

Company is defined as indicated:

(check one) ☐ PHOENIX LIFE INSURANCE COMPANY ☒ PHL VARIABLE INSURANCE COMPANY

Section I – Proposed Insured Information

Name (First, Middle, Last) John Doe				Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		Date of Birth (mm/dd/yyyy) 03/01/1960	
Birth State CT	Birth Country USA		U.S. Citizen <input checked="" type="checkbox"/> Y <input type="checkbox"/> N		Earned Income \$ 100,000		Net Worth \$ 500,000
Social Security Number 000-00-0000		Driver's License Number & State of Issue XXXX-XXXX-XX CT			Marital Status <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
Residence Street Address (include Apt #) One American Row			City Hartford		State CT	ZIP Code 06102	Home Telephone # (000) 000-0000
Email Address john.doe@email.com							
Current Employer ABC Company			Years of Service 10 Years		Current Occupation Sales		
Employer Street Address One American Row`			City Hartford		State CT	ZIP Code 06102	Employer's Telephone # (000) 000-0000
Have you used tobacco or nicotine products in any form in the last 10 years? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
a. If "Yes", check the product(s) used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars, Pipes, Snuff, Smokeless or Chewing Tobacco, <input type="checkbox"/> Nicotine Patch, Gum or Lozenge							
Other _____							
b. If "Yes", check where appropriate: <input type="checkbox"/> Use Currently <input type="checkbox"/> 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
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☐ **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
			\$	<input type="checkbox"/> Per <input type="checkbox"/> Bus	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$	<input type="checkbox"/> Per <input type="checkbox"/> Bus	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$	<input type="checkbox"/> Per <input type="checkbox"/> Bus	<input type="checkbox"/> Yes <input type="checkbox"/> 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): None				Street Address, City, State, ZIP Code				Telephone # ()		
Most Recent Visit Date (mm/dd/yyyy) 07/15/2007			Reason for Visit Cold			Results of Treatment (if any)				
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.		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 <input checked="" type="checkbox"/> Alive <input type="checkbox"/> Deceased		78		None		Mother <input checked="" type="checkbox"/> Alive <input type="checkbox"/> Deceased		80		None
Height 6' 0"		Has your weight changed by 10 pounds or more in the past 2 years? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please provide details below.				
Weight 201		If "Yes", how much _____ pounds <input type="checkbox"/> Gain <input type="checkbox"/> Loss								
Have you ever been diagnosed or treated by a physician or other health care provider for:						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.				
1. High blood pressure or hypertension? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 2. Pain, pressure, or discomfort in the chest, angina pectoris, palpitations, swelling of the ankles, or undue shortness of breath? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3. Heart disease, coronary artery disease, cardiomyopathy, heart failure, atrial fibrillation, heart rhythm abnormality, heart murmur, congenital heart disease or valvular heart disease? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 4. Peripheral vascular disease, claudication, narrowing or blockage of arteries or veins? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 5. Asthma, pulmonary fibrosis, chronic cough, emphysema, pneumonia, or any other lung disease? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 7. Depression, bipolar disorder, schizophrenia, anxiety, or other psychiatric illness? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 8. Arthritis, lupus, or any musculoskeletal or skin disorder? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 10. Diabetes, kidney disease, kidney stones, bladder disorder, prostate disorder, protein or blood in the urine? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 11. Endocrine disorder, including disorder of the thyroid, parathyroid, adrenal, or pituitary glands? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 12. Anemia, bleeding or clotting disorder, or any other disorder of the blood or bone marrow? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 13. Cancer of any type, tumor (benign or malignant), leukemia, lymphoma, or Hodgkin's disease? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
14. Are you taking any kind of medicine, therapy, or treatment regularly or at frequent intervals? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 16. Have you ever used narcotics, barbiturates, amphetamines, hallucinogens, or any prescription drug except in accordance with a physician's instructions? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 17. Have you ever been a patient in any hospital, treatment center, or similar facility within the last 5 years? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										

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) CT	Witness Signature (Must be signed in presence of Proposed Insured)	State Signed In 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) Joe B. Phoenix		Licensed Producer's Email Address Joe.Phoenix@email.com	
Licensed Producer's Signature	Date (mm/dd/yyyy) 02/03/2007	Licensed Producer's I.D. # xxx-xxxx	Licensed Producer's Telephone # (000) 000-0000