licensed member of the medical profession for insulin shock, diabetic coma, amputation, eye, or kidney problems due to complications from diabetes?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. In the past 5, years have you received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. In the past 5 years have you been convicted or pled guilty to any felony, or are you currently on probation or parole?	Yes <input type="checkbox"/> No <input type="checkbox"/>

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8. Are you currently involved in a bankruptcy that has <i>not yet been discharged</i> ?	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Are you on active duty in the military or reserves and have you received notice of deployment or are you currently deployed in a hazardous area or war zone territory?	Yes <input type="checkbox"/> No <input type="checkbox"/>

4. Ownership (Complete ONLY if other than the Proposed Insured)
Note: If the owner is a trust, complete the Certification of Trust

First Name	Middle Name	Last Name	SSN/Tax ID	Date of Birth		
Residence Street Address/Apt #		City	State	ZIP Code	Phone Number	
Current/Former (if retired) Occupation	Relationship to Proposed Insured	Email Address		Trust Name (if applicable)		
U.S. Citizen Yes <input type="checkbox"/> No <input type="checkbox"/> If "No", please complete the questions below.						
Permanent Resident Card Holder	If "Yes", Permanent Resident/Green Card No.	Issue Date	Expiration Date	Country of Birth	Country of Citizenship	Years in U. S.
Yes <input type="checkbox"/> No <input type="checkbox"/>	If "No", do not proceed.					

5. Policy Beneficiary Designation
Note: If there are additional Beneficiaries to be named, or if the beneficiary is a trust, use the Additional Policy Beneficiary form. Only the Owner has the right to change beneficiaries.

1.	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	First Name	Middle Name	Last Name	Date of Birth	% Share
Relationship to Proposed Insured		Country of Residence (if outside U.S.)		SSN/Tax ID		_____
2.	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	First Name	Middle Name	Last Name	Date of Birth	% Share
Relationship to Proposed Insured		Country of Residence (if outside U.S.)		SSN/Tax ID		_____
3.	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	First Name	Middle Name	Last Name	Date of Birth	% Share
Relationship to Proposed Insured		Country of Residence (if outside U.S.)		SSN/Tax ID		_____
4.	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	First Name	Middle Name	Last Name	Date of Birth	% Share
Relationship to Proposed Insured		Country of Residence (if outside U.S.)		SSN/Tax ID		_____

9. Insurance History

1. Do you plan to replace any existing insurance or utilize values from any existing life insurance policy or annuity (through loans, surrenders or otherwise) to pay the initial premium for this policy? (If "Yes", complete appropriate replacement form)	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Are there any life insurance policies or annuity contracts owned by, or on the life of, the applicant, or the insured, or the owner, or the annuitant? (If "Yes", complete appropriate replacement form)	Yes <input type="checkbox"/> No <input type="checkbox"/>

10. Authorization to Obtain Information

"Affiliates" means reinsurers, insurance agents and agencies and those performing services in relation to an application for insurance, insurance product or benefit claim. For purposes of assessing insurance coverage eligibility, coverage continuation and/or benefit claim, I, the Proposed Insured, authorize Phoenix and its affiliates to obtain information, including previously restricted information, about me from any: physician, medical practitioner, hospital, clinic, or medical facility; employer; benefit plan; other insurer or institution; consumer reporting agency; public records; pharmacy, pharmacy benefits manager, or other pharmacy related services organization; or MIB, Inc. This includes records or other information as to past, current, or future: diagnosis, treatment and prognosis of a physical or mental condition; drug, physical and mental health, and alcohol-related information that may be protected by federal or state laws and regulations. I, the Proposed Insured, authorize Phoenix and its affiliates to make a brief report of my personal and/or protected health information to MIB, Inc. Information may be disclosed: between and among Phoenix and its affiliates; companies that I have applied or may apply to for life or health insurance, or benefits; as required or permitted by law. Obtained or disclosed information may no longer be protected by federal privacy laws. This authorization's time limit complies with the time limit, if any, permitted by applicable law in the state of where the policy is delivered or issued for delivery. A copy of this authorization shall be as valid as the original. This authorization may be revoked at any time by written notice to Phoenix, except that action(s) taken before receipt of notice will not be affected. A copy of this authorization will be provided upon request. I have been provided the Notice of Information Practices.

11. Signature

As the Proposed Insured and / or the Owner, if other than the Proposed Insured, ("I"), understand that the Application for life insurance consists of two parts, a Part 1 and Part 2. All statements made in the Application are full, complete and true to the best of my knowledge and belief. I understand that Phoenix will rely upon the information provided in the Application and that the statements and answers made therein are the basis for any policy issued by Phoenix, and that no information about them will be considered to have been given to Phoenix unless it is stated in the application. Before issuing an insurance policy, Phoenix may require and obtain information about me to validate my identity.

I understand that 1) no statements made to or information acquired by any Licensed Producer who takes this Application shall bind Phoenix unless stated in this Application, and 2) no Licensed Producer has authority to make, modify, alter or discharge any contract hereby applied for, and 3) if there is any change in health or personal history that would alter the answers to any of the questions in the Application between now and when the policy is delivered, I will inform Phoenix in writing as soon as possible at PO Box 8027, Boston, MA 02266-8027.

I understand and agree that the insurance applied for shall not take effect unless each of the following has occurred: 1) the policy has been issued by Phoenix; 2) the premium required for issuance of the policy has been paid in full; 3) the Insured is alive when the premium is paid and when the policy is delivered; 4) all representations made in the Application remain full, complete and true as of the date the policy is delivered; 5) a policy is issued on this application and delivered to and accepted by the owner; and 6) any required forms or amendments to the Application are signed and returned to Phoenix.

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 confirm that I have received a copy of the Accelerated Death Benefit Rider disclosure form.

Proposed Insured's Signature	State Signed In	Date (mm/dd/yyyy)
Owner's Signature (Only if Owner is other than the Proposed Insured)	State Signed In	Date (mm/dd/yyyy)

If the Part 1 was completed by a phone interview, the information collected is printed above.

