PHOENIX®

PHL Variable Insurance Company (Phoenix)
Regular Mail: PO Box 8027, Boston MA 02266-8027
Overnight Mail: 30 Dan Rd., Suite 8027, Canton MA 02021-2809

Application for Individual Simplified Whole Life Insurance (Phoenix Remembrance Life)

Part I

Please print and use black ink. Any changes must be initialed by the Owner.

Section 1 – Proposed Insured Information

Name – First	Middle	Last	Gender M ○ F ○	Date of Birth (mm/dd/yyyy)	Social Security Number/Tax ID

Marital Status Single ○ Married ○ Widowed ○ Divorced ○ Civil Union Partner ○	Birth State	Birth Country	U.S. Citizen Yes ○ No ○ If "No", complete Non U.S. Citizen ONLY questions.

Non U.S. Citizen ONLY	Country of Citizenship	Green Card / Visa Type	Expiration Date (mm/dd/yyyy)	Country of Permanent Residence	ID Number	Years in U.S.

Driver's License #	State	Income $	Net Worth $

Residence Street Address (include Apt #)	City	State	ZIP Code

Home Phone # ( )	Work Phone # ( )	Cellular Phone # ( )	Best # to reach Insured Home ○ Work ○ Cellular ○	Best time to reach Insured

Current Employer	Current/Former (if retired) Occupation	Years of Service	Email Address

Employer Street Address	City	State	ZIP Code	Employer's Phone # ( )

Section 2 – Screening Questions

IF THE PROPOSED INSURED ANSWERED "YES" TO ANY QUESTIONS (1-14) BELOW, COVERAGE IS NOT AVAILABLE UNDER THIS PLAN AND THE APPLICATION SHOULD NOT BE COMPLETED OR SUBMITTED.

To the best of your knowledge and belief:

Question	Answer
1. In the past year have you been diagnosed, treated, or been given medical advice by a physician or other health care provider, for any terminal illness (life expectancy of 12 months or less)?	Yes ○ No ○
2. In the past 2 years, have you been diagnosed, treated, tested positive for or been given medical advice by a physician or other health care provider for; Alzheimer's disease; amyotrophic lateral sclerosis (ALS), aneurysm, cancer (excluding basal cell), chronic obstructive pulmonary disease (COPD) cirrhosis, dementia, coma, cystic fibrosis, Down's Syndrome, disorder of the blood, hemophilia, hepatitis B or C, Huntington's Disease, disorder of the immune system, Leukemia, multiple myeloma, multiple sclerosis, organ transplant, paralysis, Parkinson's Disease, stroke, schizophrenia, transient ischemic attack (TIA) or mini-stroke?	Yes ○ No ○
3. Have you ever been diagnosed, treated, or been given medical advice by a physician or other health care provider for more than one occurrence of cancer (excluding basal cell) or cancer that has spread (metastasis)?	Yes ○ No ○
4. In the past 2 years, have you been diagnosed, treated, or been given medical advice by a physician or other health care provider for: angina (chest pain), angioplasty, balloon procedure, cardiomyopathy, congestive heart failure (CHF), coronary artery disease (CAD), coronary artery bypass, heart attack, heart disease, heart surgery, myocardial infarction, pacemaker, pulmonary hypertension, stent placement, transplant or valve replacement.	Yes ○ No ○
5. In the past 2 years, have you been scheduled or advised by a 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 or for which the results have not been received?	Yes ○ No ○
6. 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 ○
Complete questions 7-9 if the Proposed Insured is age 59 or younger at time of application:	
7. In the past 5 years, have you received counseling or treatment for alcoholism or drug dependency or been advised by a physician or other health care provider to discontinue use of alcohol?	Yes ○ No ○
8. In the past year have you filed bankruptcy?	Yes ○ No ○
9. Are you currently incarcerated, on probation or parole?	Yes ○ No ○

Section 2 continued on next page.

Section 2 – Screening Questions – continued

Complete questions 10-14 if the Proposed Insured is age 60 or older at time of application:

To the best of your knowledge and belief:

Question	Answer
10. Do you currently require the assistance of another person for: bathing, dressing, eating, toileting, transferring or the management of bowel or bladder problems?	Yes ○ No ○
11. Are you currently confined to a bed, received or been advised to have care in any of the following: assisted living facility, home health care, hospice care, or nursing home?	Yes ○ No ○
12. In the past year, have you used or been advised to use supplemental oxygen to assist in breathing, required use of a wheelchair due to chronic illness or disease, amputation due to disease, diabetic coma, diabetic shock or had renal dialysis?	Yes ○ No ○
13. Have you been hospitalized 3 or more times in the last 12 months?	Yes ○ No ○
14. In the past 2 years, have you received counseling or treatment for alcoholism or drug dependency or been advised by a physician or other health care provider to discontinue use of alcohol?	Yes ○ No ○

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

☐ 1. Please contact me for a telephone interview at the number and time indicated in Section 1.

☐ 2. I will complete a telephone interview at point of sale.

☐ 3. I will complete and submit a paper Part II of this application.

Section 3 – Ownership – Complete only if Owner is not the Insured.

Owner's Name – First	Middle	Last	Social Security Number/Tax ID	Date of Birth (mm/dd/yyyy)

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

Relationship to Proposed Insured	Email Address

Section 4 – Coverages Applied for

Base Policy

Base Policy Face Amount $ ____________________

Complete Policy Beneficiary designation below. **Note:** Policy Beneficiary(ies) indicated below will receive the policy death benefit. If there are additional Policy Beneficiaries to be named, please use separate Additional Policy Beneficiary Designation Form. Rider beneficiaries are named separately. Percentages must equal 100%.

1. Primary Policy Beneficiary Information:

Name – First	Middle	Last	Social Security Number/Tax ID	Date of Birth (mm/dd/yyyy)

Relationship to Proposed Insured – Check one. ○ Federal Spouse ○ Civil Union Partner ○ Child ○ Other ____________	Percentage ________

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

2. Primary Policy Beneficiary Information:

Name – First	Middle	Last	Social Security Number/Tax ID	Date of Birth (mm/dd/yyyy)

Relationship to Proposed Insured – Check one. ○ Federal Spouse ○ Civil Union Partner ○ Child ○ Other ____________	Percentage ________

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

Section 4 – Coverages Applied for – continued

Additional Income Coverage Rider

Additional Income Coverage Rider Amount $ ______________

Complete Additional Income Coverage Rider Beneficiary designation below, or select one of the following:

○ Same as Policy Beneficiary #1 ○ Same as Policy Beneficiary #2

Note: Rider Beneficiary cannot be changed after policy issue.

1. Rider Beneficiary Information:

Name – First	Middle	Last	Gender M ○ F ○	Social Security Number/Tax ID
Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured - Check one. ○ Federal Spouse ○ Child ○ Civil Union Partner ○ Other ______________			
Street Address (include Apt #)	City	State	ZIP Code	Home Telephone # ( )

Section 5 – Additional Riders – Complete only if you are electing additional riders.

Lifetime Income Rider – Complete this section ONLY if you are electing the Lifetime Income Rider.

Monthly Benefit Amount $ ______________

Complete Lifetime Income Rider Beneficiary designation below, or select one of the following:

○ Same as Policy Beneficiary #1 ○ Same as Policy Beneficiary #2

Note: Rider Beneficiary cannot be changed after policy issue.

1. Rider Beneficiary Information:

Name – First	Middle	Last	Gender M ○ F ○	Social Security Number/Tax ID
Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured - Check one. ○ Federal Spouse ○ Child ○ Civil Union Partner ○ Other ______________			
Street Address (include Apt #)	City	State	ZIP Code	Home Telephone # ( )

Income Term Rider – Complete this section ONLY if you are electing the Income Term Rider.

Monthly Benefit Amount $ ______________

Complete Income Term Rider Beneficiary designation below, or select one of the following:

○ Same as Policy Beneficiary #1 ○ Same as Policy Beneficiary #2

Note: Rider Beneficiary cannot be changed after policy issue.

1. Rider Beneficiary Information:

Name – First	Middle	Last	Gender M ○ F ○	Social Security Number/Tax ID
Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured - Check one. ○ Federal Spouse ○ Child ○ Civil Union Partner ○ Other ______________			
Street Address (include Apt #)	City	State	ZIP Code	Home Telephone # ( )

Education/Legacy Rider – Complete this section ONLY if you are electing Education and/or Legacy Riders.

- Select one or both riders for each Rider Beneficiary entered.
- Only 5 Education Riders may be elected.
- Only 5 Legacy Riders may be elected.
- Note: Rider Beneficiary(ies) and Rider selection cannot be changed after policy issue.

1. Rider Beneficiary:
○ Education Rider – Annual Benefit Amount $ ____________ ○ Legacy Rider – Annual Benefit Amount $ ____________

Name – First	Middle	Last		
Gender M ○ F ○	Date of Birth (mm/dd/yyyy)		Social Security Number/Tax ID	
Street Address (include Apt #)	City	State	ZIP Code	Home Telephone # ( )

2. Rider Beneficiary:
○ Education Rider – Annual Benefit Amount $ ____________ ○ Legacy Rider – Annual Benefit Amount $ ____________

Name – First	Middle	Last		
Gender M ○ F ○	Date of Birth (mm/dd/yyyy)		Social Security Number/Tax ID	
Street Address (include Apt #)	City	State	ZIP Code	Home Telephone # ( )

3. Rider Beneficiary:
○ Education Rider – Annual Benefit Amount $ ____________ ○ Legacy Rider – Annual Benefit Amount $ ____________

Name – First	Middle	Last		
Gender M ○ F ○	Date of Birth (mm/dd/yyyy)		Social Security Number/Tax ID	
Street Address (include Apt #)	City	State	ZIP Code	Home Telephone # ( )

4. Rider Beneficiary:
○ Education Rider – Annual Benefit Amount $ ____________ ○ Legacy Rider – Annual Benefit Amount $ ____________

Name – First	Middle	Last		
Gender M ○ F ○	Date of Birth (mm/dd/yyyy)		Social Security Number/Tax ID	
Street Address (include Apt #)	City	State	ZIP Code	Home Telephone # ( )

5. Rider Beneficiary:
○ Education Rider – Annual Benefit Amount $ ____________ ○ Legacy Rider – Annual Benefit Amount $ ____________

Name – First	Middle	Last		
Gender M ○ F ○	Date of Birth (mm/dd/yyyy)		Social Security Number/Tax ID	
Street Address (include Apt #)	City	State	ZIP Code	Home Telephone # ( )

Rider Beneficiary Section continues on next page.

Education/Legacy Rider – continued.

6. Rider Beneficiary:
○ Education Rider – Annual Benefit Amount $ _____________ ○ Legacy Rider – Annual Benefit Amount $ _____________

Name – First	Middle	Last		
Gender M ○ F ○	Date of Birth (mm/dd/yyyy)		Social Security Number/Tax ID	
Street Address (include Apt #)	City	State	ZIP Code	Home Telephone # ( )

7. Rider Beneficiary:
○ Education Rider – Annual Benefit Amount $ _____________ ○ Legacy Rider – Annual Benefit Amount $ _____________

Name – First	Middle	Last		
Gender M ○ F ○	Date of Birth (mm/dd/yyyy)		Social Security Number/Tax ID	
Street Address (include Apt #)	City	State	ZIP Code	Home Telephone # ( )

8. Rider Beneficiary:
○ Education Rider – Annual Benefit Amount $ _____________ ○ Legacy Rider – Annual Benefit Amount $ _____________

Name – First	Middle	Last		
Gender M ○ F ○	Date of Birth (mm/dd/yyyy)		Social Security Number/Tax ID	
Street Address (include Apt #)	City	State	ZIP Code	Home Telephone # ( )

9. Rider Beneficiary:
○ Education Rider – Annual Benefit Amount $ _____________ ○ Legacy Rider – Annual Benefit Amount $ _____________

Name – First	Middle	Last		
Gender M ○ F ○	Date of Birth (mm/dd/yyyy)		Social Security Number/Tax ID	
Street Address (include Apt #)	City	State	ZIP Code	Home Telephone # ( )

10. Rider Beneficiary:
○ Education Rider – Annual Benefit Amount $ _____________ ○ Legacy Rider – Annual Benefit Amount $ _____________

Name – First	Middle	Last		
Gender M ○ F ○	Date of Birth (mm/dd/yyyy)		Social Security Number/Tax ID	
Street Address (include Apt #)	City	State	ZIP Code	Home Telephone # ( )

Section 6 – Mode of Premium Payment

Pay Mode: ○ Monthly Bank Draft (Phoenix Check-O-Matic) ○ Annual ○ Semi-Annual ○ Quarterly

Amount paid with Application $ ____________________ (or amount requested for initial premium draft)

Initial Premium to be paid by: ○ Check (submit check with application)
○ Bank Draft (the bank draft option is only available for the Monthly Bank Draft pay mode)

Authorization Agreement for Initial and Subsequent Premium Monthly Bank Draft

I (we) hereby authorize PHL Variable Insurance Company to initiate debit entries to my (our) checking account at the financial institution as shown on the attached voided check below.

○ Standard Date: I (we) hereby authorize PHL Variable Insurance Company to initiate debit entries to my (our) checking account for the initial premium amount stated above and I (we) request that the monthly recurring premium drafts occur approximately every thirty (30) days thereafter.

○ Custom Date: I (we) hereby authorize PHL Variable Insurance Company to initiate debit entries to my (our) checking account for the initial premium amount stated above and I (we) request that the monthly recurring premium drafts occur on the _______ date of the month.

(NOTE: You may select any date between the first and the 28th of the month.)

If processing is not complete prior to the custom date selected, two premium payments may be withdrawn to keep your coverage current. To prevent this from happening you may prefer to include an additional premium payment.

Please indicate your preference:

○ I prefer to submit an additional premium.

○ I prefer not to submit additional premiums and realize I may have two payments on my first transaction to keep my coverage current.

Signature of Depositor (if different from Owner(s)) ____

Print Depositor Name (First, Middle, Last) ____

Relationship to Owner(s) ____

Include Required Voided Check

Section 7 – Secondary Addressee

Secondary Party for purpose of notification of possible lapse in coverage.

Name – (First, Middle, Last)

Relationship to Owner

Street Address (Include Apt#)	City	State	ZIP Code

Section 8 – Insurance History

1. Do you plan to replace (in whole or in part) now or in the future any existing life insurance or annuity contract with this policy? (If "Yes", provide details below and complete appropriate replacement form)	Yes ○ No ○
2. Do you plan to utilize values from any existing life insurance policy or annuity contract (through loans, surrenders or otherwise) to pay initial premium for this policy? (If "Yes", provide details below and complete appropriate replacement form)	Yes ○ No ○
3. 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 ○

4. Amounts of coverage in force and amounts of coverage applied for at other carriers.

$ ________________ in force $ ________________ applied for amounts covered with other carriers

Company Name	Amount	Policy/Contract Number

Section 9 – Authorization To Obtain Information

I authorize any licensed physician, health care practitioner, hospital, medical laboratory, pharmacy or pharmacy benefit manager, clinic or other medically-related facility, insurance company or MIB (formerly Medical Information Bureau), having any records or knowledge of me or my health or prescription history to provide any such information to Phoenix, its affiliates, service providers or its reinsurers. The information requested may include information regarding diagnosis and treatment of physical or mental condition, including consultations occurring after the date this authorization is signed. I authorize any of the above sources to release to Phoenix, its affiliates, service providers or its reinsurers any of my information relating to alcohol use, drug use and mental health care. Further, I authorize Phoenix, its affiliates, service providers or its reinsurers to make a brief report of my personal health information to MIB.

I authorize consumer reporting agencies, insurance companies, motor vehicle departments, my attorneys, accountants and business associates, pharmacy or pharmacy benefit manager, and MIB to provide any information to Phoenix, its affiliates, service providers or its reinsurers that may affect my insurability. This may include information about my medical history, occupation, participation in hazardous activities, motor vehicle record, foreign travel, finances, insurance history or other personal information.

Any information will be used only for the purpose of risk evaluation and determining eligibility for benefits under any policies issued. Phoenix, its affiliates or service providers may disclose information it has obtained to others as permitted or required by law, including 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 agent, agency or producer authorized to do business with Phoenix, its affiliates or service providers to collect and transmit such information.

I acknowledge that I have received a copy of the Notice of Information Practices, including information about Investigative Consumer Reports and MIB. 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 copy of this signed authorization shall be as valid as the original. This authorization may be revoked by writing to Phoenix 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.

Check one:

○ I do ○ I do not require that I be interviewed in connection with any investigative consumer report that may be prepared.

Section 10 – Additional Information – Use space below for additional information/details and/or special requests.

Section 11 – Signature

I understand that the Application for life insurance consists of an Application Part I and Part II. I have reviewed this Application and all of the statements made herein are those of the Proposed Insured and all such statements have been correctly recorded and are full, complete and true to the best of the Proposed Insured's 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.

No information about them will be considered to have been given to Phoenix unless it is stated in the Application.

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 thereby applied for.

I understand that 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 during the lifetime of the Insured;
3) all representations made in the Application remain full, complete and true 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 or personal history of any Insured that would alter the answers or statements made in response to any of the questions in the Application, whether made orally or in writing; and
6) any required forms, including Part II of this Application, any amendments to the Application, or the delivery receipt, are signed and returned to us.

If applicable, I confirm that I have received a copy of the Accelerated Death Benefit Rider disclosure form(s).

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 backup withholding.

If I am an Owner who is not the Proposed Insured, I join in the foregoing affirmations, acknowledgments and undertakings of the Proposed Insured.

In addition, the statements made by me in any part of this Part I of this Application are full, complete and true to the best of my knowledge and belief and have been correctly recorded.

I understand this contract may be structured so that it is classified as a modified endowment contract (MEC) under the Internal Revenue Code; if so, loans or distributions may result in taxable income when taken. If the contract is a MEC, this will be noted on the contract schedule page. Once a contract is issued, MEC classification cannot be changed.

I received written informational materials relating to the Additional Income Coverage Rider and any other Riders for which I have applied (Income Term, Lifetime Income, Legacy, and/or Education Benefit Riders) and have reviewed the details of these Riders with my producer. After this review, I signed the Rider Acknowledgements form, which indicates that I am aware of the terms of the Riders.

Proposed Insured's Signature	**State Signed In**	Date (mm/dd/yyyy)
Owner's Signature (Only if Owner is other than Proposed Insured)	**State Signed In**	Date (mm/dd/yyyy)

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.

Section 12 – Producer Statement – All fields below MUST be completed.

Question	Answer
Are there any life insurance policies or annuity contracts, owned by, or on the life of the Owner(s) or the Annuitant?	Yes ○ No ○
Will the proposed contract replace (in whole or in part) any existing life insurance or annuity contract in force?	Yes ○ No ○

The Producer hereby confirms he/she has truly and accurately recorded on the application the information supplied by the Proposed Insured; is not aware of any decrepancies or misrepresentation in the recorded information; and that he/she is qualified and authorized to discuss the contract herein applied for.

Producer Name (Print First, Middle, Last)	Producer Address		Producer I.D. #
Producer Signature		Producer Telephone # ( ) –	Date (mm/dd/yyyy)
Firm Name	Firm Address		Firm Telephone # ( ) –

The Phoenix Companies, Inc.
One American Row
PO Box 5056
Hartford CT 06102-5056
Underwriting Service Center

For Overnight Delivery
30 Dan Road, Suite 8027
Canton MA 02021-2809

Policy Acceptance

Company is defined as indicated below:
☐ Phoenix Life Insurance Company ☐ PHL Variable Insurance Company

Policy Number	Insured's Name(s)

DECLARATION:
The Insured declares and represents that he or she has reviewed Part I and Part II of the application attached to the policy and that to the best of their knowledge and belief: (1) the representations made in Part I and Part II of the application were true and correct at the time they were submitted and/or transmitted to Phoenix; (2) any preprinted representations that were previously recorded in an underwriting telephonic interview were transferred to Part I and/or Part II of the application accurately and were properly recorded; and (3) the representations in Part I and Part II of the application remain full, complete, and true as of the date of this Policy Acceptance.

The Insured further declares and represents that since the date of application: no Insured has applied to any insurance company or society without receiving the exact policy applied for; been seen by or referred to a physician or specialist, whether or not an appointment has been scheduled; been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder; had any consultation, testing, or investigation recommended by a doctor which has not yet been completed as of this date; or had any medically related testing, screenings, or scans scheduled or performed.

The Insured agrees that the authorizations, answers, statements, and representations contained in Part I and Part II of the application shall be incorporated in this Policy Acceptance, and that the Insured's signature on the Policy Acceptance constitutes his or her execution and ratification of both Parts I and II of the application.

The Insured must attest to the above declaration before the policy may be delivered or put inforce. If the Insured cannot attest to any of the above statements or representations, please so indicate by checking the applicable box below, signing the form and returning the policy.

AMENDMENTS: The application for Policy is amended as follows:

It is agreed that the declaration and amendments contained in this form are part of the application and shall be part of the policy.

POLICY ACCEPTANCE: To be completed when policy is delivered.

This certifies that as the policy owner, (Check ONE only):

☐ I have received delivery of the insurance policy listed above.

☐ I cannot attest to the Declaration above. Policy will be returned.

Insured's Signature	**State Signed In**	Date (mm/dd/yyyy)
Owner's Signature (if other than Proposed Insured(s))	**State Signed In**	Date (mm/dd/yyyy)

If owner is a firm or corporation, please give the name of the firm or corporation and the title of the officer signing for the firm or corporation.

AGENT: Original to Underwriting and Issue - Yellow to Agent - Pink to remain with policy

PHL Variable Insurance Company (Phoenix)
Regular Mail: PO Box 8027, Boston MA 02266-8027
Overnight Mail: 30 Dan Rd., Suite 8027, Canton MA 02021-2809

Application for Individual Simplified Whole Life Insurance
Part II

Please print in Black ink.

Section 1 – Proposed Insured Information

Name – First	Middle	Last	Gender M ○ F ○	Date of Birth (mm/dd/yyyy)	Social Security Number/Tax ID

Section 2 – Underwriting Questions

To the best of your knowledge and belief:

1. What is your height and weight? Current Height _________ Current Weight _________
2. Please provide the name and address of your personal physician as well as the date and reason for your last visit.

   Personal Physician or Health Care Provider Name (if None, please indicate)

   Street Address, City, State, ZIP Code

   Most Recent Visit Date (mm/dd/yyyy) | Reason for Visit

3. Are you currently taking any medications? (If "Yes", please list all medications below.) Yes ○ No ○

   a. Rx name: ______________ What medical condition: ______________

   b. Rx name: ______________ What medical condition: ______________

   c. Rx name: ______________ What medical condition: ______________

   d. Rx name: ______________ What medical condition: ______________

4. In the past year, have you used tobacco in any form (excluding occasional pipe or cigar use) or nicotine replacement therapy? Yes ○ No ○
5. In the past 5 years, have you been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for arrhythmia, asthma, bipolar disease, brain or neurological disease, cancer or tumor, connective tissue disease, diabetes, depression, emphysema, gastrointestinal disease, heart disease, high blood pressure, kidney disease, liver disease, lung disorder, mental or nervous disorder, peripheral vascular disease, rheumatoid arthritis, seizure? Yes ○ No ○

   a. What condition: ______________ When diagnosed: ________

   How was it treated: ______________

   b. What condition: ______________ When diagnosed: ________

   How was it treated: ______________

   c. What condition: ______________ When diagnosed: ________

   How was it treated: ______________

   d. What condition: ______________ When diagnosed: ________

   How was it treated: ______________

6. In the past 2 years, have you resided outside of the U.S. for a period of more than 6 months? Yes ○ No ○
7. In the past 3 years, have you been convicted of driving under the influence of alcohol or drugs, or had your drivers license suspended or revoked, or had 3 or more moving violations? Yes ○ No ○

Complete questions 8-10 if the Proposed Insured is age 59 or younger at time of application:

8. In the past 2 years, have you been a patient in any hospital, emergency room or similar facility for any reason? Yes ○ No ○

   Date (mm/dd/yyyy)__________ Reason______________

9. In the next 2 years, do you plan to travel or reside outside of the United States? Yes ○ No ○

   Location ____________ Date ________ Duration ________ Purpose ____________

10. In the past 5 years, have you been convicted of or pled guilty to any felony? Yes ○ No ○

   Date ___________ Conviction or Charge ______________

Section 3 – Additional Information

Use space below to record all additional information.

Section 4 – Signature

I, the proposed insured, have reviewed this Application Part II and to the best of my knowledge and belief, all answers and statements accurately and properly recorded above, continue to remain full, complete and true as of this date and that there are no exceptions to any answers other than as written.

Proposed Insured's Signature	**State Signed In**	Date (mm/dd/yyyy)

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.

Phoenix
One American Row
PO Box 5056
Hartford CT 06102-5056
Underwriting Service Center

For Overnight Delivery
30 Dan Road, Suite 8027
Canton MA 02021-2809

Policy Acceptance

Company is defined as indicated below:
☐ Phoenix Life Insurance Company ☐ PHL Variable Insurance Company

Policy Number	Insured's Name(s)

DECLARATION:

The Insured declares that to the best of their knowledge and belief the statements made in the application remain full, complete, and true as of this date; that since the date of the application: no insured has applied to any insurance company or society without receiving the exact policy applied for; been seen by or referred to a physician or specialist, whether or not an appointment has been scheduled; been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder; had any consultation, testing, or investigation recommended by a doctor which has not yet been completed as of this date; or had any medically related testing, screens or scans scheduled or performed.

The Insured must attest to the above declaration before the policy may be delivered or put inforce. If the Insured cannot attest to the above statement, please so indicate by checking the applicable box below, signing form and returning the policy.

AMENDMENTS: The application for Policy is amended as follows:

It is agreed that the declaration and amendments contained in this form are part of the application and shall be part of the policy.

POLICY ACCEPTANCE: To be completed when policy is delivered.

This certifies that as the policy owner, (Check ONE only):

☐ I have received delivery of the insurance policy listed above.

☐ I cannot attest to the Declaration above. Policy will be returned.

Insured's Signature	**State Signed In**	Date (mm/dd/yyyy)
Owner's Signature (if other than Proposed Insured(s))	**State Signed In**	Date (mm/dd/yyyy)

If owner is a firm or corporation, please give the name of the firm or corporation and the title of the officer signing for the firm or corporation.

AGENT: Original to Underwriting and Issue - Yellow to Agent - Pink to remain with policy

PHL Variable Insurance Company (Phoenix)
Regular Mail: PO Box 8027, Boston MA 02266-8027
Overnight Mail: 30 Dan Rd., Suite 8027, Canton MA 02021-2809

Additional Policy Beneficiary Designation Form

Only complete this form if you are naming additional primary Policy Beneficiaries, or you wish to designate contingent Policy Beneficiaries.

Ownership

Name – First	Middle	Last	Social Security Number/Tax ID	Date of Birth (mm/dd/yyyy)
Owner's Street Address (include Apt #)	City	State	ZIP Code	Home Telephone # ( )
Relationship to Proposed Insured	Email Address			

Policy Beneficiary Designation

Complete Policy Beneficiary designation below. **Note:** Policy Beneficiary(ies) indicated below and on the application will receive the policy death benefit. Percentages assigned to the beneficiaries indicated below and on the application must total to 100%.

Name – First	Middle	Last	Social Security Number/Tax ID	Date of Birth (mm/dd/yyyy)
Beneficiary Designation - Check one. If nothing checked, the designation will be Primary ○ Primary ○ Contingent	Relationship to Proposed Insured – Check one. ○ Federal Spouse ○ Civil Union Partner ○ Child ○ Other ______			Percentage ______
Street Address (include Apt #)	City	State	ZIP Code	Home Telephone # ( )

Name – First	Middle	Last	Social Security Number/Tax ID	Date of Birth (mm/dd/yyyy)
Beneficiary Designation - Check one. If nothing checked, the designation will be Primary ○ Primary ○ Contingent	Relationship to Proposed Insured – Check one. ○ Federal Spouse ○ Civil Union Partner ○ Child ○ Other ______			Percentage ______
Street Address (include Apt #)	City	State	ZIP Code	Home Telephone # ( )

Name – First	Middle	Last	Social Security Number/Tax ID	Date of Birth (mm/dd/yyyy)
Beneficiary Designation - Check one. If nothing checked, the designation will be Primary ○ Primary ○ Contingent	Relationship to Proposed Insured – Check one. ○ Federal Spouse ○ Civil Union Partner ○ Child ○ Other ______			Percentage ______
Street Address (include Apt #)	City	State	ZIP Code	Home Telephone # ( )

Name – First	Middle	Last	Social Security Number/Tax ID	Date of Birth (mm/dd/yyyy)
Beneficiary Designation - Check one. If nothing checked, the designation will be Primary ○ Primary ○ Contingent	Relationship to Proposed Insured – Check one. ○ Federal Spouse ○ Civil Union Partner ○ Child ○ Other ______			Percentage ______
Street Address (include Apt #)	City	State	ZIP Code	Home Telephone # ( )

Signature

Owner's Signature	**State Signed In**	Date (mm/dd/yyyy)

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.

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Application for Individual Simplified Whole Life Insurance **Part II**

Section 1 – Proposed Insured Information

Name – First	Middle	Last	Gender M ◯ F ◯	Date of Birth (mm/dd/yyyy)	Social Security Number/Tax ID

Section 2 – Underwriting Questions

The following answers pre-printed on this Application were collected through a phone interview with the proposed insured.

To the best of your knowledge and belief:

1. What is your height and weight? Current Height _________ Current Weight _________
2. Please provide the name and address of your personal physician as well as the date and reason for your last visit.

   Personal Physician or Health Care Provider Name (if None, please indicate)

   Street Address, City, State, ZIP Code

Most Recent Visit Date (mm/dd/yyyy)	Reason for Visit

3. Are you currently taking any medications? (If "Yes", please list all medications below.) Yes ◯ No ◯
   a. Rx name: ________________________________ What medical condition: ____
   b. Rx name: ________________________________ What medical condition: ____
   c. Rx name: ________________________________ What medical condition: ____
   d. Rx name: ________________________________ What medical condition: ____
4. In the past year, have you used tobacco in any form (excluding occasional pipe or cigar use) or nicotine replacement therapy? Yes ◯ No ◯
5. In the past 5 years, have you been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for arrhythmia, asthma, bipolar disease, brain or neurological disease, cancer or tumor, connective tissue disease, diabetes, depression, emphysema, gastrointestinal disease, heart disease, high blood pressure, kidney disease, liver disease, lung disorder, mental or nervous disorder, peripheral vascular disease, rheumatoid arthritis, seizure? Yes ◯ No ◯
   a. What condition: ____ When diagnosed: ___________
      How was it treated: ____
   b. What condition: ____ When diagnosed: ___________
      How was it treated: ____
   c. What condition: ____ When diagnosed: ___________
      How was it treated: ____
   d. What condition: ____ When diagnosed: ___________
      How was it treated: ____
6. In the past 2 years, have you resided outside of the U.S. for a period of more than 6 months? Yes ◯ No ◯
7. In the past 3 years, have you been convicted of driving under the influence of alcohol or drugs, or had your drivers license suspended or revoked, or had 3 or more moving violations? Yes ◯ No ◯

Complete questions 8-10 if the Proposed Insured is age 59 or younger at time of application:

8. In the past 2 years, have you been a patient in any hospital, emergency room or similar facility for any reason? Yes ◯ No ◯
   Date (mm/dd/yyyy)_____________ Reason____
9. In the next 2 years, do you plan to travel or reside outside of the United States? Yes ◯ No ◯
   Location _____________________ Date ___________ Duration ___________ Purpose ______________________________
10. In the past 5 years, have you been convicted of or pled guilty to any felony? Yes ◯ No ◯
    Date _______________ Conviction or Charge____

Section 3 – Additional Information

Use space below to record all additional information.

Section 4 – Insured Representations

I, the proposed insured, hereby represent that the above preprinted answers and statements, which were previously recorded in an underwriting telephonic interview, were transferred to this Part II of the Application accurately and were properly recorded. I acknowledge that more detail may have been provided in the conversation with the interviewer. However, the responses above reflect the final answers that I provided to the interviewer. I further acknowledge that PHL Variable Insurance Company (Phoenix) has relied on the answers and statements provided during the telephonic underwriting interview to make its underwriting determination. By executing the Policy Acceptance, I represent and affirm that all answers and statements above were made during my telephonic interview and were full, complete, and true to the best of my knowledge and belief at the time they were recorded; that such answers and statements continue to remain full, complete and true as of this date; and that there are no exceptions or changes to any answers other than as written on the Amendments Section on the Policy Acceptance.

Section 5 – Fraud

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.