

SERFF Tracking Number: TPCI-126017168 State: Arkansas
Filing Company: PHL Variable Insurance Company State Tracking Number: 41432
Company Tracking Number: OL4400
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Combo Application
Project Name/Number: /

Filing at a Glance

Company: PHL Variable Insurance Company

Product Name: Combo Application

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: TPCI-126017168

SERFF Status: Closed

Co Tr Num: OL4400

Co Status:

Authors: Joseph Bonfitto, James

Bronsdon, Barbara Slater, Scott

Zweig, Elizabeth Wheeler, Kathleen

Underwood

Date Submitted: 02/03/2009

State: ArkansasLH

State Tr Num: 41432

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 02/09/2009

Disposition Status: Approved-Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 02/09/2009

Deemer Date:

Filing Description:

*Please see cover letter.

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 02/09/2009

Corresponding Filing Tracking Number:

Company and Contact

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Filing Contact Information

Barbara Slater, Compliance Coordinator barbara.slater@phoenixwm.com
 One American Row (860) 403-5607 [Phone]
 Hartford, CT 06102 (860) 403-7252[FAX]

Filing Company Information

PHL Variable Insurance Company CoCode: 93548 State of Domicile: Connecticut
 One American Row Group Code: 403 Company Type: Life Insurance and Annuities
 Hartford, CT 06102 Group Name: State ID Number:
 (860) 403-5000 ext. [Phone] FEIN Number: 06-1045829

Filing Fees

Fee Required? Yes
 Fee Amount: \$120.00
 Retaliatory? No
 Fee Explanation: 6 Application forms @ \$20.00 Each
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
PHL Variable Insurance Company	\$120.00	02/03/2009	25444371

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	02/09/2009	02/09/2009

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Application for Life Insurance Part 1	Form	Kathleen Underwood	02/05/2009	02/05/2009
Other Insured Form Supplement Part 1		Kathleen Underwood	02/05/2009	02/05/2009
Cover Letter	Supporting Document	Kathleen Underwood	02/03/2009	02/03/2009

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Disposition

Disposition Date: 02/09/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Supporting Document (revised)	Cover Letter		Yes
Supporting Document	Cover Letter		Yes
Form (revised)	Application for Life Insurance Part 1		Yes
Form	Application for Life Insurance Part 1		Yes
Form	Application Part 1 Funding Intentions		Yes
Form	Term Life - Part 1 Product Selection		Yes
Form	Universal Life - Part 1 Product Selection		Yes
Form	Variable Life - Part 1 Product Selection		Yes
Form (revised)	Other Insured Supplement Part 1		Yes
Form	Other Insured Supplement Part 1		Yes

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 Company Tracking Number: OL4400
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Combo Application
 Project Name/Number: /

Amendment Letter

Amendment Date:
 Submitted Date: 02/05/2009

Comments:

Good morning,

We realized after submitting this filing that we attached the incorrect versions of form OL4400 and OL4406. We have amended the filing with the correct forms and apologize for any inconvenience.

Sincerely,

Katie Underwood

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
OL4400	Application/EApplication nrollment Form	for Life Insurance Part 1	Initial				60	OL4400 - Generic with John Doe.pdf

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
OL4406	Application/EOther nrollment Form	Insured Supplement Part 1	Initial				59	OL4406 - Generic - with John Doe.pdf

SERFF Tracking Number: TPCI-126017168 State: Arkansas
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Company Tracking Number: OL4400
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Combo Application
Project Name/Number: /

Amendment Letter

Amendment Date:

Submitted Date: 02/03/2009

Comments:

Good morning,

We realized after submitting this filing that an extra page was added to the cover letter which should not have been included. We have removed the additional page and reattaching it for your review.

We appologize for any inconvenience.

Thanks,

Katie Underwood

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Cover Letter

Comment:

AR - Cover Letter.pdf

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 Product Name: Combo Application
 Project Name/Number: /

Form Schedule

Lead Form Number: OL4400

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	OL4400	Application/ Enrollment Form	Application for Life Insurance Part 1	Initial		60	OL4400 - Generic with John Doe.pdf
	OL4401	Application/ Enrollment Form	Application Part 1 Funding Intentions	Initial		59	OL4401 - Generic - with John Doe.pdf
	OL4402	Application/ Enrollment Form	Term Life - Part 1 Product Selection	Initial		60	OL4402 - Generic - with John Doe.pdf
	OL4403	Application/ Enrollment Form	Universal Life - Part 1 Product Selection	Initial		57	OL4403 - Generic - with John Doe.pdf
	OL4404	Application/ Enrollment Form	Variable Life - Part 1 Product Selection	Initial		58	OL4404 - Generic - with John Doe.pdf
	OL4406	Application/ Enrollment Form	Other Insured Supplement Part 1	Initial		59	OL4406 - Generic - with John Doe.pdf



PHL Variable Insurance Company (Phoenix)

Application for Life Insurance

Part 1

Regular Mail: [PO Box 8027, Boston MA 02266-8027]

Overnight Mail: [30 Dan Rd., Suite 8027, Canton MA 02021-2809]

Print and use black ink. Any changes must be initialed by the Proposed Insured(s) and Owner.

Section 1 - Type of Application

Select one type of application below and then complete information for the selected type.

Form for Section 1 with checkboxes for New Business, Face Amount Increase, and Term Conversion. Includes options for Term Life, Universal Life, and Variable Life.

Section 2 - Proposed Insured Information (Life One)

Form for Section 2 (Life One) containing personal and financial information for John A. Doe, including marital status, income, and contact details.

Section 3 - Proposed Insured Information (Life Two)

Complete if applying for a Multi - Life product. Use Other Insured Supplement (OL4406) to add additional Insureds. Skip Address and Home Phone # if same as Life One.

Form for Section 3 (Life Two) containing personal and financial information for Jane C. Doe, including marital status, income, and contact details.

Section 4 - Ownership

If Proposed Insured(s) are Owners, continue on to Section 5.

If not, complete Owner's Address, Employer-Owned question and **ONE** Ownership Type section. Use [Section 12]- Additional Information for details.

Owner's Address

Complete Owner's Address [and residency].

Street Address (include Apt #)	City	State	ZIP Code
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Do any Owner(s) reside outside of the U.S.? Yes No If "Yes", provide details.

Employer-Owned

Please indicate if the policy will be employer-owned. If the employer is also the beneficiary, complete [Notice and Consent for Employer-Owned Life Insurance (OL4320)].

If the policy is employer-owned, Section 101(j) of the Internal Revenue Code may apply and the death benefit may be subject to income taxes. **Please consult a tax professional** prior to submission of the Application to ensure compliance and understanding of the notice and consent requirements of Section 101(j).

Will the applied for policy be employer-owned? Yes No

Ownership Type

Check **ONE** Ownership Type and complete section.

A - Single Owner

Primary Owner Name (First, Middle, Last)	Social Security No./Tax ID	Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured(s)
Contingent Owner Name (First, Middle, Last) (if applicable)	Social Security No./Tax ID	Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured(s)

B - Multiple Owners

Use Section 12 - Additional Information for details.

Co-Owner Name (First, Middle, Last)	Social Security No./Tax ID	Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured(s)
Co-Owner Name (First, Middle, Last)	Social Security No./Tax ID	Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured(s)

C - Trust

Indicate name of Trust and Tax ID to be used for tax reporting purposes. **[Must complete Certification and Acknowledgment of Trust Agreement (OL4132)].** Use [Section 12]- Additional Information for details.

Name(s) of Trust(s)	Trust Tax ID	Date Trust Established	
Name(s) of Trustee(s) (First, Middle, Last)	Social Security No./Tax ID		
Name(s) of Trustee(s) (First, Middle, Last)	Social Security No./Tax ID		
Trust Beneficiary Name(s) (First, Middle, Last)	Social Security No./Tax ID	Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured(s)
Trust Beneficiary Name(s) (First, Middle, Last)	Social Security No./Tax ID	Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured(s)
Trust Beneficiary Name(s) (First, Middle, Last)	Social Security No./Tax ID	Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured(s)

D - Partnership

List all partners and Tax ID used for tax reporting purposes. If there is a general partner, complete **Partnership Authorization** letter.

Name of Partnership	Tax ID
Name(s) of All Partner(s) (First, Middle, Last)	

E - Corporation

Please provide name of Corporation and Tax ID for tax reporting purposes. Attach a **Corporate Resolution Agreement**.

Name of Corporation	Contact Name (First, Last)	Work Phone # () -	Tax ID
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Is Corporate Resolution Agreement with authorization signatures attached? Yes No

Section 5 - Beneficiary Designation

Owner
 Trust under Insured's will
 Surviving Insured(s) (Joint Edge VUL only)
 Beneficiaries stated below

Select Primary Beneficiary type(s) (to the left). If the Beneficiary box is checked or there is more than 1 (one) beneficiary type selected use the grid below for details. Unless otherwise specified, payments will be shared equally by all surviving primary beneficiaries, or if none, by all surviving contingent beneficiaries.

Only the owner has the right to change the beneficiaries unless otherwise stated.

Use [Section 12.] Additional Information for additional beneficiaries.

Beneficiary Name (First, Middle, Last) or Entity Name	Beneficiary Designation Select one per beneficiary. If nothing checked, the designation will be Primary	Relationship to Proposed Insured	Date of Birth or Date of Trust (mm/dd/yyyy)	Social Security or Tax ID Number	Percent %
Mary Doe	<input checked="" type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse/Civil Union Partner <input type="checkbox"/> Child <input type="checkbox"/> Trust <input checked="" type="checkbox"/> Other <u>Mother</u>	4/2/1957	345-67-8912	100
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse/Civil Union Partner <input type="checkbox"/> Child <input type="checkbox"/> Trust <input type="checkbox"/> Other _____			
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse/Civil Union Partner <input type="checkbox"/> Child <input type="checkbox"/> Trust <input type="checkbox"/> Other _____			
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse/Civil Union Partner <input type="checkbox"/> Child <input type="checkbox"/> Trust <input type="checkbox"/> Other _____			

Do any Proposed Beneficiaries reside outside of the U.S.? Yes No If "Yes", provide details.

Complete Life One questions.
 If applying for a Multi - Life product complete Life One and Life Two questions.

Section 6 - Existing and Pending Life Insurance

1. a. 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? Life One Life Two
 Yes No Yes No

b. 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? Yes No Yes No

c. Are there any life insurance policies or annuity contracts owned by, or on the life of, the applicant(s) or the insured(s) or the owner(s) or the annuitant? Yes No Yes No

2. Provide information for each policy in force with all companies on the life of the insured. Include any policy that has been sold, assigned, transferred or settled with any other person or entity.

If no coverage in force, check for which life or lives Life One Life Two. Continue to question 3.

Proposed Insured	Company	Insurance Personal Business	Issue Date mm/yyyy	Replacing? Yes No	Amount Including Riders	Indicate if Sold, Assigned, Transferred or Settled
<input type="checkbox"/> Life One <input type="checkbox"/> Life Two		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	\$	
<input type="checkbox"/> Life One <input type="checkbox"/> Life Two		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	\$	
<input type="checkbox"/> Life One <input type="checkbox"/> Life Two		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	\$	
<input type="checkbox"/> Life One <input type="checkbox"/> Life Two		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	\$	

Section 6 - Existing and Pending Life Insurance continued

3. Have you ever had an application for life insurance declined, postponed, rated substandard or offered with a reduced face amount?

Life One Yes No If "Yes", provide details. _____

Life Two Yes No If "Yes", provide details. _____

4. List the total insurance currently applied for with all companies including this Application (**do not include informal inquiries**). Provide name of the life insurance company and total amount **applied for**.

Life One		Life Two	
Company	Amount Including Riders	Company	Amount Including Riders
Phoenix (current application information)	\$ 1,000,000	Phoenix (current application information)	\$ 1,000,000
	\$		\$
	\$		\$
	\$		\$

5. List the total amount of new coverage to be placed in force including Phoenix and all other carriers.

Life One – Total Amount	Life Two – Total Amount
\$ 1,000,000	\$ 1,000,000

SKIP questions 6a-d If Life One and Life Two are married/civil union partners and are applying for multi-life coverage. Continue to question 7.

6. a. Provide name of Spouse/Civil Union Partner.

Life One Spouse/Civil Union Partner Name (First, Middle, Last)	Life Two Spouse/Civil Union Partner Name (First, Middle, Last)
-----------------------------------------------------------------------	-----------------------------------------------------------------------

b. Provide information on each policy **in force** with all companies on the life of the Spouse/Civil Union Partner of the Proposed Insured. Include any policy that has been sold, assigned, transferred or settled with any other person or entity.

Spouse/ Civil Union Partner	Company	Insurance Personal Business	Issue Date mm/yyyy	Amount Including Riders	Indicate if Sold, Assigned, Transferred or Settled
<input type="checkbox"/> Life One <input type="checkbox"/> Life Two		<input type="checkbox"/> <input type="checkbox"/>		\$	
<input type="checkbox"/> Life One <input type="checkbox"/> Life Two		<input type="checkbox"/> <input type="checkbox"/>		\$	
<input type="checkbox"/> Life One <input type="checkbox"/> Life Two		<input type="checkbox"/> <input type="checkbox"/>		\$	
<input type="checkbox"/> Life One <input type="checkbox"/> Life Two		<input type="checkbox"/> <input type="checkbox"/>		\$	

c. Provide name of the life insurance company and amount applied for on the life of the Spouse/Civil Union Partner of the Proposed Insured. List the total insurance currently **applied for** with all companies (**do not include informal inquiries**).

Life One (Spouse/Civil Union Partner)		Life Two (Spouse/Civil Union Partner)	
Company	Amount Including Riders	Company	Amount Including Riders
Phoenix (current application information)	\$	Phoenix (current application information)	\$
	\$		\$
	\$		\$
	\$		\$

d. List the total amount of new coverage to be placed including Phoenix and all other carriers on the Spouse/Civil Union Partner of the Proposed Insured.

Life One – Total Amount	Life Two – Total Amount
\$	\$

Section 6 - Existing and Pending Life Insurance continued

7. Juvenile Insurance (complete if applicant is a juvenile)

- a. Are all siblings equally insured? Yes No If "No", provide reason. _____
- b. Amount of life insurance currently in force or pending on parent(s)/guardian(s) \$ _____
 If none, provide reason _____

Life One		Life Two	
Name of Parent/Guardian	Amount Including Riders	Name of Parent/Guardian	Amount Including Riders
	\$		\$
	\$		\$
	\$		\$
	Total Amount \$		Total Amount \$

Section 7 Term Conversion Options

Complete if application is for Term Conversion.

1. a. If you are converting a term policy, do you want to continue any existing rider coverage under the new policy? Yes No
 If none checked, current rider coverage will be included on the new plan if applicable.
- b. If you are requesting a partial conversion, should the balance of the policy remain in force? Yes No
 If none checked, balance will remain inforce subject to contractual minimum amounts.
- c. Are you returning the original policy(ies) with this Application? Yes No
 If "No", check here if policy has been lost or destroyed.

Existing Policy Number to be Converted	Existing Plan Name or Rider Name	Face Amount to be Converted
		\$
		\$
		\$
	Total Amount	\$

Section 8 Mode of Premium Payment

- Annual Semi-Annual Quarterly Phoenix Check-O-Matic Service (checking account withdrawal) (PCS) Minimum Monthly Payment - \$25.00
 [Other] _____

Authorization Agreement for Preauthorized Payments

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.

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

Print Depositor Name (First, Middle, Last) _____ Relationship to Owner(s) _____

Include Voided Check

Send additional premium notices to:

Name (First, Middle, Last) _____

Street Address _____

City _____ State _____ ZIP Code _____ Relationship to Owner(s) _____

Complete when submitting medical examinations from another insurance company.
NOTE: Medical History [Section 10] must be completed if a Phoenix exam is not used.

Section 9 - Medical Transfer Statement

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 exam, and authorize my producer, broker or other life insurance company to provide such exam to Phoenix.

Life One	Life Two
1. Name of the insurance company for which examination(s) was completed. Insurion Associates	1. Name of the insurance company for which examination(s) was completed. Insurion Associates
2. Date of examination (mm/dd/yyyy) 1/2/2009	2. Date of examination (mm/dd/yyyy) 1/2/2009
3. To the best of your knowledge and belief, are the statements in the examination true, accurate and complete as of today? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "No", please explain.	3. To the best of your knowledge and belief, are the statements in the examination true, accurate and complete as of today? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "No", please explain.
4. Have you consulted a medical doctor or other practitioner since the above examination? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	4. Have you consulted a medical doctor or other practitioner since the above examination? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Complete section in its entirety if using an exam from another company. **If using a Phoenix exam, ONLY questions in bold and with an asterisk (*) are required.** Use Section 12 - Additional Information for details.

Section 10 - Medical History

Life One				Life Two			
Current Height 6' 2"		Current Weight 198		Current Height 5' 6"		Current Weight 130	
Has your weight changed by 10 pounds or more in the past 2 years? If "Yes", how many _____ pounds <input type="checkbox"/> Gain <input type="checkbox"/> Loss Reason _____				Has your weight changed by 10 pounds or more in the past 2 years? If "Yes", how many _____ pounds <input type="checkbox"/> Gain <input type="checkbox"/> Loss Reason _____			
Family History:	Age if Alive	Age at Death	If alive, indicate health problems or if deceased, indicate cause of death:	Family History:	Age if Alive	Age at Death	If alive, indicate health problems or if deceased, indicate cause of death:
Father <input checked="" type="checkbox"/> Alive <input type="checkbox"/> Deceased	58		None	Father <input checked="" type="checkbox"/> Alive <input type="checkbox"/> Deceased	60		None
Mother <input checked="" type="checkbox"/> Alive <input type="checkbox"/> Deceased	51		None	Mother <input checked="" type="checkbox"/> Alive <input type="checkbox"/> Deceased	57		None
Has anyone in your immediate family developed any hereditary condition, cancer, or heart disease before age 60? <input type="checkbox"/> Yes (please provide details) <input checked="" type="checkbox"/> No				Has anyone in your immediate family developed any hereditary condition, cancer, or heart disease before age 60? <input type="checkbox"/> Yes (please provide details) <input checked="" type="checkbox"/> No			
* Personal Physician or Healthcare Provider Name (First, Last) Dr. John Johnson				* Personal Physician or Healthcare Provider Name (First, Last) Dr. John Johnson			
* Street Address (include Suite #) 2 Medical Drive, Suite 2500				* Street Address (include Suite #) 2 Medical Drive, Suite 2500			
* City Anytown		* State CT	* ZIP Code 11256	* City Anytown		* State CT	* ZIP Code 11256
* Phone # (860) 555 - 4444		* Date of most recent visit (mm/dd/yyyy) 1/2/2008		* Phone # (860) 555 - 4444		* Date of most recent visit (mm/dd/yyyy) 1/2/2008	
* Reason for visit Annual Physical				* Reason for visit Annual Physical			
* Results of treatment (if any)				* Results of treatment (if any)			

This section must be completed in its entirety if using an exam from another company. **If using a Phoenix exam, ONLY questions 1-4 in bold and asterisk (*) must be completed.** Use Section 12 - Additional Information for details.

Section 10 - Medical History continued

To the best of your knowledge and belief, have you ever had, or been told by a licensed medical professional, licensed physician or other health care provider that you have:

	Life One	Life Two
* 1. 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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
* 2. 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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
* 3. Diabetes, kidney disease, kidney stones, bladder disorder, prostate disorder, protein or blood in the urine?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
* 4. Cancer of any type, tumor (benign or malignant), leukemia, lymphoma, or Hodgkin's disease?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5. High blood pressure or hypertension?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6. Peripheral vascular disease, claudication, narrowing or blockage of arteries or veins?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7. Asthma, pulmonary fibrosis, chronic cough, emphysema, pneumonia, or any other lung disease?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
8. 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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9. Depression, bipolar disorder, schizophrenia, anxiety, or other psychiatric illness?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10. Arthritis, lupus, or any musculoskeletal or skin disorder?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
11. 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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
12. Endocrine disorder, including disorder of the thyroid, parathyroid, adrenal, or pituitary glands?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
13. Anemia, bleeding or clotting disorder, or any other disorder of the blood (excluding Human Immunodeficiency Virus) or bone marrow?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
15. Have you ever been treated for alcoholism or been advised to limit or stop your use of alcohol?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<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	<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 10 years?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<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 Acquired Immune Deficiency Syndrome test), or other tests within the last 5 years?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<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	<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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Please provide details of "Yes" answers (include question number, diagnosis, date of occurrence, current status, hospital and/or treating physician's name and address). Use Section 12 - Additional Information if additional space is necessary to record all details.

Life One	Life Two

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

Section [11] - Non - Medical Information

Provide full details for all "Yes" answers below. Use [Section 12] Additional Information to record additional details.

	Life One	Life Two
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," provide date, company and reason.) Date (mm/dd/yyyy): Company: Reason:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. Do you intend to travel or reside outside of the United States or Canada? (If "Yes," state where, how long and purpose.) Location City, Country: How Long: (Specify weeks, months, years) Purpose:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. Have you flown during the past 3 years as a pilot, student pilot or crew member or do you plan to do so? (If "Yes," complete [Aviation Questionnaire.])	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4. Have you participated in the past 3 years or plan to engage in any extreme sport activities such as motorized vehicle racing, parachute jumping, underwater diving, or any other extreme avocation? (If "Yes," complete [Avocation Questionnaire.])	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5. Have you ever been convicted of a felony? (If "Yes," provide details.) Details:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6. Have you ever been convicted of driving under the influence of alcohol or drugs, or had any moving violations in the past 3 years? (If "Yes," provide details.) Details:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7. State in detail what bona fide need the Proposed Owner(s) and/or Proposed Insured(s) has for this insurance. Use [Section 12]- Additional Information if additional space is necessary to record all details.		

Section [13]- Authorization To Obtain Information

I authorize any licensed physician, health care practitioner, hospital, medical laboratory, clinic or other medically-related facility, medical data provider, insurance company or the Medical Information Bureau (MIB), or any other similar person or organization, having any records or knowledge of me or my health, to provide to PHL Variable Insurance Company (Phoenix), or its reinsurers the following information: 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 or its reinsurers any of my information relating to alcohol use, drug use and mental health care.

Any information (medical and non-medical) will be used for the purpose of risk evaluation and determining eligibility for benefits under any policies issued. Phoenix 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 provide such records or knowledge to any agency employed by Phoenix 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 to Phoenix or its reinsurers the following information regarding my insurability: information about my occupation, participation in hazardous activities, motor vehicle record, foreign travel, finances, general health, insurable interest and other 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 (24 months in Colorado, Iowa, Kansas, Kentucky, Oklahoma, West Virginia and Wyoming) 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 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.

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

Section [14]- Signature

The Application consists of Part I and Part II. I have reviewed this Application, and the statements made herein are those of the Proposed Insured(s) and all such statements made by the Proposed Insured(s) in Part I of this Application (and Part II, if applicable are) full, complete and true to the best of my knowledge and belief 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 Phoenix unless stated in Part I and/or Part II of this Application (not applicable in ND and SD) and 2) no Licensed Producer has 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 Phoenix; 2) the premium required for issuance of the policy has been paid in full during the lifetime of the Insured(s); 3) all the representations made in the Application remain true, complete and accurate as of the date the policy is delivered; 4) the Insured(s) are alive when the policy is delivered, and 5) as of the date of delivery of the policy, there has been no change in the health of any Insured(s) that would change the answers to any of the questions in the Application.

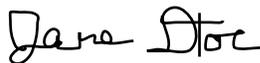
I understand that if there is any change in health or physical condition of any Proposed Insured, or if any Proposed Insured visits a physician or is hospitalized, subsequent to the date I complete the Application or provide any information to be contained in the Application, I will inform Phoenix in writing as soon as possible at address [PO Box 8027, Boston MA 02266-8027.]

If I have applied for the Acceleration of Death Benefit Rider I confirm that I have received a copy of the disclosure form, Summary of Coverage of Death Benefit Rider.

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.

If I am Owner who is not a Proposed Insured, I join in the foregoing affirmations, acknowledgments, and undertakings of the Proposed Insured(s). In addition, the statements made by me in any Part of this Application are full, complete, and true to the best of my knowledge and belief, and have been correctly recorded.

[For Conversions Only - Unless otherwise attached, the Owner hereby verifies that the policy(ies) named in Section 6 of this Application are either lost or destroyed, and have not been pledged or assigned as collateral, except as has been previously disclosed to Phoenix. The new policy will be based on the written statements made in any evidence of insurability submitted. A copy of those statements are attached to the new policy.]

Proposed Insured's (Life One) Signature 	State Signed In CT	Date (mm/dd/yyyy) 2/1/2009
Proposed Insured's (Life Two) Signature 	State Signed In CT	Date (mm/dd/yyyy) 2/1/2009
Owner's Signature/Title (if other than Proposed Insureds)	State Signed In	Date (mm/dd/yyyy)
Owner's Signature/Title (if other than Proposed Insureds)	State Signed In	Date (mm/dd/yyyy)
Collateral Assignee's Signature (if applicable)	State Signed In	Date (mm/dd/yyyy)
Parent or Guardian of Minor Signature (if applicable)	State Signed In	Date (mm/dd/yyyy)

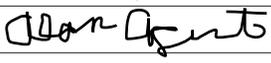
[Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of competent jurisdiction. (Not applicable in AR, DC, FL, LA, ME, MA, NJ, NM, NY, OH, OR, PA, TX, VA and WA).

In AR and LA any person who knowingly presents a false or fraudulent claim for payments 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.

In DC, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON, PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, ANY INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

In OH, any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.]

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 discrepancies or misrepresentations in the recorded information; and that he/she is qualified and authorized to discuss the contract herein applied for.

Licensed Producer's Name (Print First, Middle, Last)	Licensed Producer's Email Address	Phoenix Producer I.D. #	Licensed Producer's Telephone #	Licensed Producer's Signature
Alan Agent	Alan.Agent@phoenixwm.com	12-56598-2001	(860) 403 - 5000	
			() -	
			() -	

Funding Questions

The following questions must be completed if: A) the Proposed Insured is under the age of 65 and the face amount of the policy (including any riders) is \$3,000,000 or greater; or B) if the Proposed Insured is age 65 or older and the face amount of the policy is \$2,000,000 or greater.

1. Will any of the first year or subsequent premiums for the policy be borrowed, loaned or otherwise financed by the proposed owner or proposed insured or by any other individual, trust, partnership, corporation or similar or related entity, including by a policy beneficiary or trust beneficiary? Yes No
If "Yes," provide the name of the Premium Financing Program or Lender: _____

Note: Submission of this form constitutes written authorization to Phoenix by the proposed owner and proposed insured to contact the program sponsor and/or lender to obtain further information regarding the loan and the terms and conditions of the financing program.

2. a. Who will contribute the funds? (check all that apply)
 Premium Financing Program or Lender identified above Proposed Insured Proposed Owner
 Grantor of the trust (if other than the insured): _____
 Another individual and/or Entity, including a Trust or Policy Beneficiary
(Please provide the name, relationship, and reason for the contribution): _____

b. If you have not identified a Premium Financing Program or Lender above, please identify the source of funding for the premiums (check all that apply)
 Current Income Cash and Equivalents Marketable Securities Non-Readily Marketable Securities Retirement Accounts
 Other Assets (explain): _____

Note: A financial statement is required from the premium payor if funds are not provided by the Insured(s), the Owner(s) or a Premium Financing Entity or Lender.

Statement Of Client Intent

Use Section 12 - Additional Information if additional space is necessary to record details.

The following questions must be completed if the Proposed Insured is age 65 or older and the face amount of the policy (including any riders) is \$2,000,000 or greater.

	Life One	Life Two
1. Is there an agreement or arrangement between the premium payer and the owner, insured or beneficiary in which the premium payer will receive a portion of the death benefit or an interest or right to an interest in the death benefit? (If "Yes", provide details.) Details:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. Have you discussed with, or been solicited by, any person or entity to directly or indirectly sell, assign, settle or otherwise transfer the policy or an interest in the policy or an ownership or beneficial interest in the entity that will own the policy to any third party? (If "Yes", provide details including the names of the parties involved and dates of the discussions.) Details:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. Have you discussed with, or been solicited by, any person or entity to directly or indirectly participate in a transaction involving an option agreement, sale or a beneficial interest or merger arrangement? (If "Yes", provide details including the names of the parties involved and dates of the discussions.) Details:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4. Has any entity, including, for example, any life expectancy valuation company or premium financing company, conducted (or made plans to conduct in the future) a life expectancy evaluation of the insured within the past two years? (If "Yes", identify the entity or entities that provided the life expectancy valuations.) Details:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5. Has the proposed insured or the proposed owner participated in a transaction involving the sale or transfer of a life insurance policy insuring the life of the proposed insured(s) occurring within 60 months of the issuance of such policy or policies? (If "Yes", provide details including the issue date of the policy settled.) Details:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6. Has the proposed insured or proposed owner, or any individual, trust, partnership, corporation or similar or related entity received or been promised cash or other financial or non-financial inducements in connection with this Application or the purchase of this insurance? (If "Yes", provide details.) Details:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No



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]

Term Life – Part 1
Product Selection

Print and use black ink. Any changes must be initialed by the Proposed Insured(s) and Owner.

Section 1 - Proposed Insured Information

Proposed Insured

Name (First, Middle, Last) John Doe

Section 2 - [Phoenix Protector Term Life Portfolio]

Product (select product)

- Phoenix Protector Term Life - 10
- Phoenix Protector Term Life - 20
- Phoenix Protector Term Life - 30
- Other _____]

Face Amount \$ _____

Riders (select all applicable riders)

- Disability Benefit Rider
- Acceleration of Death Benefit Rider (Accelerated Benefit Rider) **(Non Qualified Only)**
- Return of Premium (Endowment Benefit Rider)
- Other (Rider Name) _____]



PHL Variable Insurance Company (Phoenix)

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Overnight Mail: [30 Dan Rd., Suite 8027, Canton MA 02021-2809]

Universal Life – Part 1
Product Selection

Print and use black ink. Any changes must be initialed by the Proposed Insured(s) and Owner.

Section 1 - Proposed Insured Information

Table with 2 columns: Proposed Insured (Life One) and Proposed Insured (Life Two). Row 1: Name (First, Middle, Last) John A. Doe and Jane A. Doe.

Section 2A - Single Life Plan of Insurance

Complete only ONE Life Plan of Insurance. If Single Life Plan is requested select Section 2A, otherwise see Section 2B for Multi - Life Plans.

[X] 1. Phoenix Accumulator Universal Life

Face Amount \$ 1,000,000

Death Benefit Option: (check one) If none checked, Option A will apply.

[X] Option A Level [] Option B Increasing

Life Insurance Qualification Test: (check one) If none checked, [Guideline Premium] will apply. Elected test cannot be changed after the policy is issued. You may request an Illustration on both tests before making your election.

[X] Guideline Premium Test [] Cash Value Accumulation Test

Riders (select all applicable riders)

[] Increasing Term Protection Rider (Individual Increasing Term Rider) (available only with Death Benefit Option A)

Annual Rider Increase Options

- [] Percentage Increase %
[] Fixed Dollar Increase \$
[] Increase Equal to Premiums Paid

[X] Disability Benefit Rider Specified Amount \$

[X] Acceleration of Death Benefit Rider (Accelerated Benefit Rider) (Non Qualified only)

[] Alternate Surrender Value Rider Select a benefit period of 1-7 years years

* Minimum Premium amount required. (If elected, cannot elect Waiver of Surrender Charge Rider)

[] Waiver of Surrender Charge Rider

* Minimum Premium amount required. (If elected, cannot elect Alternate Surrender Value Rider)

[] Other (Rider Name)]

[] 2. Phoenix Universal Life with Guarantee

Face Amount \$

Riders (select all applicable riders)

[] Disability Benefit Rider Specified Amount \$

[] Other (Rider Name)]

Section 2A - Single Life Plans of Insurance (continued)

3. **Phoenix Indexed Universal Life**

Face Amount \$ _____

Death Benefit Option: (check one) If none checked, Option A will apply.

Option A Level Option B Increasing]

Life Insurance Qualification Test: (check one) If none checked, Guideline Premium will apply. **Elected test cannot be changed after the policy is issued.** You may request an Illustration on both tests before making your election.

Guideline Premium Test Cash Value Accumulation Test]

Riders (select all applicable riders)

Increasing Term Protection Rider (Individual Increasing Term Rider) (available only with Death Benefit Option A)

Annual Rider Increase Options

Percentage Increase %

Fixed Dollar Increase \$ _____

Increase Equal to Premiums Paid

Level Term Protection Rider (Individual Level Term Rider) Face Amount \$ _____

Disability Benefit Rider Specified Amount \$ _____

Early Crediting Option Rider

Alternate Surrender Value Rider Select a benefit period of 1-7 years years

* Minimum Premium amount required. (If elected, cannot elect Waiver of Surrender Charge Rider)

Waiver of Surrender Charge Rider

* Minimum Premium amount required. (If elected, cannot elect Alternate Surrender Value Rider)

Other (Rider Name) _____]

Features (select applicable feature(s))

Monthly Transfer Strategy]

Premium Allocation (All requests must be in whole percentages and total allocation **MUST** equal 100%)

Fixed Account %

Indexed Account A – Annual Point-to-Point with CAP %

Indexed Account B – Annual Point-to-Point with Participation Rate %

Other %]

TOTAL 100%

By selecting this Plan of Insurance, I understand the following:

- I am applying for an indexed universal life insurance product, which includes a Fixed Account and one or more Indexed Accounts. While Policy Value for each Indexed Account is affected by the value of an outside index, the policy does not directly participate in any stock, bond or equity investment.
- Premiums are initially applied to the Fixed Account and will not be transferred to the Indexed Account(s) until the next eligible Transfer Date and Premium Allocation election(s) can be made by written request to Phoenix.
- Index Credits, if any, are not credited to the Indexed Account until the Segment Maturity Date.

Section 2B - Multi - Life Plans of Insurance

Complete only **ONE** Multi - Life Plan of Insurance.

1. Phoenix Survivorship Universal Life with Guarantee

Face Amount \$ _____

Riders (select all applicable riders)

- Disability Benefit Rider Specified Amount \$ _____
 - Life One
 - Life Two
- Conditional Exchange Option Rider
- Other (Rider Name) _____

2. Phoenix Estate Legacy

Face Amount \$ _____

Death Benefit Option: (check one) If none checked, Option will apply.

- Option 1 Level Option 2 Increasing

Life Insurance Qualification Test: (check one) If none checked, [Guideline Premium] will apply. **Elected test cannot be changed after the policy is issued.** You may request an Illustration on both tests before making your election.

- Guideline Premium Test Cash Value Accumulation Test

Riders (select all applicable riders)

- Alternate Surrender Value Rider (Select a benefit period of 1-7 years) _____ years
- Conditional Exchange Option Rider
- 4 Year Survivorship Term Rider
- Other (Rider Name) _____



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]

Variable Life – Part 1
Product Selection

Print and use black ink. Any changes must be initialed by the Proposed Insured(s) and Owner.

Section 1 - Proposed Insured Information

Table with 2 columns: Proposed Insured (Life One) and Proposed Insured (Life Two). Includes Name (First, Middle, Last) for John A. Doe and Jane A. Doe.

Section 2A - Single Life Plan of Insurance

[] Phoenix Benefit Choice VUL

Face Amount \$ 1,000,000

Death Benefit Option: (check one) If none checked, Option [A] will apply.

[X] Option A Level [] Option B Increasing

Life Insurance Qualification Test: (check one) If none checked, [Guideline Premium] will apply. Elected test cannot be changed after the policy is issued. You may request an Illustration on both tests before making your election.

[X] Guideline Premium Test [] Cash Value Accumulation Test

Riders (select all applicable riders)

[] Increasing Term Protection Rider (Individual Increasing Term Rider) (available only with Death Benefit Option A)

Annual Rider Increase Options

[] Percentage Increase %

[] Fixed Dollar Increase \$

[] Increase Equal to Premiums Paid

[X] Level Term Protection Rider (Individual Level Term Rider) Face Amount \$

[X] Disability Benefit Rider Specified Amount \$

[] Alternate Surrender Value Rider (Select a benefit period of 1-7 years) years

* Minimum Premium amount required.

[] Other (Rider Name)]

Section 2B - Multi - Life Plan of Insurance

[] Phoenix Joint Edge VUL (First-to-die)

Face Amount \$

Death Benefit Option: (check one) If none checked, Option [A] will apply.

[] Option A Level [] Option B Increasing [] Option C Return of Premium

Riders (select all applicable riders)

[] Disability Benefit Rider Specified Amount \$

[] Life One

[] Life Two

[] Level Term Protection Rider (Individual Level Term Rider)

[] Life One Face Amount \$

[] Life Two Face Amount \$

[] Alternate Surrender Value Rider (Select a benefit period of 1-7 years) years

[] Survivor Purchase Option Rider (Survivor Insurance Purchase Option Rider)

[] Other (Rider Name)]

Section 3 - Suitability

Do you understand that the Death Benefit may be variable or fixed under certain conditions and the Death Benefit and Cash Values under any Variable Policy may increase or decrease in amount or duration or even be exhausted to zero based on the investment experience of the underlying investment options? Yes No

Do you believe that the variable life policy you are purchasing is suitable to meet your financial objectives? Yes No

My signature in the Signature section of this application acknowledges that (a) I understand that a variable life insurance policy is not an appropriate investment vehicle for short term trading strategy or short term savings and (b) I confirm that I have received the prospectus for the variable life policy I am purchasing.

Illustrations of benefits including death benefits, policy values and cash surrender values are available on request.

Section 4 - Temporary Money Market Allocation

If your state of issue does not require refund of premium during the Right to Return This Policy period, but you prefer to temporarily allocate your premiums to the Money Market investment options until the end of the Right to Return This Policy period, as stated in the policy, please check this box.

Section 5 - Telephone/Electronic Authorization

If none checked, Owner ONLY will apply.

I, the Owner, will receive this privilege automatically. By checking "Yes", I am authorizing and directing Phoenix to act upon telephone or electronic instructions from my licensed representative who can furnish proper identification. Phoenix will use reasonable procedures to confirm that these instructions are authorized and genuine. As long as these procedures are followed, Phoenix and its affiliates and their directors, trustees, officers, employees and licensed representatives, will be held harmless for any claims, liability, loss or cost. Yes No



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]

Other Insured Supplement

Part 1

To be completed only if applying to insure more than 2 lives

Print and use black ink. Any changes must be initialed by the Proposed Insured and Owner.

Section 1 - Proposed Insured Information

Form for Section 1 containing personal and financial information for Jim A. Doe, including marital status, birth details, income, and residence information.

Section 2 - Multi - Life Plan of Insurance

[] Phoenix Joint Edge VUL (First-to-die)]

Riders (select all applicable riders) section with checkboxes for Disability Benefit Rider, Level Term Protection Rider, and Other.

Section 3 - Existing and Pending Life Insurance

1. a. 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
- b. 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? Yes No
- c. Are there any life insurance policies or annuity contracts owned by, or on the life of, the applicant(s) or the insured(s) or the owner(s) or the annuitant? Yes No

2. Provide information for each policy in force with all companies on the life of the insured. Include any policy that has been sold, assigned, transferred or settled with any other person or entity.

If no coverage in force, check here. Continue to question 3.

Proposed Insured	Company	Insurance		Issue Date mm/yyyy	Replacing?		Amount Including Riders	Indicate if Sold, Assigned, Transferred or Settled
		Personal	Business		Yes	No		
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	\$	
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	\$	
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	\$	
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	\$	

3. Have you ever had an application for life insurance declined, postponed, rated substandard or offered with a reduced face amount?

Yes No If "Yes", provide details. _____

4. List the total insurance currently applied for with all companies including this Application (**do not include informal inquiries**). Provide name of Life Insurance Company and amount **applied for**.

Company	Amount Including Riders
Phoenix (current application information)	\$ 1,050,000
	\$
	\$
	\$
Total Amount	\$ 1,050,000

5. List the total amount of new coverage to be placed including Phoenix and all other carriers. (**do not include informal inquiries**)

]

Section 4 - Medical Transfer Statement

Complete when submitting medical examinations of another insurance company.
NOTE: Medical History section must be completed if a Phoenix exam is not used.

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 exam, and authorize my producer, broker or other life insurance company to provide such exam to Phoenix.

- Name of the insurance company for which examination(s) was completed. Insurion Associates
- Date of examination (mm/dd/yyyy) 12/1/2008
- 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.
- Have you consulted a medical doctor or other practitioner since the above examination? Yes No

Section 5 - Medical History

Complete section in its entirety if using an exam from another company.
If using a Phoenix exam, ONLY questions in bold and with an asterisk (*) are required.

Current Height <u> 6'2" </u>		Has your weight changed by 10 pounds or more in the past 2 years? If "Yes", how many <u> </u> pounds <input type="checkbox"/> Gain <input type="checkbox"/> Loss	
Current Weight <u> 203 </u>		Reason _____	
Family History:	Age if Alive	Age at Death	If alive, indicate health problems or if deceased, indicate cause of death:
Father <input checked="" type="checkbox"/> Alive <input type="checkbox"/> Deceased	75		
Mother <input checked="" type="checkbox"/> Alive <input type="checkbox"/> Deceased	72		
Has anyone in your immediate family developed any hereditary condition, cancer, or heart disease before age 60? <input type="checkbox"/> Yes (please provide details) <input checked="" type="checkbox"/> No			
* Personal Physician or Healthcare Provider Name (First, Last) Dr. John Johnson			* Phone # (860) 525 - 6363
* Street Address (include Suite #) 123 Medical Drive, Suite 100			
* City Anytown			* State CT
			* ZIP Code 11256
* Date of most recent visit (mm/dd/yyyy) 1/13/2009		* Reason for visit Annual Physical	
* Results of treatment (if any)			

This section must be completed in its entirety if using an exam from another company.

Section 5 - Medical History continued

If using a Phoenix exam, ONLY questions 1-4 in bold and asterisk (*) must be completed.

To the best of your knowledge and belief, have you ever had, or been told by a licensed medical professional, licensed physician or other health care provider that you have:

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

Please provide details of "Yes" answers (include question number, diagnosis, date of occurrence, current status, hospital and/or treating physician's name and address). Use Section 7 - Additional Information if additional space is necessary to record all details.

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

Section 6 - Non - Medical Information

Provide full details for all "Yes" answers below.

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," provide date, company and reason.) Date (mm/dd/yyyy): Company: Reason:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. Do you intend to travel or reside outside of the United States or Canada? (If "Yes," state where, how long and purpose.) Location City, Country: How Long: (Specify weeks, months, years) Purpose:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. Have you flown during the past 3 years as a pilot, student pilot or crew member or do you plan to do so? (If "Yes," complete [Aviation Questionnaire.]	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4. Have you participated in the past 3 years or plan to engage in any extreme sport activities such as motorized vehicle racing, parachute jumping, underwater diving, or any other extreme avocation? (If "Yes," complete [Avocation Questionnaire.]	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5. Have you ever been convicted of a felony? (If "Yes," provide details.) Details:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6. Have you ever been convicted of driving under the influence of alcohol or drugs, or had any moving violations in the past 3 years? (If "Yes," provide details.) Details:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7. State in detail what bona fide need the Proposed Owner or Proposed Insured has for this insurance. Use Section 7 - Additional Information if additional space is necessary to record all details.	

Section 8 - Authorization To Obtain Information

I authorize any licensed physician, health care practitioner, hospital, medical laboratory, clinic or other medically-related facility, medical data provider, insurance company or the Medical Information Bureau (MIB), or any other similar person or organization, having any records or knowledge of me or my health, to provide to PHL Variable Insurance Company (Phoenix), or its reinsurers the following information: 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 or its reinsurers any of my information relating to alcohol use, drug use and mental health care.

Any information (medical and non-medical) will be used for the purpose of risk evaluation and determining eligibility for benefits under any policies issued. Phoenix 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 provide such records or knowledge to any agency employed by Phoenix 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 to Phoenix or its reinsurers the following information regarding my insurability: information about my occupation, participation in hazardous activities, motor vehicle record, foreign travel, finances, general health, insurable interest and other 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 (24 months in Colorado, Iowa, Kansas, Kentucky, Oklahoma, West Virginia and Wyoming) 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 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.

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

Section 9 - Signature

The Application consists of Part I and Part II. I have reviewed this Application, and the statements made herein are those of the Proposed Insured(s) and all such statements made by the Proposed Insured(s) in Part I of this Application (and Part II, if applicable are) full, complete and true to the best of my knowledge and belief 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 Phoenix unless stated in Part I and/or Part II of this Application (not applicable in ND and SD) and 2) no Licensed Producer has authority to make, modify, alter or discharge any contract thereby applied for.

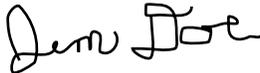
I understand and agree that the insurance applied for shall not take effect unless and until each of the following has occurred: 1) the policy has been issued by Phoenix; 2) the premium required for issuance of the policy has been paid in full during the lifetime of the Insured(s); 3) all the representations made in the Application remain true, complete and accurate as of the date the policy is delivered; 4) the Insured(s) are alive when the policy is delivered, and 5) as of the date of delivery of the policy, there has been no change in the health of any Insured(s) that would change the answers to any of the questions in the Application.

I understand that if there is any change in health or physical condition of any Proposed Insured, or if any Proposed Insured visits a physician or is hospitalized, subsequent to the date I complete the Application or provide any information to be contained in the Application, I will inform Phoenix in writing as soon as possible at address [PO Box 8027, Boston MA 02266-8027.]

If I have applied for the Acceleration of Death Benefit Rider I confirm that I have received a copy of the disclosure form, Summary of Coverage of Death Benefit Rider.

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.

If I am Owner who is not a Proposed Insured, I join in the foregoing affirmations, acknowledgments, and undertakings of the Proposed Insured(s). In addition, the statements made by me in any Part of this Application are full, complete, and true to the best of my knowledge and belief, and have been correctly recorded.

Proposed Insured's Signature 	State Signed In CT	Date (mm/dd/yyyy) 2/2/2009
Owner's Signature/Title (if other than Proposed Insured)	State Signed In	Date (mm/dd/yyyy)
Owner's Signature/Title (if other than Proposed Insured)	State Signed In	Date (mm/dd/yyyy)
Collateral Assignee's Signature (if applicable)	State Signed In	Date (mm/dd/yyyy)
Parent or Guardian of Minor Signature (if applicable)	State Signed In	Date (mm/dd/yyyy)

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of competent jurisdiction. (Not applicable in AR, DC, FL, LA, ME, MA, NJ, NM, NY, OH, OR, PA, TX, VA and WA).

In AR and LA any person who knowingly presents a false or fraudulent claim for payments 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.

In DC, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON, PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, ANY INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

In OH, any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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 discrepancies or misrepresentations in the recorded information; and that he/she is qualified and authorized to discuss the contract herein applied for.

Licensed Producer's Name (Print First, Middle, Last)	Licensed Producer's Email Address	Phoenix Producer I.D. #	Licensed Producer's Telephone #	Licensed Producer's Signature
Alan A. Agent	alan.agent@phoenixwm.com	12-565-1212	(860) 757 - 4242	
			() -	
			() -	

SERFF Tracking Number: TPCI-126017168 State: Arkansas
Filing Company: PHL Variable Insurance Company State Tracking Number: 41432
Company Tracking Number: OL4400
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Combo Application
Project Name/Number: /

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: TPCI-126017168

State: Arkansas

Filing Company: PHL Variable Insurance Company

State Tracking Number: 41432

Company Tracking Number: OL4400

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Product Name: Combo Application

Project Name/Number: /

Supporting Document Schedules

Review Status:

Satisfied -Name: Flesch Certification

02/02/2009

Comments:

Attachment:

AR certification - Combo.pdf

Review Status:

Satisfied -Name: Statement of Variability

02/03/2009

Comments:

Attachment:

Statement of Variability - Generic.pdf

Review Status:

Satisfied -Name: Cover Letter

02/03/2009

Comments:

Attachment:

AR - Cover Letter.pdf

**ARKANSAS
CERTIFICATION**

FORM NO.	OL4400
FORM TITLE	Application for Life Insurance Part 1
FLESCH SCORE	60.07
FORM NO.	OL4401
FORM TITLE	Application Part 1 Funding Intentions
FLESCH SCORE	*58.72
FORM NO.	OL4402
FORM TITLE	Term Life - Part 1 Product Selection
FLESCH SCORE	*59.82
FORM NO.	OL4403
FORM TITLE	Universal Life - Part 1 Product Selection
FLESCH SCORE	*56.96
FORM NO.	OL4404
FORM TITLE	Variable Life - Part 1 Product Selection
FLESCH SCORE	*58.23
FORM NO.	OL4406
FORM TITLE	Other Insured Supplement Part 1
FLESCH SCORE	59.26

* This form was scored in conjunction with form OL4400.

I hereby certify the following:

- To the best of my knowledge and belief, the above form(s) and submission comply with Reg. 19 and Reg. 49, as well as the other laws and regulations of the State of Arkansas.
- The attached forms have achieved Flesch Reading Ease scores in compliance with Arkansas Code 23-80-206.

PHL Variable Insurance Company



Signature: _____

Name: Barbara Slater
Title: Compliance Coordinator
Date: February 2, 2009

Statement of Variability – Application for Life Insurance Part 1

This Statement of Variability sets forth the variable information which will appear in brackets in form OL4400 (Application for Life Insurance Part 1). No change in variability will be made which in any way expands the scope of the wording being changed.

Page Numbers – The page numbers have been bracketed to accommodate the insertion of forms OL4401 (dependent on insured’s age and coverage amount requested), and the necessary insertion of one of the following forms for selection of product type: OL4402 (Term Life – Part 1 Funding Intentions), OL4403 (Universal Life – Part 1 Funding Intentions), and OL4404 (Variable Life – Part 1 Funding Intentions). These forms will be inserted between the sections titled “Additional Information” and “Authorization to Obtain Information.” The page numbering of these forms will be consecutive from page 1 through the “Signature” section, and exhibited in the “1 of 11,” “2 of 11” format. The page numbers are also bracketed to account for the possibility of additional space being made for answers or special instructions.

Form Names and Numbers – The bracketing of form names and numbers throughout the application indicates that they may either change or additional references to forms may be added in the future.

Addresses – Each address shown in the application has been bracketed to indicate that it may either change or an additional address may be added in the future.

OL4400, Page 1 of 11

Section 1 – Type of Application – The New Business application types have been bracketed to indicate that either all the options shown here may not be available, or that additional application types may be added.

The Face Amount Increase has been bracketed to indicate that this option may not be made available on this form. If that is the case, another form will be available.

The Term Conversion has been bracketed to indicate that this option may not be made available on this form. If that is the case, another form will be available.

Section 2 – Proposed Insured Information (Life One) – The language under “U.S. Citizen” has been bracketed to indicate that it may be deleted in the future. If it is deleted, it will be done so on a non-discriminatory basis, and will be deleted regardless.

“Non U.S Citizen Only” has been bracketed to indicate that it may be deleted in the future. If it is deleted, it will be done so on a non-discriminatory basis, and will be deleted regardless of product type applied for.

Section 3 – Proposed Insured Information (Life Two) – The language under “U.S. Citizen” has been bracketed to indicate that it may be deleted in the future. If it is deleted, it will be done so on a non-discriminatory basis, and will be deleted regardless of product type applied for.

“Non U.S Citizen Only” has been bracketed to indicate that it may be deleted in the future. If it is deleted, it will be done so on a non-discriminatory basis, and will be deleted regardless of product type applied for.

OL4400, Page 2 of 11

Section 4 – Ownership – The bracketing of the text in this section indicates that it may be deleted in the future. If it is deleted, it will be done so on a non-discriminatory basis, and will be deleted regardless.

OL4400, Page 3 of 11

The bracketing of the text regarding residence outside of the U.S. in this section indicates that it may be deleted in the future. If it is deleted, it will be done so on a non-discriminatory basis, and will be deleted regardless of product type applied for.

OL4400, Page 4 of 11

Section 6 – Existing and Pending Life Insurance continued

Questions 5 and 6.d have been bracketed to indicate they may or may not appear on the form. If they do appear on the form the text that appears will be identical to the text that appears on the form. Should the text be removed, the remaining questions in Section 6 will be renumbered to accommodate the deletion of these questions.

OL4400, Page 5 of 11

Section 6 – Existing and Pending Life Insurance continued - Question 7 has been bracketed to indicate that it may not appear on this form.

All section headings from 7 to 14 have been bracketed to indicate that the ordering of sections may change and/or bracketed sections may be deleted causing a reordering. Any cross reference to these sections in the form will change accordingly.

Section 7 – Term Conversion Options – This section has been bracketed to indicate that it may not be made available on this form. If that is the case, another form will be available.

Section 8 – Mode of Premium Payment – The different payment options have been bracketed to indicate that either all of the options shown here may not be available, or that additional payment options may be added.

OL4400, Page 11 of 11

The “Fraud” language has been bracketed to indicate that it may change in the event state-specific requirements / terminology change.

The “For Conversions Only” language has been bracketed to indicate that it may not be made available on this form. If that is the case, another form will be available.

Statement of Variability – Application Part 1 Funding Intentions

This Statement of Variability sets forth the variable information which will appear in brackets in form OL4401 (Application Part 1 Funding Intentions). No change in variability will be made which in any way expands the scope of the wording being changed.

OL4401, Page 1 of 1

Page Number – The page number has been bracketed to accommodate the insertion of form OL4401 between the sections titled “Additional Information” and “Authorization to Obtain Information” of form OL4400, so as to provide for consecutive numbering. The insertion of this form will be dependent on the age of the insured and the amount of coverage being applied for.

Funding Questions – The criteria (insured’s age and coverage amount) used to determine if the applicant is required to complete this form has been bracketed to indicate that it might change in the future.

The questions have been bracketed to indicate that a combination of all or some will appear on this form. If questions are deleted we will renumber accordingly.

Statement of Client Intent – The criteria (insured’s age and face amount) used to determine if the applicant is required to complete this form has been bracketed to indicate that it might change in the future.

The questions have been bracketed to indicate that a combination of all or some will appear on this form. If questions are deleted we will renumber accordingly.

Statement of Variability – Term Life - Part 1 Product Selection

This Statement of Variability sets forth the variable information which will appear in brackets in form OL4402 (Term Life - Part 1 Product Selection). No change in variability will be made which in any way expands the scope of the wording being changed.

OL4402, Page 1 of 1

Page Number – The page number has been bracketed to accommodate the insertion of form OL4402 between the sections titled “Additional Information” and “Authorization to Obtain Information” of form OL4400, so as to provide for consecutive numbering. The insertion of this form will be dependent on the product type being applied for.

Company Address – Each address on this page has been bracketed to indicate that it may either change or an additional address may be added in the future.

Section 2 – Phoenix Protector Term Life Portfolio – The product marketing name has been bracketed to indicate that it may change in the future.

The different products have been bracketed to indicate that either all the options shown may not be available or that additional term products may be added.

The riders have been bracketed to indicate that additional riders or endorsements may be added in the future, or riders currently offered may no longer be offered. However, no riders will be added to this form unless they have been previously approved by your Department, if approval is required.

Statement of Variability – Universal Life - Part 1 Product Selection

This Statement of Variability sets forth the variable information which will appear in brackets in form OL4403 (Universal Life - Part 1 Product Selection). No change in variability will be made which in any way expands the scope of the wording being changed.

Page Numbers – The page numbers have been bracketed to accommodate the insertion of form OL4403 between the sections titled “Additional Information” and “Authorization to Obtain Information” of form OL4400, so as to provide for consecutive numbering. The insertion of this form will be dependent on the product type being applied for.

Company Address – Each address on this page has been bracketed to indicate that it may either change or an additional address may be added in the future.

Sections 2A – Single Life Plan of Insurance and 2B – Multi-Life Plan of Insurance

The product marketing names have been bracketed to indicate that the marketing name may change in the future.

The products have been bracketed to indicate either all the options may not be available or that additional universal life products may be added.

The Death Benefit Option, Life Insurance Qualification Test, Riders, Features and Premium Allocation: The bracketing of the checkboxes and text in this section indicates that if certain riders, features or options are no longer offered, they will not appear on this form. It is also bracketed to indicate that other riders, features or options may be added to this form. However, no riders will be added to this form unless they have been previously approved by your Department.

Statement of Variability – Variable Life - Part 1 Product Selection

This Statement of Variability sets forth the variable information which will appear in brackets in form OL4404 (Variable Life - Part 1 Product Selection). No change in variability will be made which in any way expands the scope of the wording being changed.

Page Numbers – The page numbers have been bracketed to accommodate the insertion of form OL4404 between the sections titled “Additional Information” and “Authorization to Obtain Information” of form OL4400, so as to provide for consecutive numbering. The insertion of this form will be dependent on the product type being applied for.

Company Address – Each address on this page has been bracketed to indicate that it may either change or an additional address may be added in the future.

Sections 2A – Single Life Plan of Insurance and 2B – Multi-Life Plan of Insurance

The product marketing names have been bracketed to indicate that the marketing name may change in the future.

The products have been bracketed to indicate either all the options may not be available or that additional variable life products may be added.

The Death Benefit Option, Life Insurance Qualification Test and Riders: The bracketing of the checkboxes and text in this section indicates that if certain riders, features or options are no longer offered, they will not appear on this form. It is also bracketed to indicate that other riders, features or options may be added to this form. However, no riders will be added to this form unless they have been previously approved by your Department, if approval is required.

OL4404 Page 2 of 2

Section 5 – Telephone/Electronic Authorization – The word “Electronic” has been bracketed to indicate that the option to authorize instructions electronically may not always be available.

Statement of Variability – Other Insured Supplement Part 1

This Statement of Variability sets forth the variable information which will appear in brackets in form OL4406 (Other Insured Supplement Part 1). No change in variability will be made which in any way expands the scope of the wording being changed.

Page Numbers – The page numbers have been bracketed to accommodate the insertion of form OL4401, depending on insured’s age and coverage amount requested. This form will be inserted between the sections titled “Non-Medical Information” and “Authorization to Obtain Information.” The page numbering of these forms will be consecutive from page 1 through the “Signature” section, and exhibited in the “1 of 11,” “2 of 11” format. The page numbers are also bracketed to account for the possibility of additional space being made for answers or special instructions.

Form Names and Numbers – The bracketing of form names and numbers throughout the application indicates that they may either change or additional references to forms may be added in the future.

Addresses – Each address shown in the application has been bracketed to indicate that it may either change or an additional address may be added in the future.

OL4406, Page 1 of 8

Section 1 – Proposed Insured Information – The language under “U.S. Citizen” has been bracketed to indicate that it may be deleted in the future. If it is deleted, it will be done so on a non-discriminatory basis, and will be deleted regardless.

“Non U.S Citizen Only” has been bracketed to indicate that it may be deleted in the future. If it is deleted, it will be done so on a non-discriminatory basis, and will be deleted regardless of product type applied for.

Section 2 – Multi-Life Plan of Insurance - The product marketing name has been bracketed to indicate that the marketing name may change in the future.

The product has been bracketed to indicate either the option may not be available or that additional variable life products may be added.

The riders have been bracketed to indicate that additional riders or endorsements may be added in the future or riders currently offered may no longer be offered. However, no riders will be added to this form unless they have been previously approved by your Department, if approval is required.

OL4406, Page 2 of 8

Section 3 – Existing Life Insurance - Question 5 has been bracketed to indicate it may or may not appear on the form. If it does appear on the form the text that appears will be identical to the text that appears on the form.

OL4406, Page 8 of 8

The “Fraud” language has been bracketed to indicate that it may change in the event state-specific requirements / terminology change.



Barbara Slater -
State Compliance Coordinator
Life & Annuity State Compliance Office
One American Row Hartford, CT 06102-5056
(860) 403-5607 Fax: (860) 403-7252
Toll Free: 1-800-349-9267 (press 2, then 7)
Email: Barbara.Slater@phoenixwm.com

February 2, 2009

Mr. Joe Musgrove
Department of Insurance
State of Arkansas
1200 West Third Street
Little Rock, Arkansas 72201

RE: **PHL Variable Insurance Company**
NAIC # 93548, FEIN #06-1045829

For Approval Purposes

Form OL4400 – Application for Life Insurance Part 1
Form OL4401 – Application Part 1 Funding Intentions
Form OL4402 – Term Life – Part 1 Product Selection
Form OL4403 – Universal Life – Part 1 Product Selection
Form OL4404 – Variable Life – Part 1 Product Selection
Form OL4406 – Other Insured Supplement Part 1

Dear Mr. Musgrove:

We are filing the above-referenced forms for approval in your jurisdiction. The forms are filed in accordance with the applicable statutes and regulations of your jurisdiction and are laser printed, subject only to minor variations in paper stock, color, fonts, duplexing, and positioning. These forms are new and are not intended to replace any existing forms. The forms will be effective on the date of approval. These forms will be used on an individual basis in our general market. These forms were approved by our domiciliary state of Connecticut for use outside of Connecticut effective 2/2/2009.

The Application for Life Insurance Part 1, form **OL4400**, has been designed for use with our Term, Universal and Variable Life products and may be used with any Term, Universal and Variable Life Insurance Products that have been previously approved by your department and any Term, Universal or Variable Life Insurance Products we may develop in the futures. The Application for Life Insurance Part 1 will be used in conjunction with the Application Part 1 Funding Intentions and the Product Selection forms for the product applied for. The use of form **OL4401**, Application Part 1 Funding Intentions, will be dependent on the age of the insured and the amount of coverage being applied for. Form **OL4402**, Term Life – Part 1 Product Selection will be used when the applicant is applying for Term Life Insurance. Form **OL4403**, Universal Life – Part 1 Product Selection will be used when an applicant is applying for one of our Universal Life Products. Form **OL4404**, Variable Life – Part 1 Product selection will be used when the application is applying for Variable Life Insurance.

The Other Insured Supplement, form **OL4406**, allows for the addition of an additional insured on a life policy approved for multiple lives (excluding any survivorship product.) In addition, Application Part 1 Funding Intentions, form **OL4401**, will be used in conjunction with form **OL4406** for the other insured(s) depending on the age of the insured(s) and the amount of coverage being applied for.

Please see the enclosed Statement of Variability for a description of the bracketing that appears in the forms. These forms will be filed in all states, the District of Columbia and Puerto Rico.

Any requisite fees and filing documents have been enclosed.

Your attention to this submission is appreciated. Should you have any questions or comments regarding this filing, please contact me at (860) 403-5607, or by email at Barbara.Slater@PhoenixWM.com.

Thank you in advance for your immediate attention.

Sincerely,

A handwritten signature in cursive script that reads "Barbara Slater". The signature is written in black ink and is positioned to the left of the typed name.

Barbara Slater

SERFF Tracking Number: TPCI-126017168 State: Arkansas
 Filing Company: PHL Variable Insurance Company State Tracking Number: 41432
 Company Tracking Number: OL4400
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Combo Application
 Project Name/Number: /

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Application for Life Insurance Part 1	02/03/2009	OL4400 - Generic with John Doe.pdf
No original date	Form	Other Insured Supplement Part 1	02/03/2009	OL4406 - Generic - with John Doe.pdf
No original date	Supporting Document	Cover Letter	02/03/2009	AR - Cover Letter.pdf



PHL Variable Insurance Company (Phoenix)

Application for Life Insurance Part 1

Regular Mail: [PO Box 8027, Boston MA 02266-8027]

Overnight Mail: [30 Dan Rd., Suite 8027, Canton MA 02021-2809]

Print and use black ink. Any changes must be initialed by the Proposed Insured(s) and Owner.

Section 1 - Type of Application

Select one type of application below and then complete information for the selected type.

Form for Section 1 with checkboxes for New Business, Face Amount Increase, and Term Conversion. Includes options for Term Life, Universal Life, and Variable Life.

Section 2 - Proposed Insured Information (Life One)

Form for Section 2 containing personal information for John A. Doe, including marital status, birth details, income, residence, and contact information.

Section 3 - Proposed Insured Information (Life Two)

Complete if applying for a Multi - Life product. Use Other Insured Supplement (OL4406) to add additional Insureds. Skip Address and Home Phone # if same as Life One.

Form for Section 3 containing personal information for Jane C. Doe, including marital status, birth details, income, residence, and contact information.

Section 4 - Ownership

If Proposed Insured(s) are Owners, continue on to Section 5.

If not, complete Owner's Address, Employer-Owned question and **ONE** Ownership Type section. Use [Section 12]- Additional Information for details.

Owner's Address

Complete Owner's Address [and residency].

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

Do any Owner(s) reside outside of the U.S.? Yes No If "Yes", provide details.

Employer-Owned

Please indicate if the policy will be employer-owned. If the employer is also the beneficiary, complete [Notice and Consent for Employer-Owned Life Insurance (OL4320)].

If the policy is employer-owned, Section 101(j) of the Internal Revenue Code may apply and the death benefit may be subject to income taxes. **Please consult a tax professional** prior to submission of the Application to ensure compliance and understanding of the notice and consent requirements of Section 101(j).

Will the applied for policy be employer-owned? Yes No

Ownership Type

Check **ONE** Ownership Type and complete section.

A - Single Owner

Primary Owner Name (First, Middle, Last)	Social Security No./Tax ID	Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured(s)
Contingent Owner Name (First, Middle, Last) (if applicable)	Social Security No./Tax ID	Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured(s)

B - Multiple Owners

Use Section 12 - Additional Information for details.

Co-Owner Name (First, Middle, Last)	Social Security No./Tax ID	Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured(s)
Co-Owner Name (First, Middle, Last)	Social Security No./Tax ID	Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured(s)

C - Trust

Indicate name of Trust and Tax ID to be used for tax reporting purposes. **[Must complete Certification and Acknowledgment of Trust Agreement (OL4132)].** Use [Section 12]- Additional Information for details.

Name(s) of Trust(s)	Trust Tax ID	Date Trust Established	
Name(s) of Trustee(s) (First, Middle, Last)	Social Security No./Tax ID		
Name(s) of Trustee(s) (First, Middle, Last)	Social Security No./Tax ID		
Trust Beneficiary Name(s) (First, Middle, Last)	Social Security No./Tax ID	Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured(s)
Trust Beneficiary Name(s) (First, Middle, Last)	Social Security No./Tax ID	Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured(s)
Trust Beneficiary Name(s) (First, Middle, Last)	Social Security No./Tax ID	Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured(s)

D - Partnership

List all partners and Tax ID used for tax reporting purposes. If there is a general partner, complete **Partnership Authorization** letter.

Name of Partnership	Tax ID
Name(s) of All Partner(s) (First, Middle, Last)	

E - Corporation

Please provide name of Corporation and Tax ID for tax reporting purposes. Attach a **Corporate Resolution Agreement**.

Name of Corporation	Contact Name (First, Last)	Work Phone # () -	Tax ID
Is Corporate Resolution Agreement with authorization signatures attached? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Section 5 - Beneficiary Designation

Owner

Trust under Insured's will

Surviving Insured(s) (Joint Edge VUL only)

Beneficiaries stated below

Select Primary Beneficiary type(s) (to the left). If the Beneficiary box is checked or there is more than 1 (one) beneficiary type selected use the grid below for details. Unless otherwise specified, payments will be shared equally by all surviving primary beneficiaries, or if none, by all surviving contingent beneficiaries.

Only the owner has the right to change the beneficiaries unless otherwise stated.

Use Section 12. Additional Information for additional beneficiaries.

Beneficiary Name (First, Middle, Last) or Entity Name	Beneficiary Designation Select one per beneficiary. If nothing checked, the designation will be Primary	Relationship to Proposed Insured	Date of Birth or Date of Trust (mm/dd/yyyy)	Social Security or Tax ID Number	Percent %
Mary Doe	<input checked="" type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse/Civil Union Partner <input type="checkbox"/> Child <input type="checkbox"/> Trust <input checked="" type="checkbox"/> Other <u>Mother</u>	4/2/1957	345-67-8912	100
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse/Civil Union Partner <input type="checkbox"/> Child <input type="checkbox"/> Trust <input type="checkbox"/> Other _____			
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse/Civil Union Partner <input type="checkbox"/> Child <input type="checkbox"/> Trust <input type="checkbox"/> Other _____			
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse/Civil Union Partner <input type="checkbox"/> Child <input type="checkbox"/> Trust <input type="checkbox"/> Other _____			

Do any Proposed Beneficiaries reside outside of the U.S.? Yes No If "Yes", provide details.

Complete Life One questions.
If applying for a Multi - Life product complete Life One and Life Two questions.

Section 6 - Existing and Pending Life Insurance

1. a. 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? Life One Life Two
 Yes No Yes No

b. 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? Life One Life Two
 Yes No Yes No

c. Are there any life insurance policies or annuity contracts owned by, or on the life of, the applicant(s) or the insured(s) or the owner(s) or the annuitant? Life One Life Two
 Yes No Yes No

2. Provide information for each policy in force with all companies on the life of the insured. Include any policy that has been sold, assigned, transferred or settled with any other person or entity.

If no coverage in force, check for which life or lives Life One Life Two. Continue to question 3.

Proposed Insured	Company	Insurance Personal Business	Issue Date mm/yyyy	Replacing? Yes No	Amount Including Riders	Indicate if Sold, Assigned, Transferred or Settled
<input type="checkbox"/> Life One <input type="checkbox"/> Life Two		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	\$	
<input type="checkbox"/> Life One <input type="checkbox"/> Life Two		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	\$	
<input type="checkbox"/> Life One <input type="checkbox"/> Life Two		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	\$	
<input type="checkbox"/> Life One <input type="checkbox"/> Life Two		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	\$	

Section 6 - Existing and Pending Life Insurance continued

3. Have you ever had an application for life insurance declined, postponed, rated substandard or offered with a reduced face amount?

Life One Yes No If "Yes", provide details. _____

Life Two Yes No If "Yes", provide details. _____

4. List the total insurance currently applied for with all companies including this Application (**do not include informal inquiries**). Provide name of the life insurance company and total amount **applied for**.

Life One		Life Two	
Company	Amount Including Riders	Company	Amount Including Riders
Phoenix (current application information)	\$ 1,000,000	Phoenix (current application information)	\$ 1,000,000
	\$		\$
	\$		\$
	\$		\$

5. List the total amount of new coverage to be placed in force including Phoenix and all other carriers.

Life One – Total Amount	Life Two – Total Amount
\$ 1,000,000	\$ 1,000,000

SKIP questions 6a-d If Life One and Life Two are married/civil union partners and are applying for multi-life coverage. Continue to question 7.

6. a. Provide name of Spouse/Civil Union Partner.

Life One Spouse/Civil Union Partner Name (First, Middle, Last)	Life Two Spouse/Civil Union Partner Name (First, Middle, Last)
-----------------------------------------------------------------------	-----------------------------------------------------------------------

b. Provide information on each policy **in force** with all companies on the life of the Spouse/Civil Union Partner of the Proposed Insured. Include any policy that has been sold, assigned, transferred or settled with any other person or entity.

Spouse/ Civil Union Partner	Company	Insurance		Issue Date mm/yyyy	Amount Including Riders	Indicate if Sold, Assigned, Transferred or Settled
		Personal	Business			
<input type="checkbox"/> Life One <input type="checkbox"/> Life Two		<input type="checkbox"/>	<input type="checkbox"/>		\$	
<input type="checkbox"/> Life One <input type="checkbox"/> Life Two		<input type="checkbox"/>	<input type="checkbox"/>		\$	
<input type="checkbox"/> Life One <input type="checkbox"/> Life Two		<input type="checkbox"/>	<input type="checkbox"/>		\$	
<input type="checkbox"/> Life One <input type="checkbox"/> Life Two		<input type="checkbox"/>	<input type="checkbox"/>		\$	

c. Provide name of the life insurance company and amount applied for on the life of the Spouse/Civil Union Partner of the Proposed Insured. List the total insurance currently **applied for** with all companies (**do not include informal inquiries**).

Life One (Spouse/Civil Union Partner)		Life Two (Spouse/Civil Union Partner)	
Company	Amount Including Riders	Company	Amount Including Riders
Phoenix (current application information)	\$	Phoenix (current application information)	\$
	\$		\$
	\$		\$
	\$		\$

d. List the total amount of new coverage to be placed including Phoenix and all other carriers on the Spouse/Civil Union Partner of the Proposed Insured.

Life One – Total Amount	Life Two – Total Amount
\$	\$

Section 6 - Existing and Pending Life Insurance continued

7. Juvenile Insurance (complete if applicant is a juvenile)

- a. Are all siblings equally insured? Yes No If "No", provide reason. _____
- b. Amount of life insurance currently in force or pending on parent(s)/guardian(s) \$ _____
 If none, provide reason _____

Life One		Life Two	
Name of Parent/Guardian	Amount Including Riders	Name of Parent/Guardian	Amount Including Riders
	\$		\$
	\$		\$
	\$		\$
	Total Amount \$		Total Amount \$

Section 7 Term Conversion Options

Complete if application is for Term Conversion.

1. a. If you are converting a term policy, do you want to continue any existing rider coverage under the new policy? Yes No
 If none checked, current rider coverage will be included on the new plan if applicable.
- b. If you are requesting a partial conversion, should the balance of the policy remain in force? Yes No
 If none checked, balance will remain inforce subject to contractual minimum amounts.
- c. Are you returning the original policy(ies) with this Application? Yes No
 If "No", check here if policy has been lost or destroyed.

Existing Policy Number to be Converted	Existing Plan Name or Rider Name	Face Amount to be Converted
		\$
		\$
		\$
	Total Amount	\$

Section 8 Mode of Premium Payment

- Annual Semi-Annual Quarterly Phoenix Check-O-Matic Service (checking account withdrawal) (PCS) Minimum Monthly Payment - \$25.00
 [Other] _____

Authorization Agreement for Preauthorized Payments

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.

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

Print Depositor Name (First, Middle, Last) _____ Relationship to Owner(s) _____

Include Voided Check

Send additional premium notices to:

Name (First, Middle, Last) _____

Street Address _____

City _____ State _____ ZIP Code _____ Relationship to Owner(s) _____

Complete when submitting medical examinations from another insurance company.
NOTE: Medical History [Section 10] must be completed if a Phoenix exam is not used.

Section 9 - Medical Transfer Statement

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 exam, and authorize my producer, broker or other life insurance company to provide such exam to Phoenix.

Life One	Life Two
1. Name of the insurance company for which examination(s) was completed. Insurion Associates	1. Name of the insurance company for which examination(s) was completed. Insurion Associates
2. Date of examination (mm/dd/yyyy) 1/2/2009	2. Date of examination (mm/dd/yyyy) 1/2/2009
3. To the best of your knowledge and belief, are the statements in the examination true, accurate and complete as of today? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "No", please explain.	3. To the best of your knowledge and belief, are the statements in the examination true, accurate and complete as of today? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "No", please explain.
4. Have you consulted a medical doctor or other practitioner since the above examination? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	4. Have you consulted a medical doctor or other practitioner since the above examination? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Complete section in its entirety if using an exam from another company. **If using a Phoenix exam, ONLY questions in bold and with an asterisk (*) are required.** Use Section 12 - Additional Information for details.

Section 10 - Medical History

Life One				Life Two			
Current Height 6' 2"		Current Weight 198		Current Height 5' 6"		Current Weight 130	
Has your weight changed by 10 pounds or more in the past 2 years? If "Yes", how many _____ pounds <input type="checkbox"/> Gain <input type="checkbox"/> Loss Reason _____				Has your weight changed by 10 pounds or more in the past 2 years? If "Yes", how many _____ pounds <input type="checkbox"/> Gain <input type="checkbox"/> Loss Reason _____			
Family History:	Age if Alive	Age at Death	If alive, indicate health problems or if deceased, indicate cause of death:	Family History:	Age if Alive	Age at Death	If alive, indicate health problems or if deceased, indicate cause of death:
Father <input checked="" type="checkbox"/> Alive <input type="checkbox"/> Deceased	58		None	Father <input checked="" type="checkbox"/> Alive <input type="checkbox"/> Deceased	60		None
Mother <input checked="" type="checkbox"/> Alive <input type="checkbox"/> Deceased	51		None	Mother <input checked="" type="checkbox"/> Alive <input type="checkbox"/> Deceased	57		None
Has anyone in your immediate family developed any hereditary condition, cancer, or heart disease before age 60? <input type="checkbox"/> Yes (please provide details) <input checked="" type="checkbox"/> No				Has anyone in your immediate family developed any hereditary condition, cancer, or heart disease before age 60? <input type="checkbox"/> Yes (please provide details) <input checked="" type="checkbox"/> No			
* Personal Physician or Healthcare Provider Name (First, Last) Dr. John Johnson				* Personal Physician or Healthcare Provider Name (First, Last) Dr. John Johnson			
* Street Address (include Suite #) 2 Medical Drive, Suite 2500				* Street Address (include Suite #) 2 Medical Drive, Suite 2500			
* City Anytown		* State CT	* ZIP Code 11256	* City Anytown		* State CT	* ZIP Code 11256
* Phone # (860) 555 - 4444		* Date of most recent visit (mm/dd/yyyy) 1/2/2008		* Phone # (860) 555 - 4444		* Date of most recent visit (mm/dd/yyyy) 1/2/2008	
* Reason for visit Annual Physical				* Reason for visit Annual Physical			
* Results of treatment (if any)				* Results of treatment (if any)			

This section must be completed in its entirety if using an exam from another company. **If using a Phoenix exam, ONLY questions 1-4 in bold and asterisk (*) must be completed.** Use Section 12 - Additional Information for details.

Section 10 - Medical History continued

To the best of your knowledge and belief, have you ever had, or been told by a licensed medical professional, licensed physician or other health care provider that you have:

	Life One	Life Two
* 1. 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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
* 2. 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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
* 3. Diabetes, kidney disease, kidney stones, bladder disorder, prostate disorder, protein or blood in the urine?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
* 4. Cancer of any type, tumor (benign or malignant), leukemia, lymphoma, or Hodgkin's disease?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5. High blood pressure or hypertension?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6. Peripheral vascular disease, claudication, narrowing or blockage of arteries or veins?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7. Asthma, pulmonary fibrosis, chronic cough, emphysema, pneumonia, or any other lung disease?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
8. 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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9. Depression, bipolar disorder, schizophrenia, anxiety, or other psychiatric illness?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10. Arthritis, lupus, or any musculoskeletal or skin disorder?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
11. 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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
12. Endocrine disorder, including disorder of the thyroid, parathyroid, adrenal, or pituitary glands?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
13. Anemia, bleeding or clotting disorder, or any other disorder of the blood (excluding Human Immunodeficiency Virus) or bone marrow?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
15. Have you ever been treated for alcoholism or been advised to limit or stop your use of alcohol?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<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	<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 10 years?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<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 Acquired Immune Deficiency Syndrome test), or other tests within the last 5 years?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<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	<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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Please provide details of "Yes" answers (include question number, diagnosis, date of occurrence, current status, hospital and/or treating physician's name and address). Use Section 12 - Additional Information if additional space is necessary to record all details.

Life One	Life Two

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

Section [11] - Non - Medical Information

Provide full details for all "Yes" answers below. Use [Section 12] Additional Information to record additional details.

	Life One	Life Two
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," provide date, company and reason.) Date (mm/dd/yyyy): Company: Reason:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. Do you intend to travel or reside outside of the United States or Canada? (If "Yes," state where, how long and purpose.) Location City, Country: How Long: (Specify weeks, months, years) Purpose:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. Have you flown during the past 3 years as a pilot, student pilot or crew member or do you plan to do so? (If "Yes," complete [Aviation Questionnaire.])	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4. Have you participated in the past 3 years or plan to engage in any extreme sport activities such as motorized vehicle racing, parachute jumping, underwater diving, or any other extreme avocation? (If "Yes," complete [Avocation Questionnaire.])	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5. Have you ever been convicted of a felony? (If "Yes," provide details.) Details:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6. Have you ever been convicted of driving under the influence of alcohol or drugs, or had any moving violations in the past 3 years? (If "Yes," provide details.) Details:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7. State in detail what bona fide need the Proposed Owner(s) and/or Proposed Insured(s) has for this insurance. Use [Section 12]- Additional Information if additional space is necessary to record all details.		

Section [13]- Authorization To Obtain Information

I authorize any licensed physician, health care practitioner, hospital, medical laboratory, clinic or other medically-related facility, medical data provider, insurance company or the Medical Information Bureau (MIB), or any other similar person or organization, having any records or knowledge of me or my health, to provide to PHL Variable Insurance Company (Phoenix), or its reinsurers the following information: 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 or its reinsurers any of my information relating to alcohol use, drug use and mental health care.

Any information (medical and non-medical) will be used for the purpose of risk evaluation and determining eligibility for benefits under any policies issued. Phoenix 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 provide such records or knowledge to any agency employed by Phoenix 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 to Phoenix or its reinsurers the following information regarding my insurability: information about my occupation, participation in hazardous activities, motor vehicle record, foreign travel, finances, general health, insurable interest and other 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 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.

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

Section [14]- Signature

The Application consists of Part I and Part II. I have reviewed this Application, and the statements made herein are those of the Proposed Insured(s) and all such statements made by the Proposed Insured(s) in Part I of this Application (and Part II, if applicable are) full, complete and true to the best of my knowledge and belief 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 Phoenix unless stated in Part I and/or Part II of this Application (not applicable in ND and SD) and 2) no Licensed Producer has 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 Phoenix; 2) the premium required for issuance of the policy has been paid in full during the lifetime of the Insured(s); 3) all the representations made in the Application remain true, complete and accurate as of the date the policy is delivered; 4) the Insured(s) are alive when the policy is delivered, and 5) as of the date of delivery of the policy, there has been no change in the health of any Insured(s) that would change the answers to any of the questions in the Application.

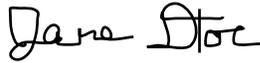
I understand that if there is any change in health or physical condition of any Proposed Insured, or if any Proposed Insured visits a physician or is hospitalized, subsequent to the date I complete the Application or provide any information to be contained in the Application, I will inform Phoenix in writing as soon as possible at address [PO Box 8027, Boston MA 02266-8027.]

If I have applied for the Acceleration of Death Benefit Rider I confirm that I have received a copy of the disclosure form, Summary of Coverage of Death Benefit Rider.

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.

If I am Owner who is not a Proposed Insured, I join in the foregoing affirmations, acknowledgments, and undertakings of the Proposed Insured(s). In addition, the statements made by me in any Part of this Application are full, complete, and true to the best of my knowledge and belief, and have been correctly recorded.

[For Conversions Only - Unless otherwise attached, the Owner hereby verifies that the policy(ies) named in Section 6 of this Application are either lost or destroyed, and have not been pledged or assigned as collateral, except as has been previously disclosed to Phoenix. The new policy will be based on the written statements made in any evidence of insurability submitted. A copy of those statements are attached to the new policy.]

Proposed Insured's (Life One) Signature 	State Signed In CT	Date (mm/dd/yyyy) 2/1/2009
Proposed Insured's (Life Two) Signature 	State Signed In CT	Date (mm/dd/yyyy) 2/1/2009
Owner's Signature/Title (if other than Proposed Insureds)	State Signed In	Date (mm/dd/yyyy)
Owner's Signature/Title (if other than Proposed Insureds)	State Signed In	Date (mm/dd/yyyy)
Collateral Assignee's Signature (if applicable)	State Signed In	Date (mm/dd/yyyy)
Parent or Guardian of Minor Signature (if applicable)	State Signed In	Date (mm/dd/yyyy)

[Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of competent jurisdiction. (Not applicable in AR, DC, FL, LA, ME, MA, NJ, NM, NY, OH, OR, PA, TX, VA and WA).

In AR and LA any person who knowingly presents a false or fraudulent claim for payments 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.

In DC, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON, PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, ANY INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

In OH, any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.]

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 discrepancies or misrepresentations in the recorded information; and that he/she is qualified and authorized to discuss the contract herein applied for.

Licensed Producer's Name (Print First, Middle, Last)	Licensed Producer's Email Address	Phoenix Producer I.D. #	Licensed Producer's Telephone #	Licensed Producer's Signature
Alan Agent	Alan.Agent@phoenixwm.com	12-56598-2001	(860) 403 - 5000	
			() -	
			() -	



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]

Other Insured Supplement

Part 1

To be completed only if applying to insure more than 2 lives

Print and use black ink. Any changes must be initialed by the Proposed Insured and Owner.

Section 1 - Proposed Insured Information

Form for Section 1 containing personal and financial information for Jim A. Doe, including marital status, birth details, income, and residence information.

Section 2 - Multi - Life Plan of Insurance

[] Phoenix Joint Edge VUL (First-to-die)]

Riders section containing checkboxes for Disability Benefit Rider, Level Term Protection Rider, and Other, with specified amounts.

Section 3 - Existing and Pending Life Insurance

1. a. 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
- b. 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? Yes No
- c. Are there any life insurance policies or annuity contracts owned by, or on the life of, the applicant(s) or the insured(s) or the owner(s) or the annuitant? Yes No

2. Provide information for each policy in force with all companies on the life of the insured. Include any policy that has been sold, assigned, transferred or settled with any other person or entity.

If no coverage in force, check here. Continue to question 3.

Proposed Insured	Company	Insurance		Issue Date mm/yyyy	Replacing?		Amount Including Riders	Indicate if Sold, Assigned, Transferred or Settled
		Personal	Business		Yes	No		
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	\$	
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	\$	
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	\$	
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	\$	

3. Have you ever had an application for life insurance declined, postponed, rated substandard or offered with a reduced face amount?

Yes No If "Yes", provide details. _____

4. List the total insurance currently applied for with all companies including this Application (**do not include informal inquiries**).

Provide name of Life Insurance Company and amount **applied for**.

Company	Amount Including Riders
Phoenix (current application information)	\$ 1,050,000
	\$
	\$
	\$
Total Amount	\$ 1,050,000

5. List the total amount of new coverage to be placed including Phoenix and all other carriers. (**do not include informal inquiries**)

]

Complete when submitting medical examinations of another insurance company.
NOTE: Medical History section must be completed if a Phoenix exam is not used.

Section 4 - Medical Transfer Statement

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 exam, and authorize my producer, broker or other life insurance company to provide such exam to Phoenix.

1. Name of the insurance company for which examination(s) was completed. Insurion Associates
2. Date of examination (mm/dd/yyyy) 12/1/2008
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? Yes No

Complete section in its entirety if using an exam from another company.
If using a Phoenix exam, ONLY questions in bold and with an asterisk (*) are required.

Section 5 - Medical History

Current Height <u> 6'2" </u>	Has your weight changed by 10 pounds or more in the past 2 years? If "Yes", how many <u> </u> pounds <input type="checkbox"/> Gain <input type="checkbox"/> Loss		
Current Weight <u> 203 </u>	Reason _____		
Family History:	Age if Alive	Age at Death	If alive, indicate health problems or if deceased, indicate cause of death:
Father <input checked="" type="checkbox"/> Alive <input type="checkbox"/> Deceased	75		
Mother <input checked="" type="checkbox"/> Alive <input type="checkbox"/> Deceased	72		
Has anyone in your immediate family developed any hereditary condition, cancer, or heart disease before age 60? <input type="checkbox"/> Yes (please provide details) <input checked="" type="checkbox"/> No			
* Personal Physician or Healthcare Provider Name (First, Last) Dr. John Johnson			* Phone # (860) 525 - 6363
* Street Address (include Suite #) 123 Medical Drive, Suite 100			
* City Anytown			* State CT
			* ZIP Code 11256
* Date of most recent visit (mm/dd/yyyy) 1/13/2009	* Reason for visit Annual Physical		
* Results of treatment (if any)			

This section must be completed in its entirety if using an exam from another company.

Section 5 - Medical History continued

If using a Phoenix exam, ONLY questions 1-4 in bold and asterisk (*) must be completed.

To the best of your knowledge and belief, have you ever had, or been told by a licensed medical professional, licensed physician or other health care provider that you have:

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

Please provide details of "Yes" answers (include question number, diagnosis, date of occurrence, current status, hospital and/or treating physician's name and address). Use Section 7 - Additional Information if additional space is necessary to record all details.

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

Section 6 - Non - Medical Information

Provide full details for all "Yes" answers below.

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," provide date, company and reason.) Date (mm/dd/yyyy): Company: Reason:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. Do you intend to travel or reside outside of the United States or Canada? (If "Yes," state where, how long and purpose.) Location City, Country: How Long: (Specify weeks, months, years) Purpose:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. Have you flown during the past 3 years as a pilot, student pilot or crew member or do you plan to do so? (If "Yes," complete [Aviation Questionnaire.]	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4. Have you participated in the past 3 years or plan to engage in any extreme sport activities such as motorized vehicle racing, parachute jumping, underwater diving, or any other extreme avocation? (If "Yes," complete [Avocation Questionnaire.]	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5. Have you ever been convicted of a felony? (If "Yes," provide details.) Details:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6. Have you ever been convicted of driving under the influence of alcohol or drugs, or had any moving violations in the past 3 years? (If "Yes," provide details.) Details:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7. State in detail what bona fide need the Proposed Owner or Proposed Insured has for this insurance. Use Section 7 - Additional Information if additional space is necessary to record all details.	

Section 8 - Authorization To Obtain Information

I authorize any licensed physician, health care practitioner, hospital, medical laboratory, clinic or other medically-related facility, medical data provider, insurance company or the Medical Information Bureau (MIB), or any other similar person or organization, having any records or knowledge of me or my health, to provide to PHL Variable Insurance Company (Phoenix), or its reinsurers the following information: 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 or its reinsurers any of my information relating to alcohol use, drug use and mental health care.

Any information (medical and non-medical) will be used for the purpose of risk evaluation and determining eligibility for benefits under any policies issued. Phoenix 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 provide such records or knowledge to any agency employed by Phoenix 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 to Phoenix or its reinsurers the following information regarding my insurability: information about my occupation, participation in hazardous activities, motor vehicle record, foreign travel, finances, general health, insurable interest and other 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 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.

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

Section 9 - Signature

The Application consists of Part I and Part II. I have reviewed this Application, and the statements made herein are those of the Proposed Insured(s) and all such statements made by the Proposed Insured(s) in Part I of this Application (and Part II, if applicable are) full, complete and true to the best of my knowledge and belief 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 Phoenix unless stated in Part I and/or Part II of this Application (not applicable in ND and SD) and 2) no Licensed Producer has authority to make, modify, alter or discharge any contract thereby applied for.

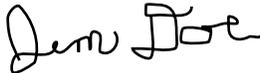
I understand and agree that the insurance applied for shall not take effect unless and until each of the following has occurred: 1) the policy has been issued by Phoenix; 2) the premium required for issuance of the policy has been paid in full during the lifetime of the Insured(s); 3) all the representations made in the Application remain true, complete and accurate as of the date the policy is delivered; 4) the Insured(s) are alive when the policy is delivered, and 5) as of the date of delivery of the policy, there has been no change in the health of any Insured(s) that would change the answers to any of the questions in the Application.

I understand that if there is any change in health or physical condition of any Proposed Insured, or if any Proposed Insured visits a physician or is hospitalized, subsequent to the date I complete the Application or provide any information to be contained in the Application, I will inform Phoenix in writing as soon as possible at address [PO Box 8027, Boston MA 02266-8027.]

If I have applied for the Acceleration of Death Benefit Rider I confirm that I have received a copy of the disclosure form, Summary of Coverage of Death Benefit Rider.

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.

If I am Owner who is not a Proposed Insured, I join in the foregoing affirmations, acknowledgments, and undertakings of the Proposed Insured(s). In addition, the statements made by me in any Part of this Application are full, complete, and true to the best of my knowledge and belief, and have been correctly recorded.

Proposed Insured's Signature 	State Signed In CT	Date (mm/dd/yyyy) 2/2/2009
Owner's Signature/Title (if other than Proposed Insured)	State Signed In	Date (mm/dd/yyyy)
Owner's Signature/Title (if other than Proposed Insured)	State Signed In	Date (mm/dd/yyyy)
Collateral Assignee's Signature (if applicable)	State Signed In	Date (mm/dd/yyyy)
Parent or Guardian of Minor Signature (if applicable)	State Signed In	Date (mm/dd/yyyy)

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of competent jurisdiction. (Not applicable in AR, DC, FL, LA, ME, MA, NJ, NM, NY, OH, OR, PA, TX, VA and WA).

In AR and LA any person who knowingly presents a false or fraudulent claim for payments 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.

In DC, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON, PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, ANY INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

In OH, any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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 discrepancies or misrepresentations in the recorded information; and that he/she is qualified and authorized to discuss the contract herein applied for.

Licensed Producer's Name (Print First, Middle, Last)	Licensed Producer's Email Address	Phoenix Producer I.D. #	Licensed Producer's Telephone #	Licensed Producer's Signature
Alan A. Agent	alan.agent@phoenixwm.com	12-565-1212	(860) 757 - 4242	
			() -	
			() -	



Barbara Slater -
State Compliance Coordinator
Life & Annuity State Compliance Office
One American Row Hartford, CT 06102-5056
(860) 403-5607 Fax: (860) 403-7252
Toll Free: 1-800-349-9267 (press 2, then 7)
Email: Barbara.Slater@phoenixwm.com

February 2, 2009

Mr. Joe Musgrove
Department of Insurance
State of Arkansas
1200 West Third Street
Little Rock, Arkansas 72201

RE: **PHL Variable Insurance Company**
NAIC # 93548, FEIN #06-1045829

For Approval Purposes

Form OL4400 – Application for Life Insurance Part 1
Form OL4401 – Application Part 1 Funding Intentions
Form OL4402 – Term Life – Part 1 Product Selection
Form OL4403 – Universal Life – Part 1 Product Selection
Form OL4404 – Variable Life – Part 1 Product Selection
Form OL4406 – Other Insured Supplement Part 1

Dear Mr. Musgrove:

We are filing the above-referenced forms for approval in your jurisdiction. The forms are filed in accordance with the applicable statutes and regulations of your jurisdiction and are laser printed, subject only to minor variations in paper stock, color, fonts, duplexing, and positioning. These forms are new and are not intended to replace any existing forms. The forms will be effective on the date of approval. These forms will be used on an individual basis in our general market. These forms were approved by our domiciliary state of Connecticut for use outside of Connecticut effective 2/2/2009.

The Application for Life Insurance Part 1, form **OL4400**, has been designed for use with our Term, Universal and Variable Life products and may be used with any Term, Universal and Variable Life Insurance Products that have been previously approved by your department and any Term, Universal or Variable Life Insurance Products we may develop in the futures. The Application for Life Insurance Part 1 will be used in conjunction with the Application Part 1 Funding Intentions and the Product Selection forms for the product applied for. The use of form **OL4401**, Application Part 1 Funding Intentions, will be dependent on the age of the insured and the amount of coverage being applied for. Form **OL4402**, Term Life – Part 1 Product Selection will be used when the applicant is applying for Term Life Insurance. Form **OL4403**, Universal Life – Part 1 Product Selection will be used when an applicant is applying for one of our Universal Life Products. Form **OL4404**, Variable Life – Part 1 Product selection will be used when the application is applying for Variable Life Insurance.

The Other Insured Supplement, form **OL4406**, allows for the addition of an additional insured on a life policy approved for multiple lives (excluding any survivorship product.) In addition, Application Part 1 Funding Intentions, form **OL4401**, will be used in conjunction with form **OL4406** for the other insured(s) depending on the age of the insured(s) and the amount of coverage being applied for.

Please see the enclosed Statement of Variability for a description of the bracketing that appears in the forms. These forms will be filed in all states, the District of Columbia and Puerto Rico.

Any requisite fees and filing documents have been enclosed.

Your attention to this submission is appreciated. Should you have any questions or comments regarding this filing, please contact me at (860) 403-5607, or by email at Barbara.Slater@PhoenixWM.com.

Thank you in advance for your immediate attention.

Sincerely,

A handwritten signature in cursive script that reads "Barbara Slater". The signature is written in black ink and is positioned to the left of the typed name.

Barbara Slater



Barbara Slater -
State Compliance Coordinator
Life & Annuity State Compliance Office
One American Row Hartford, CT 06102-5056
(860) 403-5607 Fax: (860) 403-7252
Toll Free: 1-800-349-9267 (press 2, then 7)
Email: Barbara.Slater@phoenixwm.com

February 2, 2009

Ms. Susan Stapp
California Department of Insurance
State of California
45 Fremont Street, 23rd Floor
San Francisco, California 94105

RE: **PHL Variable Insurance Company**
NAIC # 93548, FEIN #06-1045829

For Approval Purposes

Form OL4400 – Application for Life Insurance Part 1
Form OL4401 – Application Part 1 Funding Intentions
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Form OL4406 – Other Insured Supplement Part 1

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