PHOENIX [PO Box 8027 Boston MA 02266-8027] For Overnight Delivery [30 Dan Road, Suite 8027 Canton MA 02021-2809]

Application for Term Individual Life Insurance
Part I

Company is defined as indicated:
(check one) [☒ PHOENIX LIFE INSURANCE COMPANY ☐ PHL VARIABLE INSURANCE COMPANY]

Section I – Proposed Insured Information

Name (First, Middle, Last)	Sex	Date of Birth (mm/dd/yyyy)
John Doe	☒ M ☐ F	03/01/1960

Birth State	Birth Country	U.S. Citizen	Earned Income	Net Worth	Other Income
CT	USA	☒ Y ☐ N	$ 100,000	$ 500,000	$ -

Social Security Number	Driver's License Number & State of Issue	Marital Status
000-00-0000	XXXX-XXXX-XX CT	☐ Single ☒ Married ☐ Widowed ☐ Divorced

Residence Street Address (include Apt #)	City	State	ZIP Code	Home Telephone #
One American Row	Hartford	CT	06102	(000)000-0000

Email Address: john.doe@email.com

Current Employer	Years of Service	Current Occupation
ABC Company	10 Years	Sales

Employer Street Address	City	State	ZIP Code	Employer's Telephone #
One American Row`	Hartford	CT	06102	(000) 000-0000

Have you used tobacco or nicotine products in any form in the last 10 years? ☐ Yes ☒ No
a. If "Yes", check the product(s) used: ☐ Cigarettes ☐ Cigars, Pipes, Snuff, Smokeless or Chewing Tobacco, ☐ Nicotine Patch, Gum or Lozenge
Other_____
b. If "Yes", check where appropriate: ☐ Use Currently ☐ Date Quit (mm/yyyy) _____

Section II – Ownership (Indicate the Owner of the policy.) If Insured is Owner, go to Section III

☐ **A. Partnership** - list all partners. If there is a general partner, complete Partnership Authorization form.
Name(s) of All Partner(s) (First, Middle, Last)

Employer's Street Address	City	State	ZIP Code

☐ **B. Trust** (If Owner is a Trust, complete Certification of Trust Agreement)

☐ **C. Other**

Owner's Name (First, Middle, Last)	Social Security Number/Tax ID	Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured

Owner's Street Address (include Apt #)	City	State	ZIP Code	Home Telephone #
				( )

Email Address

Section III – Beneficiary Designation

Unless otherwise specified, payments will be shared equally by all primary beneficiaries who survive the Proposed Insured or if none, by all contingent beneficiaries who survive the Proposed Insured. Only the Owner has the right to change the beneficiary(ies) unless otherwise stated.

Primary Beneficiary(ies) Name(s) (First, Middle, Last)	Date of Birth (mm/dd/yyyy)	Social Security # or Tax ID#	Relationship to Proposed Insured	% Share
Jane Doe	04/20/1960	000-00-0000	Wife	100

Contingent Beneficiary(ies) Name(s) (First, Middle, Last)	Date of Birth (mm/dd/yyyy)	Social Security # or Tax ID#	Relationship to Proposed Insured	% Share
James Doe, Jr.	07/18/1993	000-00-0000	Son	100

Section IV – Plans of Insurance, Riders and Features

Plan of Insurance (Check One): [☒ 10 Yr Term ☐ 20 Yr Term (guaranteed) ☐ 30 Yr Term ☐ 20 Yr Value Term (non-guaranteed)

☐ Other _____

Face Amount $ 100,000

☒ Disability Waiver of Premium

☒ Return of Premium (Note: Rider is not available with 20 Yr Value Term Plan)

☐ Other (Rider Name) _____]

Section V – Premium Payments

Please note, there is a higher cost if the mode of payment is other than Annual. Please consult with your Licensed Producer.

☒ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly Bank Draft (Complete PreAuth (PCS) (OL511) Amount paid with application $_____

Send premium notices to (in addition to owner)

☐ Insured at: ☐ Home Address ☐ Business Address

☒ Other

Name (First, Middle, Last) Amy Doe

Street Address One American Row

City Hartford State CT ZIP Code 06102

Relationship to Owner Daughter

Special Requests

Section VI – Existing Life Insurance

☐ Yes ☒ No 1. 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 that are presently in force?

☐ Yes ☒ No 2. With this policy, do you plan to replace (in whole or in part) now or in the future any existing life insurance or annuity contract in force with this policy?

☐ Yes ☒ No 3. Do you plan to utilize values from any existing life insurance policy or annuity contract (through loans, surrenders or otherwise) to pay any initial or subsequent premium(s) for this policy?

Company	Issue Date (mm/yyyy)	Plan/Policy Number	Amount	Personal or Business	Replacing
			$	☐ Per ☐ Bus	☐ Yes ☐ No
			$	☐ Per ☐ Bus	☐ Yes ☐ No
			$	☐ Per ☐ Bus	☐ Yes ☐ No
	Total Life Insurance in Force		$		

Section VII – Proposed Insured Medical Transfer Statement *(Complete when submitting medical examinations of another insurance company.)*

I request that Phoenix review and consider the exam conducted by the Life Insurance Company listed below in evaluating my application. I authorize Phoenix to receive and review such application(s), and authorize my producer, broker or other life insurance company to provide such application to Phoenix.

1. Name of the insurance company for which examination(s) was made
   Insurion Inc.

2. Date of examination (mm/dd/yyyy) 10/1/2007

3. To the best of your knowledge and belief, are the statements in the examination true, accurate and complete as of today? ☒ Yes ☐ No
   If "No", please explain.

4. Have you consulted a medical doctor or other practitioner since the above examination? *(If "Yes", complete Section IX)* ☐ Yes ☒ No

Section VIII – Proposed Insured Additional Information

Give full details for all "Yes" answers below. If necessary, use additional piece of paper and please sign it.

☐ Yes ☒ No 1. Have you ever applied for life, accident, disability or health insurance and been declined, postponed, or been offered a policy differing in plan, amount or premium rate from that applied for? (If "Yes," give date, company and reason).
Date (mm/dd/yyyy): Company: Reason:

☐ Yes ☒ No 2. Are you negotiating for other insurance? (If "Yes," name companies and total amount to be placed in force.)
Company(ies) Total Amount to be placed in force:

☐ Yes ☒ No 3a. Have you lived or traveled outside the United States or Canada in the past 2 years?
☐ Yes ☒ No 3b. Do you plan to do so within the next 2 years?
(If "Yes," state where, how long and purpose).
Location City, Country: Purpose: How Long: (Specify weeks, months, years)

☐ Yes ☒ No 4.a Have you flown during the past 3 years as a pilot, student pilot or crew member? (If "Yes," complete Aviation Questionnaire)
☐ Yes ☒ No 4b. Do you plan to do so within the next 2 years.? (If "Yes," complete Aviation Questionnaire).

☐ Yes ☒ No 5a. Have you participated in the past 3 years in ATV (all-terrain vehicle), motorized vehicle racing, stunt driving, motorcycle, motorboat, horse, or truck racing, rodeo, jet ski, scuba/skin diving, spelunking (cave exploration), heleskiing, hang gliding, cliff diving, bungee jumping, snowmobile, bobsled, skeleton, luge, skydiving/sport parachuting, ultralight flying, ballooning, mountain climbing, big game hunting, boxing, martial arts? (If "Yes," complete Avocation Questionnaire).
☐ Yes ☒ No 5b. Do you plan to do so within the next 2 years? (If "Yes," complete Avocation Questionnaire)

☐ Yes ☒ No 6a. In the past 3 years, have you been the driver of a motor vehicle involved in an accident in which you were found to be at fault? (If "Yes," give details)?
☐ Yes ☒ No 6b. Have you been convicted of a moving violation? (If "Yes," give details)
☐ Yes ☒ No 6c. Have you had your driver's license suspended, or revoked? (If "Yes," give details)
Details:

☐ Yes ☒ No 7a. Have you ever been convicted of a felony? (If "Yes," give details)
☐ Yes ☒ No 7b. Have you ever plead guilty to a felony? (If "Yes," give details)
☐ Yes ☒ No 7c. Do you currently have a felony charge pending? (If "Yes," give details)
Details:

Section IX – Proposed Insured Medical History (Please Complete)

Personal Physician or Health Care Provider Name *(if None, please indicate):*	Street Address, City, State, ZIP Code	Telephone #
None		( )

Most Recent Visit Date (mm/dd/yyyy)	Reason for Visit	Results of Treatment (if any)
07/15/2007	Cold	

Family History:	Age if Alive	Age at Death	If alive, indicate whether this person has been diagnosed or treated by a member of the medical profession for heart disease, cancer, or any blood disorder? or if deceased, indicate the cause of death.
Father ☒ Alive ☐ Deceased	78		None
Mother ☒ Alive ☐ Deceased	80		None

Height 6'0 / Weight 201	Has your weight changed by 10 pounds or more in the past 2 years? ☒ Yes ☐ No If "Yes", how much _____ pounds ☐ Gain ☐ Loss	Has anyone in your immediate family (parent or sibling) been diagnosed or treated by a member of the medical profession for heart disease, cancer, or any blood disorder before age 60? ☒ Yes ☐ No If "Yes" please provide details below.

Have you ever been diagnosed or treated by a physician or other health care provider for:

1. High blood pressure or hypertension? ☐ Yes ☒ No
2. Pain, pressure, or discomfort in the chest, angina pectoris, palpitations, swelling of the ankles, or undue shortness of breath? ☐ Yes ☒ No
3. Heart disease, coronary artery disease, cardiomyopathy, heart failure, atrial fibrillation, heart rhythm abnormality, heart murmur, congenital heart disease or valvular heart disease? ☐ Yes ☒ No
4. Peripheral vascular disease, claudication, narrowing or blockage of arteries or veins? ☐ Yes ☒ No
5. Asthma, pulmonary fibrosis, chronic cough, emphysema, pneumonia, or any other lung disease? ☐ Yes ☒ No
6. Neurologic disease, seizures, fainting, falls, concussion, stroke, transient ischemic attack (TIA), tremor, neuropathy, weakness, paralysis, Parkinson's disease, memory loss, dementia, or any other disease of the brain or nervous system? ☐ Yes ☒ No
7. Depression, bipolar disorder, schizophrenia, anxiety, or other psychiatric illness? ☐ Yes ☒ No
8. Arthritis, lupus, or any musculoskeletal or skin disorder? ☐ Yes ☒ No
9. Ulcers, abdominal pain, colitis, Crohn's disease, gall bladder disease, liver disease, hepatitis, jaundice, pancreatitis, or any other disease of the gastrointestinal system? ☐ Yes ☒ No
10. Diabetes, kidney disease, kidney stones, bladder disorder, prostate disorder, protein or blood in the urine? ☐ Yes ☒ No
11. Endocrine disorder, including disorder of the thyroid, parathyroid, adrenal, or pituitary glands? ☐ Yes ☒ No
12. Anemia, bleeding or clotting disorder, or any other disorder of the blood or bone marrow? ☐ Yes ☒ No
13. Cancer of any type, tumor (benign or malignant), leukemia, lymphoma, or Hodgkin's disease? ☐ Yes ☒ No
14. Are you taking any kind of medicine, therapy, or treatment regularly or at frequent intervals? ☐ Yes ☒ No
15. Have you ever received medical treatment or counseling for alcoholism, or been advised by a physician to limit or stop your use of alcohol? ☐ Yes ☒ No
16. Have you ever used narcotics, barbiturates, amphetamines, hallucinogens, or any prescription drug except in accordance with a physician's instructions? ☐ Yes ☒ No
17. Have you ever been a patient in any hospital, treatment center, or similar facility within the last 5 years? ☐ Yes ☒ No
18. Have you had, or been advised to have, any surgery, X-rays, electrocardiograms, blood studies (excluding Human Immunodeficiency Virus or AIDS tests), or other tests within the last 5 years? ☐ Yes ☒ No
19. Other than above, have you had any other physical or psychological disorder or been treated by a physician or other health care provider for any reason within the past 5 years? ☐ Yes ☒ No
20. Have you ever been diagnosed or treated by a member of the medical profession for specified symptoms such as: immune deficiency, anemia, recurrent fever, fatigue or unexplained weight loss, malaise, loss of appetite, diarrhea, fever of unknown origin, severe night sweats; unexplained or unusual infections or skin lesions; unexplained swelling of the lymph glands; Kaposi's Sarcoma or Pneumocystis Carinii Pneumonia ☐ Yes ☒ No
21. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☒ No

Please provide details of "Yes" answers (include question number, diagnosis, date of occurrence, current status, hospital or treating physician's name and address. Use Application Part II Addendum if additional space is necessary to record all details.

Phoenix reserves the right to require additional medical information, medical examination or testing to complete the underwriting process.

Section X – Proposed Insured Authorization To Obtain Information

I authorize any licensed physician, health care practitioner, hospital, medical laboratory, clinic or other medically-related facility, insurance company or the Medical Information Bureau (MIB), having any records or knowledge of me or my health, to provide any such information to The Company (as defined on page 1 of this application) or its reinsurers. The information requested may include information regarding diagnosis and treatment of physical or mental conditions, including consultations occurring after the date this authorization is signed. I authorize any of the above sources to release to the Company or its reinsurers any of my information relating to alcohol use, drug use and mental health care.

Medical information will be used only for the purpose of risk evaluation and determining eligibility for benefits under any policies issued. The Company may disclose information it has obtained to others as permitted or required by law, including the MIB, our reinsurers and other persons or entities performing business or legal services in connection with this application, any contract issued pursuant to it or in connection with the determination of eligibility for benefits under an existing policy. Information that is not personally identifiable may be used for insurance statistical studies.

To facilitate rapid submission of information, I authorize all of the above sources, except MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information.

I authorize consumer reporting agencies, insurance companies, motor vehicle departments, my attorneys, accountants and business associates and the MIB to provide any information to the Company or its reinsurers that may affect my insurability. This may include information about my occupation, participation in hazardous activities, motor vehicle record, foreign travel, finances, and other insurance coverage in place.

I acknowledge that I have received a copy of the Notice of Information Practices, including information about Investigative Consumer Reports and the Medical Information Bureau. I authorize the preparation of an investigative consumer report. I understand that upon written request, I am entitled to receive a copy of the investigative consumer report.

This authorization shall continue to be valid for 30 months from the date it is signed unless otherwise required by law. A photocopy of this signed authorization shall be as valid as the original. This authorization may be revoked by writing to the Company prior to the time the insurance coverage has been placed in force. I understand my authorized representative or I may receive a copy of this authorization on request.

☒ **I do** ☐ **I do not** (check one) require that I be interviewed in connection with any investigative consumer report that may be prepared.

Section XI – Signature

I have reviewed this application, and the statements made herein are those of the proposed insured and all such statements made by the proposed insured in Part I and/or in Part II of this application are full, complete, and true to the best knowledge and belief of the undersigned and have been correctly recorded.

I understand that 1) no statement made to, or information acquired by any Licensed Producer who takes this application, shall bind the Company unless stated in Part I and/or Part II of this application, the Licensed Producer has no authority to make, modify, alter or discharge any contract thereby applied for.

I understand and agree that the insurance applied for shall not take effect unless and until each of the following has occurred: 1) the policy has been issued by the Phoenix; 2) the premium required for issuance of the policy has been paid in full during the lifetime of the insured; 3) all the representations made in the application remain true, complete and accurate as of the date the policy is delivered; 4) the Insured is alive when the policy is delivered; 5) as of the date of delivery of the policy, there has been no change in the health of any proposed insured that would change the answers to any of the questions in the application. I understand that if there is any change in my health or physical condition, or if I visit a physician or am hospitalized, after the date I complete the application or provide any information to be contained in the application, I will inform the Company as soon as possible, and 6) the statements and answers in the application are the basis for any policy issued by the Company and no information about them will be considered to have been given to the Company unless it is stated in the application.

Under penalty of perjury, I confirm that 1) the Social Security or Tax Identification Number shown is correct, and 2) that I am not subject to back-up withholding.

Proposed Insured's Signature	**Date (mm/dd/yyyy)**	**Witness Signature (Must be signed in presence of Proposed Insured)**	**State Signed In**
	CT		02/03/2007
Owner's Signature/Title (if other than Proposed Insured, trustee, etc.)	**Date (mm/dd/yyyy)**	**Witness Signature (Must be signed in presence of Owner)**	**State Signed In**

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.

The Producer hereby confirms he/she has truly and accurately recorded on the application the information supplied by the Proposed Insured; and that he/she is qualified and authorized to discuss the contract herein applied for.

Licensed Producer's Name (Print First, Middle, Last)		**Licensed Producer's Email Address**	
Joe B. Phoenix		Joe.Phoenix@email.com	
Licensed Producer's Signature	**Date (mm/dd/yyyy)**	**Licensed Producer's I.D. #**	**Licensed Producer's Telephone #**
	02/03/2007	xxx-xxxx	(000) 000-0000