PHOENIX®

# Phoenix Safe Harbor Term Life
# Application for Individual Term Life Insurance
## Part 1

**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

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 ☐ F ☐ | | |

| 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 ☐ No ☐ ***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 ☐ No ☐ | If "No", do not proceed. | | | | | |

## 2. Coverage Applied For

| Face Amount | Level Term Period | Band | Accidental DB (Optional) |
|---|---|---|---|
| $ | 10 year ☐ 15 year ☐ 20 year ☐ 30 year ☐ | High ☐ Low ☐ | $ |

| Amount Paid or Amount For Initial Draft | Pay Mode (If Monthly Bank Draft complete Section 8) |
|---|---|
| $ | Monthly Bank Draft ☐ Semi-Annual ☐ Annual ☐ Quarterly ☐ |

## 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 ☐ No ☐ |
| 2. Are you currently hospitalized, confined to a nursing facility or receiving hospice care, or using oxygen equipment to assist in breathing? | Yes ☐ No ☐ |
| 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 ☐ No ☐ |
| 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 ☐ No ☐ |
| 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 ☐ No ☐ |
| c. More than one occurrence or metastasis (spreading) of cancer (excluding basal cell or squamous cell skin cancer)? | Yes ☐ No ☐ |
| 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 ☐ No ☐ |
| 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 ☐ No ☐ |
| 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 ☐ No ☐ |

Continued on next page

| | |
|---|---|
| 8. Are you currently involved in a bankruptcy that has *not yet been discharged?* | Yes ☐ No ☐ |
| 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 ☐ No ☐ |

**All applicants must answer additional underwriting questions. Please select one of the following:**

☐ 1. I will complete a telephone interview at point of sale. Call 1-844-805-LIFE (5433)
☐ 2. I will complete and submit a Part 2 of this application.
☐ 3. Please contact me for a telephone interview at the number indicated in Section 1. Best time to call: _____

## 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 ☐ No ☐ ***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 ☐ No ☐ | _____ 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.** ☐ **Primary** ☐ **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.** ☐ **Primary** ☐ **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.** ☐ **Primary** ☐ **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.** ☐ **Primary** ☐ **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 | | |

## 6. Premium Payor Information (Complete ONLY if premium is paid by someone other than Owner)

| First Name | Middle Name | Last Name | SSN/Tax ID | | |
|---|---|---|---|---|---|
| Residence Street Address/Apt # | | City | State | ZIP Code | Phone Number |
| Relationship to Proposed Insured/Owner | | | | | |

The USA PATRIOT Act requires insurance companies to obtain all relevant customer-related information necessary to establish an effective anti-money laundering program. In accordance with the USA PATRIOT ACT and the Company's anti-money laundering program, the Company will ask individuals for identifying information including their name, address, date of birth, and a driver's license or other government issued identification that will allow us to verify their identity. For certain entities, such as trusts, estates, corporations, partnerships, or other organizations, identifying documentation is also required. For both individuals and legal entities, the Company may include the use of third party sources to verify the information provided.

## 7. Secondary Addressee (Complete ONLY if designating another person to receive notification of possible lapse in coverage)

| First Name | Middle Name | Last Name | Relationship to Owner | |
|---|---|---|---|---|
| Residence Street Address/Apt # | | City | State | ZIP Code |

## 8. Bank Draft Authorization (Complete ONLY if Bank Draft is requested)

*Please attach a voided check OR provide the banking information below.*

**Electronic Funds Transfer:** ☐ Checking ☐ Savings

Routing Number: ☐☐☐☐☐☐☐☐☐ 9 positions in Routing Number

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Can have up to 17 positions in Account Number

Name of Financial Institution: _____

☐ Draft my initial premium on the issue date of my policy and draft subsequent premiums approximately every 30 days thereafter.

☐ Draft my initial premium on the issue date of my policy. Draft my ***SUBSEQUENT*** premiums on _____ of each month (if this option is selected you may select any date between the 1st and the 28th of the month).

**Authorization Agreement for Preauthorized Payments**

I, the bank account owner, authorize Phoenix to initiate Electronic Funds Transfers (EFT) for the above named bank and bank account in an amount no greater than the scheduled premium indicated on the application. I understand that I must contact you at least three business days before a scheduled withdrawal to change or cancel this authorization. I understand that for the initial draft, multiple payments may be withdrawn when the EFT date selected is after the contract date. I understand that Phoenix will only consider a premium paid if the EFT is honored by my bank. I further understand that if the account has insufficient funds to pay the premium or if the EFT cannot be successfully made, for any reason, the policy may lapse. I understand that any bank fees are my responsibility.

| Bank Account Owner Name – First | Middle | Last |
|---|---|---|
| Bank Account Owner Signature | | Date (mm/dd/yyyy) |

## 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 ☐ No ☐ |
| 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 ☐ No ☐ |

## 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 is valid for two years from the date of this application. 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. 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; and 5) 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.**

## 12. Producer Certification

| | |
|---|---|
| 1. Will this policy 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? | Yes ☐ No ☐ |
| 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? | Yes ☐ No ☐ |
| 3. If applicable, was the customer given the state required replacement disclosures? | Yes ☐ No ☐ |
| 4. Was a copy of the Buyer's Guide provided to the owner at the time of sale? **Note:** The states of GA, ME, NH, WA and WI require a Buyer's Guide be given at the time of application. | Yes ☐ No ☐ |
| 5. Was a copy of the Accelerated Death Benefit Rider disclosure form provided to the owner? | Yes ☐ No ☐ |
| 6. Is the Owner/Insured an active duty service member of the United States Armed Forces, including Reserves? If "Yes", I have provided the Military Disclosure form to my client. | Yes ☐ No ☐ |

7. Select a policy delivery method: ☐ Deliver to the Owner
☐ Deliver to Producer for delivery to Owner

## Please certify one of the following:

☐ I certify that I personally met with the Proposed Insured and reviewed the identification documents. To the best of my knowledge, it accurately reflects the identity of the Proposed Insured.

☐ I was unable to personally review the identification documents for the reason stated below. I certify that, to the best of my knowledge, the information provided by the Proposed Insured is true and accurate.

Reason for not reviewing documents: ☐ Application was completed via phone
☐ Other _____

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. I agree that no person other than the undersigned shall profit by any commission on insurance issued on this application. Commission will be paid as described according to contracts on file at the Home Office.

| Producer Name – First | Middle | Last | Producer Phone # | Producer I.D. # | % Split |
|---|---|---|---|---|---|
| | | | | | |

| Producer Signature | Date (mm/dd/yyyy) |
|---|---|
| | |

| Producer Address | Producer Email |
|---|---|
| | |

| Second Producer – First | Middle | Last | Producer I.D. # | % Split |
|---|---|---|---|---|
| | | | | |

| Second Producer Signature | Date (mm/dd/yyyy) |
|---|---|
| | |

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# 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.**

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# HIPAA Authorization to Release Medical Information

**Phoenix Life Insurance Company (Phoenix)**
**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

## THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

| Name of Insured | Insured Date of Birth |
|---|---|
| | |

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to Phoenix Life Insurance Company (Phoenix) or its subsidiaries, its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. I authorize any of the sources listed above having any knowledge of my genetic information to provide any such information to Phoenix and its affiliated insurers or its reinsurers.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Phoenix may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage including riders, features, changes and reinstatements; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Phoenix.

This authorization shall remain in force for 30 months (24 months in Alaska, Colorado, Florida, Iowa, Kansas, Kentucky, Montana, New Hampshire, New York, North Dakota, Oklahoma, Texas, West Virginia and Wyoming) following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Phoenix at One American Row, Hartford, CT 06103-2899, Attention: Chief Privacy Officer. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Phoenix has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal HIPAA rules governing privacy and confidentiality of health information. Phoenix maintains full compliance with applicable federal and state privacy rules. A copy of the Phoenix privacy policy is available upon request.

I understand that if I refuse to sign this authorization to release my complete medical record, Phoenix may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

| Signature of Insured or Authorizing Party | Date of Signature |
|---|---|
| | |

**Description of Authority** (if signed by an individual's personal representative or the parent of unemancipated minor)

Please return this original copy to Company

PHOENIX®

Phoenix Life Insurance Company (Phoenix)
PHL Variable Insurance Company (Phoenix)
PO Box 8027, Boston MA 02266-8027

# Phoenix Safe Harbor Term Accelerated Death Benefit Rider Disclosure for Terminal Illness, Chronic Illness and Critical Illness Riders

**Note: Terminal, Chronic and Critical riders have not been approved in CA. Critical rider has not been approved in CT.**

This summary of coverage briefly highlights some of the major provisions of each Accelerated Death Benefit Rider. The details of the rights and obligations of all parties under each Rider as well as any limitations or restrictions are set forth in the Rider documents.

**Note:**
- **Please check your Policy and the Riders for detail and benefit requirements for each Accelerated Death Benefit Rider. All Riders may not be available with your Policy.**
- **Payment of an Accelerated Death Benefit may be subject to federal or state income tax. A tax advisor should be consulted regarding possible tax consequences prior to request for an Accelerated Death Benefit.**

## READ YOUR RIDER(s) CAREFULLY.

**Rider Descriptions:** The request for a benefit under any of the Riders below must be in writing signed by the Owner. If one of the three Riders is exercised, this may impact the later ability to exercise another Rider. All Rider Payments are made in a lump sum to the Owner.

**A. Accelerated Death Benefit Rider - Terminal Illness:** This Rider allows the Owner to receive payment of a portion of the death benefits under the policy upon terminal illness of the Insured. The Owner must provide written evidence from a licensed Physician that the Insured has an illness or condition that is expected to result in the Insured's death within twelve months.

**B. Accelerated Death Benefit Rider - Chronic Illness:** This Rider allows the Owner to receive payment of a portion of the death benefits under the policy upon chronic illness of the Insured. The Owner must provide written evidence from a licensed Physician that the Insured has been certified as; (1) Being unable to perform at least two activities of daily living for at least 90 days, as defined in the Rider, or (2) Requiring substantial supervision due to severe cognitive impairment for at least 90 days, as defined in the Rider.

**C. Accelerated Death Benefit Rider - Critical Illness:** This Rider allows the Owner to receive payment of a portion of the death benefits under the policy upon the Insured experiencing a covered Qualifying Event. The Owner must provide written evidence from a licensed Physician of the Insured's Qualifying Event. Election of a benefit must be made within 365 days following the occurrence of the qualifying event. The Qualifying Events covered under this Rider are:

1. **Heart attack (myocardial infarction):** The death of a portion of the heart muscle resulting from inadequate blood supply. Heart attack does not include angina or the chance finding of electrocardiographic (EKG) changes indicative of a previous Heart Attack. The diagnosis of heart attack must be based on the presence of all of the following:
   a. Chest pain and/or dyspnea (shortness of breath);
   b. Associated new EKG changes which support the diagnosis; and
   c. Elevation of cardiac (heart) biomarker levels which support the diagnosis.
2. **Stroke:** A cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism, or thrombosis lasting more than 24 hours and producing measurable neurological deficit which persists for at least 30 consecutive days following the occurrence of the Stroke. Stroke does not include transient ischemic attacks.
3. **Diagnosis of Cancer:** A disease manifested by the presence of one or more malignant tumors and characterized by the uncontrolled growth and spread of malignant cells and the invasion of normal tissue. Cancer does not include:
   a. Any skin cancer, except invasive malignant melanoma into the dermis or deeper;
   b. Pre-malignant lesions, benign tumors, or polyps; or
   c. Carcinoma in-situ.
4. **Diagnosis of End Stage Renal Failure:** End Stage Renal Failure means an irreversible and total failure of both kidneys which requires the undergoing of renal transplantation or regular renal dialysis.
5. **Major Organ Transplant:** The receipt by transplant of any of the following organs or tissues: heart, lungs, liver, kidney, pancreas, or bone marrow.
6. **Diagnosis of ALS (Amyotrophic Lateral Sclerosis)**.

**Premium Charge:** There are no separate premium charges for the Accelerated Death Benefit Riders.

**Administrative Charge:** There is an administrative charge for each exercise of any Rider. This is due at the time of benefit payment. The amount of this charge is specified in each Rider.

**Leave with Applicant**

**Amount of Accelerated Death Benefit Payment:** The request for a benefit under the Rider must specify the amount of the Policy Death Benefit to be accelerated, subject to the terms in the Rider. The actual payment will be a discounted value of the accelerated death benefit minus administrative fees. The discounted value, calculated at the time of claim, will take into account the medical condition of the Insured, required future premiums under the base policy, and the applicable interest rate at the time of claim. If future premiums are expected to increase significantly, this could further lower the actual payment.

## Additional Information:

- Accelerated Death Benefits are paid as a lump sum.
- In the event that the Insured dies after a written request for an Accelerated Death Benefit is submitted but before payment is made and we receive written notice at our home office of this death, the request for an Accelerated Death Benefit will be considered void and no benefit will be paid under the Rider.
- Once an Accelerated Death Benefit has been paid, the election to request such Accelerated Death Benefit cannot be revoked.
- Consent of an assignee or irrevocable policy beneficiary may be required.

**Effect on Policy:** After payment of an Accelerated Death Benefit, the Policy Face Amount will be reduced on a proportional basis. Base policy premiums payable will also be reduced accordingly. There will be no reduction in the annual policy fee. Each Rider has specific exercise limitations. **Please see specific Rider terms for details.**

**Government Benefit Eligibility:** You should note that the actual or constructive receipt of payment under the rider may adversely affect your eligibility for Medicaid, Supplemental Security Income, or other government benefits or entitlements. Exercising the option to accelerate benefits and receiving those benefits before application for these programs, or while benefits are being received, may affect initial or continued eligibility; an elder law or elder care advisor should be consulted.

## Accelerated Benefit Rider Numerical Example

NOTE: The following hypothetical example bears NO necessary relationship to your actual policy. It is provided for illustrative purposes ONLY.

### Before Your Benefit Request

At the time of benefit election, your policy has the following values

- Base Policy Face Amount / Death Benefit . . . . . $125,000
- Annual Base Policy premium (before Policy Fee) . . . . . $1,000
- Annual Policy Fee . . . . . $100

### Amount of Benefit Payment*

The following are some hypothetical payments based on a few different scenarios. Depending on your particular situation (medical condition, premium schedule, age, gender, risk class), the amount of payment may vary considerably. Scenario 1 assumes a Terminal Illness with a life expectancy of one year or less, Scenario 2 assumes a Critical or Chronic Illness with a 50% reduction in future life expectancy and your policy has 18 years until the end of the level term period, and Scenario 3 assumes a Critical or Chronic Illness with a 50% reduction in future life expectancy and your policy has 9 years until the end of the level term period.

| | Scenario 1 | Scenario 2 | Scenario 3 |
|---|---|---|---|
| • Benefit Request (e.g. 60% of the Eligible Amount) | $75,000 | $75,000 | $75,000 |
| • Amount of Benefit Payment | $69,244 | $31,198 | $19,909 |

### After Benefit Payment

After payment is made under the Accelerated Benefit Rider, your policy has the following values;

- Base Policy Death Benefit . . . . . $50,000
- Annual Policy premium . . . . . $400
- Annual Policy Fee** . . . . . $100

*Based on a male age 65 standard non-tobacco class. Hypothetical values are based on interest rate and mortality rates. Actual payout under these riders may be different.

**No reduction in Annual Policy Fee after deduction.

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# Notice of Information Practices

## Our Commitment

We thank you for choosing Phoenix for you financial needs and for entrusting us with your personal information. Maintaining the highest standards to protect the confidentiality of your personal information is our commitment to you.

In order to complete the underwriting process, we need to collect some personal information about you. We gather different types of information on you depending on the type of product and the amount of risk. Our goal is to provide life insurance at the lowest cost while taking into account the degree of risk involved. By paying careful attention to factors that affect the likelihood of a claim, we are able to assure our policyholders, insurance regulators, and rating agencies that we will be able to meet our obligations to pay claims when they become due.

We recognize that protecting the privacy of your confidential personal information is an important responsibility and understand the need to safeguard information you have disclosed to Phoenix. We hope the following information will help you understand our privacy policy and how we handle and maintain confidential information to fulfill our obligations to protect your privacy.

## Sources of Information

Your application is our primary source of information. We may contact you by telephone or by mail to obtain or clarify information. With your authorization, we may obtain medical information from doctors or other medical providers or facilities that you have used, and we may obtain a physical examination as well as blood, urine or other medical tests. We also need information about your finances, occupation, participation in hazardous activities, and other insurance coverage in place or applied for. In addition to medical providers, we may obtain information from other insurance companies, public records, pharmaceutical databases, pharmacy benefit managers, your attorney, accountant, business associates, friends, neighbors, associates, consumer reporting agencies or MIB, Inc. (see Medical Information Bureau, below).

## Investigative Consumer Reports

In some cases, we may request an independent reporting agency to prepare an investigative consumer report which contains information related to your personal characteristics, finances, general reputation, character, and mode of living. Information is obtained primarily through personal interviews with friends, neighbors or associates. You have the right to be interviewed in connection with the preparation of such a report. Upon written request, a complete disclosure of the nature and scope of such a report, if one is made, will be provided as well as the name, address and phone number of the reporting agency so that you may request a copy of the report. If the information in a consumer report leads us to not approve your application or to charge an extra premium we will notify you and provide the reporting agency's name, address and phone number. You should be aware that when an independent consumer reporting agency prepares such a report, they may keep it and disclose it to other companies upon request.

## Medical Information Bureau

Information regarding your insurability will be treated as confidential. Phoenix, or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not for profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

If you have questions or you wish to have a more detailed explanation of our information practices, please contact your producer or write Phoenix directly. Write to: Phoenix, Chief Underwriter, PO Box 8027, Boston, MA 02266-8027.

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# Notice and Consent for HIV-Related Testing

To evaluate your insurability, the Insurer named above (Phoenix Life Insurance Company and its subsidiaries) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

### Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

### Meaning of Positive Test Results

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

### Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

## Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result: _____

Address: _____

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

### Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

| | |
|---|---|
| _____ | _____ |
| Name of Proposed Insured | Signature of Proposed Insured or Parent/Guardian |
| _____ | _____ |
| Address | Date Signed |

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**PHL Variable Insurance Company**
**Phoenix Life and Annuity Company**
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Boston MA 02266-8027

# Sales Material List

❑ I certify that I only used insurer-approved sales material and that copies of all sales material, including presentations done electronically, were left with the applicant.

List form number(s) for all sales material used.

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

_____ _____
Print Client's Name Plan of Insurance

_____ _____
Agent's Signature Date

**Additional Comments**

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# Important Notice Replacement of Life Insurance or Annuities

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ YES ☐ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ YES ☐ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the contract number if available) and whether each policy will be replaced or used as a source of financing:

| Insurer Name | Contract or Policy # | Insured or Annuitant | Replaced (R) or Financing (F) |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. (If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.) Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____

Applicant's Name (Print) Applicant's Signature Date

_____ _____

Producer's Name (Print) Producer's Signature Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud).

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

**PREMIUMS:**

Are they affordable?

Could they change?

You're older — are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

**POLICY VALUES:**

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

**INSURABILITY:**

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

(Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage).

**IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:**

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deduced from death benefits?

What values from the old policy are being used to pay premiums?

**IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:**

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

**OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:**

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? (see your tax advisor.)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code.

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?