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 Death Benefit (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

To the best of your knowledge and belief:

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. AIDS/ARC or previously tested for the purpose of obtaining insurance?	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 counseling for, been treated for, or been advised by a licensed member of the medical profession to have treatment for alcohol or drug substance abuse or addiction?	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 or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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?	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)

PHOENIX®

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:
To the best of your knowledge and belief:

1. Name of Physician / Health Care Provider:	Date of Last Visit: (mm/yyyy)	Were the results within normal limits? ☐ Yes ☐ No If no, provide details in Section B
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 due to a disability, or are you currently unable to work at your regular job due to disability?	Yes ☐ No ☐
8. In the past 3 years, have you been convicted of any misdemeanor, of 2 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 for cancer, heart disease, stroke, Alzheimer's disease, polycystic kidney disease, Huntington's chorea or other hereditary disorder 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 or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

PHOENIX®

HIPAA Authorization to Release Medical Information

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 PHL Variable 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.

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 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 and its subsidiaries
One American Row
PO Box 5056
Hartford CT 06102-5056

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.

PHOENIX®

Temporary Insurance Receipt

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

Instructions

All premium checks must be made payable to Phoenix. Do not make checks payable to the producer or leave the payee blank.

If either of the questions below is answered "Yes" or left blank, the producer is not authorized to accept money, a Temporary Insurance Receipt ("Receipt") will not be issued, and no coverage will take effect under this Receipt. No coverage will be provided under this Receipt if any Proposed Insured is over the age of 70 as of the date of this Receipt. The producer is not authorized to give this Receipt to the applicant unless the Required Payment, as described below, is made. No producer is authorized to waive or modify the terms of this Receipt.

Questions

1. Within the past two years have you been diagnosed or treated by a licensed member of the medical profession for heart disease, stroke or cancer?	Yes ☐ No ☐
2. Within the past 60 days, have you been scheduled or advised by a licensed member of the medical profession to have any diagnostic tests (excluding Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome test) or surgery not yet performed?	Yes ☐ No ☐

Temporary Insurance Coverage

Terms
Subject to the limitations stated in this Receipt, this Receipt provides a limited amount of temporary life insurance coverage from the Temporary Insurance Begin Date to the Temporary Insurance End Date, as those terms are defined below. Upon the death of the Proposed Insured, Phoenix will pay in one sum, under this and all other Receipts then in effect covering the Proposed Insured, the Temporary Coverage Amount, as defined below. The Temporary Coverage Amount will be paid to the same beneficiary and in the same manner as provided in the beneficiary provision of the policy applied for.

Required Payment
The Required Payment is an amount equal to a minimum of at least one month of the annual premium for the policy applied for, including any optional riders.

Temporary Coverage Amount
The Temporary Coverage Amount is the lesser of the face amount of the policy applied for in the application or $500,000, regardless of the number of current receipts or applications. In no event will the Temporary Coverage Amount under this and all other Receipts on the life of the Proposed Insured exceed $500,000.

Temporary Insurance Begin Date
Coverage under this Receipt will begin on the date all of the following have been completed: (1) completion of this Receipt; (2) completion of application Part 1 and Part 2; (3) receipt of the Required Payment.

Temporary Insurance End Date
Coverage under this Receipt will end on the earliest of the following dates: (1) when the insurance begins on the policy applied for; (2) when the applicant receive notice from Phoenix that the application has been disapproved for issuance of the policy; (3) 5 days after Phoenix mails to the applicant written notice that the application has been disapproved for issuance of the policy; (4) when a policy other than applied for is offered to the applicant; (5) 90 days from the Temporary Insurance Begin Date under this Receipt.

Limitations
If death of the Proposed Insured is due to suicide, Phoenix's liability under this Receipt will be limited to the return of the premium paid under this Receipt. No coverage will take effect under this Receipt if given in exchange for a check or draft not honored upon first presentation. No coverage will take effect under this Receipt if either of the questions above is answered "Yes" or left blank or if there is any material misrepresentation in this Receipt or in any part of the life insurance application.

Application of Amount Paid
The amount paid under this Receipt will be credited to the first year's premium due under the policy if Phoenix issues a policy. The full amount of premium paid under this Receipt will be refunded to the applicant if: (1) the application is declined by the Phoenix; or (2) the applicant refuses a policy as offered by Phoenix.

I declare that I have read and agree to the terms of this Receipt and that I have received a copy of this Receipt.

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

I have received $ _____ in connection with an application for life insurance.

Producer's Signature	Date (mm/dd/yyyy)

California Advance Notice Meeting Disclosure

Check one and submit form with application:

☐ This notice was completed and presented to the applicant at least 24 hours prior to our meeting in his/her home.

☐ I did not meet with the applicant in his/her home so this notice was not provided.

Prior to our meeting at your home on _____, I am required by the state of California to advise you of the following:

- I am a licensed insurance agent. My purpose for coming to your home is to sell, discuss, and/or deliver one of the following (indicate all that apply):
  - ☐ Life insurance, including annuities
  - ☐ Other insurance products, please specify: _____
- You have the right to have other persons present at the meeting, including family members, financial advisors, or attorneys.
- You have the right to end the meeting at any time.
- You have the right to contact the Department of Insurance for information or to file a complaint. You may contact the California Department of Insurance Consumer Hotline at 1.800.927.4357.

The following individuals will be coming to your home (list all attendees):

Name	Address	Phone Number	CA License #

Copy with Application - Copy to Applicant

PHOENIX®
Phoenix Life Insurance Company
PHL Variable Insurance Company
Phoenix Life and Annuity Company
PO Box 8027
Boston MA 02266-8027

FINANCIAL PRODUCTS DISCLOSURE
For Client's Age 65 and Older

In the process of evaluating the purchase of any life insurance or annuity product, you should understand that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity or other asset to fund the purchase of this product may have tax consequences, early withdrawal penalties or other cost or penalties as a result of the sale or liquidation.

Prior to purchasing the new life insurance or annuity product, you may want to obtain independent legal or financial advice before selling or liquidating any assets.

PHOENIX®
Phoenix Life Insurance Company and its subsidiaries
PO Box 8027
Boston MA 02266-8027

Notice and Consent for Body Fluids Testing Which May Include Aids Virus (HIV) Antibody/Antigen Testing

To determine your insurability, the insurer named above (Phoenix Life Insurance Company and its subsidiaries) may request a sample of your body fluids for testing and analysis. All tests will be performed by a licensed laboratory. The test or tests to be performed are used to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These test are extremely reliable.

Tests To Be Performed

We will use an ELISA test or a Western Blot Assay, or both.

An ELISA test is an enzyme-linked immunosorbent assay serologic test which has been licensed by the Federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus. A positive ELISA test means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same serum or plasma specimen.

A Western Blot Assay is an assay which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus. A reactive Western Blot Assay is a Western Blot Assay which is reactive according to the standards of performance and results specified in the manufacturer's Federal Food and Drug Administration approved product circular for the Western Blot Assay reagents and laboratory apparatus.

Meaning of Positive Test Result

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test/screening results or other significant body fluid abnormalities 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.

You may consult, at your expense, with a personal physician or counselor of the state health department before deciding whether to consent to this testing. Public health officials recommend that persons who test positive for the HIV antibodies should seek counseling to become informed about the implications of the test results.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. Results other than positive results also may be reported to the Insurer's affiliates, reinsurers, medical personnel, laboratories, and insurance support organizations in connection with insurance for which you have applied. In addition, if your HIV antibody test is positive or indeterminate, a code for a nonspecific body fluids abnormality will be made known to the Medical Information Bureau. No other disclosures will be made, except as may be required by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are positive, the Insurer will contact your designated physician if you have given written consent authorizing your physician to receive the test results. The Insurer may also contact you or your designated physician if there are other abnormal test results which, in the Insurer's opinion, are significant.

This consent shall be valid for a period of 30 months from the date noted below.

You may designate below the physician to whom test results may be reported:

Name _____

Address _____

City _____State_____ ZIP Code _____

I have read and I understand this Notice and Consent For Body Fluids Testing Which May Include HIV Antibody Testing. I voluntarily consent to the withdrawal of body fluids from me. The testing of that body fluid, and the disclosure of the test results as described above.

I understand that I have the right to respond 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

_____ DATE OF BIRTH

_____ STATE OF RESIDENCE

_____ DATE

Counseling Resources List for California

Public health authorities urge that everyone become educated about how to protect themselves for HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to Phoenix and its Subsidiaries. Therefore, Phoenix and its Subsidiaries makes no representations or warranties that this information is accurate as of the date you receive this list. Also, Phoenix and its Subsidiaries makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department, or local chapter of the American Red Cross, for further information.

AIDS HOTLINE-U.S.
PUBLIC HEALTH SERVICE
(800) 342-AIDS

SPANISH AIDS HOTLINE
(800) 222-SIDA

TTY INFORMATION
Information and Referral
for Hearing Impaired
(213) 464-0029

KERN COUNTY AIDS TEAM
Bakersfield
(805) 861-3631

CENTRAL VALLEY AIDS TEAM
Fresno
(209) 264-2436

AIDS PROJECT - EAST BAY
Oakland
(415) 420-8181

SACRAMENTO AIDS FOUNDATION - Sacramento
(916) 448-2437

SAN FRANCISCO AIDS FOUNDATION - San Francisco
(415) 846-5855

SAN DIEGO AIDS PROJECT
(619) 543-0300 - City of San diego
(620) 945-6000 - City of Vista

SHASTA COUNTY HELPLINE
(916) 225-5252

SANTA CLARA COUNTY ARIS PROJECT
Campbell
(408) 370-3272

SONOMA COUNTY AIDS INFORMATION HOTLINE
(801) 579-AIDS

AIDS HOTLINE - SOUTHERN CALIFORNIA
(800) 922-AIDS

HEMOPHILIA FOUNDATION OF SOUTHERN
CALIFORNIA - Social Services - Southern California
Hemophilia AIDS Information
(818) 792-6192
(714) 740-2222

CALIFORNIA DEPT. OF HEALTH SERVICES
Statewide Services - Office of AIDS - Sacramento
(916) 323-7415

AIDS SERVICES FOUNDATION OF ORANGE COUNTY-
Costa Mesa
(714) 646-0411

AIDS PROJECT - LOS ANGELES
West Hollywood
(213) 876-8951

INLANDS AIDS PROJECT
Riverside/San bernardino Counties
(714) 784-2437

SANTA BARBARA COUNTY AIDS HOTLINE
(805) 965-2925

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Replacing Your Life Insurance Policy or Annuity?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one — or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

_____ _____

Date Agent's Signature

_____

Applicant's Signature