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	Accidental DB (Optional)
$	10 year ☐ 15 year ☐ 20 year ☐ 30 year ☐	$

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 ☐

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: _____

Please select one of the following. If selecting a draft date, select any date between the 1st and the 28th of the month.

☐ 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.

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

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 – First Name	Middle Name	Last Name

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'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.

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 – First Name	Middle Name	Last Name	Initials/Last 4 SSN #	Producer I.D. #	% Split

Producer Signature	Date (mm/dd/yyyy)

Producer Address	Producer Phone #	Producer Email

Second Producer – First Name	Middle Name	Last Name	Initials/Last 4 SSN #	Producer I.D. #	% Split

Second Producer Signature	Date (mm/dd/yyyy)

Second Producer Address	Second Producer Phone #	Second Producer Email

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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

1. Proposed Insured

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

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)