

SERFF Tracking Number: TPCI-126464075 State: Arkansas  
Filing Company: PHL Variable Insurance Company State Tracking Number: 44891  
Company Tracking Number: ICCOL4348  
TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.101 External Indexed - Single Life  
Adjustable Life  
Product Name: Simplified Issue Application  
Project Name/Number: /

## Filing at a Glance

Company: PHL Variable Insurance Company

Product Name: Simplified Issue Application

TOI: L09I Individual Life - Flexible Premium

Adjustable Life

Sub-TOI: L09I.101 External Indexed - Single Life

Filing Type: Form

SERFF Tr Num: TPCI-126464075

SERFF Status: Closed-Approved-

Closed

Co Tr Num: ICCOL4348

Authors: Scott Zweig, Joseph

Bonfitto, Barbara Slater, Kathleen

Richter, Jeanie Gagnon, Elizabeth

Stevens

Date Submitted: 02/16/2010

State: Arkansas

State Tr Num: 44891

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 02/18/2010

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: 02/18/2010

Deemer Date:

Submitted By: Kathleen Richter

Filing Description:

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: 02/18/2010

Created By: Kathleen Richter

Corresponding Filing Tracking Number:

## Company and Contact

SERFF Tracking Number: TPCI-126464075 State: Arkansas  
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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 860-403-5296 [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

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**Filing Fees**

Fee Required? No  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
PHL Variable Insurance Company	\$0.00	02/16/2010	
PHL Variable Insurance Company	\$60.00	02/16/2010	34235440

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	02/18/2010	02/18/2010

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Flesch Certification	Kathleen Richter	02/16/2010	02/16/2010
Supporting Document	Cover Letter	Kathleen Richter	02/16/2010	02/16/2010

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Filing Fees	Note To Reviewer	Kathleen Richter	02/16/2010	02/16/2010

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## Disposition

Disposition Date: 02/18/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document (revised)	Flesch Certification		Yes
Supporting Document	Flesch Certification	Replaced	Yes
Supporting Document	Application		No
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document (revised)	Cover Letter		Yes
Supporting Document	Cover Letter	Replaced	Yes
Supporting Document	Statement of Variability		Yes
Form	Simplified Universal Life Insurance Application Part I		Yes
Form	Simplified Universal Life Product Selection Part I		Yes
Form	Simplified Universal Life Application Part II		Yes

SERFF Tracking Number: TPCI-126464075 State: Arkansas  
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**Note To Reviewer**

**Created By:**

Kathleen Richter on 02/16/2010 04:42 PM

**Last Edited By:**

Linda Bird

**Submitted On:**

02/18/2010 01:52 PM

**Subject:**

Filing Fees

**Comments:**

Please note that we accidentally bypassed the filing fee requirement. We have submitted the required fees:

3 Application forms @ \$20.00 each = \$60.00.

We apologize for this oversight.

Sincerely,

Katie Richter

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**Amendment Letter**

Submitted Date: 02/16/2010

**Comments:**

Good afternoon,

After submitting this filing we realized that we attached the wrong readability certification and cover letter. We have corrected this error and apologize for any inconvenience.

Sincerely,

Katie Richter

**Changed Items:**

**Supporting Document Schedule Item Changes:**

**Satisfied -Name: Flesch Certification**

Comment:

AR certification - OL4348.pdf

**User Added -Name: Cover Letter**

Comment:

AR - Cover Letter.pdf

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## Form Schedule

Lead Form Number: OL4348

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	OL4348	Application/ Enrollment Form	Simplified Universal Life Insurance Application Part I	Initial		52.860	OL4348 Generic with John Doe.pdf
	OL4349	Application/ Enrollment Form	Simplified Universal Life Product Selection Part I	Initial		52.520	OL4349 Generic with John Doe.pdf
	OL4361	Application/ Enrollment Form	Simplified Universal Life Application Part II	Initial		59.190	OL4361 Generic with John Doe.pdf



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]

Simplified Universal Life Insurance Application Part I

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

Section 1 Proposed Insured Information

Form for Section 1: Proposed Insured Information. Fields include Name (John A. Doe), Sex (M), Date of Birth (01/01/1980), Social Security Number (123-45-6789), Marital Status (Married), Birth State (CT), Birth Country (USA), U.S. Citizen (Yes), Driver's License # (0201-259-55885), State (CT), Earned Income (\$ 100,000), Unearned Income (\$), Net Worth (\$ 100,000), Residence Street Address (1 State Street), City (Anytown), State (CT), ZIP Code (11256), Home Phone # ((860) 555-1212), Work Phone # ((860) 444-1212), Cellular Phone # ((860) 333-1212), Best # to reach Insured (Cellular), Email Address (john.doe@email.com), Current Employer (Eastman Corporation), Years of Service (6), Current/Former (if retired) Occupation (Sales), Employer Street Address (123 American Avenue), City (Hometown), State (CT), ZIP Code (11225), Employer's Phone # ((860) 565-1212). Includes a question about tobacco use in the past 5 years.

Section 2 Ownership

Select one, if B is elected, complete the following.

[X] A. Proposed Insured [ ] B. Other (If Owner is a Trust please complete [Certification of Trust Agreement - OL4132])

Form for Section 2: Ownership. Fields include Primary Owner's Name, Social Security Number/Tax ID, Date of Birth, Relationship to Proposed Insured, Primary Owner's Street Address, City, State, ZIP Code, Home Telephone #, Employer's Street Address, City, State, ZIP Code, Employer's Telephone #, and Email Address.

Section 3 Beneficiary Designation

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.

Table for Section 3: Beneficiary Designation. Columns: 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; Share (%). Row 1: Mary Doe, [X] Primary, Other Mother, 4/2/1957, 345-67-8912, 100. Row 2: [ ] Contingent, [ ] Spouse/Civil Union Partner, [ ] Child, [ ] Trust, [ ] Other.

**Section 4 Mode of Premium Payment**

Amount paid with Application \$ \_\_\_\_\_

Annual

Phoenix Check-O-Matic Service (PCS) ]

**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) \_\_\_\_\_

**Section 5 Existing Life Insurance**

1. a. With this policy, do you plan to replace (in whole or in part, now or in the future) any existing insurance or annuity in force? . . . . .  Yes  No
- b. 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
- c. 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
2. 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). . . . .  Yes  No  
 Date (mm/dd/yyyy): \_\_\_\_\_ Company: \_\_\_\_\_ Reason: \_\_\_\_\_
3. Are you negotiating for other insurance? (If "Yes", name companies and total amount to be placed in force). . . . .  Yes  No  
 Company(ies): \_\_\_\_\_ Total Amount to be placed in force: \_\_\_\_\_

If no coverage in force, check here

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

**IF THE PROPOSED INSURED ANSWERED "YES" TO ANY PART OF QUESTIONS 1-3 BELOW, COVERAGE IS NOT AVAILABLE UNDER THIS PLAN AND THE APPLICATION SHOULD NOT BE COMPLETED OR SUBMITTED.**

**Section [6] Medical History**

Personal Physician or Health Care Provider Name (if None, please indicate): Dr. John Johnson			Telephone # ( 860 ) 555 4444	
Street Address, City, State, ZIP Code 2 Medical Drive, Suite 2500 Anytown CT 11256				
Most Recent Visit Date (mm/dd/yyyy) 1/2/2008	Reason for Visit Annual Physical	Results of Treatment (if any) None	Height 6' 2"	Weight 198

**To the best of your knowledge and belief, have you:**

1. Ever had or been treated for, Alzheimer's disease, chest pain, dementia, demyelinating disease, Downs syndrome, heart disease, Huntington's disease, leukemia, multiple myeloma, organ transplant, Parkinson's disease, stroke, schizophrenia? .....  Yes  No
- 2a. In the last 5 years received counseling or medical treatment for alcoholism, alcohol abuse or other drug use? .....  Yes  No
- 2b. In the last 5 years have you used amphetamines, barbiturates, cocaine, hallucinogens, marijuana, narcotics or any other drug except as legally prescribed by a health care provider? .....  Yes  No
3. Have you ever been diagnosed by a member of the medical profession for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? .....  Yes  No

**Section [7] Authorization To Obtain Information**

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

Medical information will be used only for the purpose of risk evaluation and determining eligibility for benefits under any policies issued. 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 give 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 any information to Phoenix or its reinsurers that may affect my insurability. This may include information about my occupation, participation in hazardous activities, motor vehicle record, foreign travel, finances, and other insurance coverage in place.

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

This authorization shall continue to be valid for 30 months (24 months for North Dakota) 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 8 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 and all such statements made by the Proposed Insured 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.

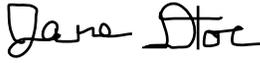
I understand and agree that the insurance applied for shall not take effect unless and until each of the following has occurred: 1) the policy has been issued by Phoenix; 2) the premium required for issuance of the policy has been paid in full during the lifetime of the Insured; 3) all the representations made in the Application remain true, complete and accurate as of the date the policy is delivered; 4) the Insured are alive when the policy is delivered; 5) as of the date of delivery of the policy, there has been no change in the health of any Insured that would change the answers to any of the questions in the Application; and 6) the statements and answers in the Application are the basis for any policy issued by Phoenix and no information about them will be considered to have been given to Phoenix unless it is stated 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 an Owner who is not a Proposed Insured, I join in the foregoing affirmations, acknowledgments, and undertakings of the Proposed Insured. In addition, the statements made by me in any Part of this Application are full, complete, and true to the best of my knowledge and belief, and have been correctly recorded.

Proposed Insured's Signature 	<b>State Signed In</b> CT	Witness Signature (Must be signed in presence of Proposed Insured)	Date (mm/dd/yyyy) 2/1/2010
Owner's Signature 	<b>State Signed In</b> CT	Witness Signature (Must be signed in presence of Owner)	Date (mm/dd/yyyy) 2/1/2010
Owner's Signature	<b>State Signed In</b>	Witness Signature (Must be signed in presence of Owner)	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.

In AR 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.

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 misrepresentation 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	Date (mm/dd/yyyy)
Alan Agent	Alan.Agent@phoenixwm.com	12-56598-2001	( 860 ) 403 - 5000		2/1/2010
			( ) -		



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 ]

Simplified Universal Life
Product Selection
Part I

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 A. Doe

Section 2 - Single Life Plan of Insurance

Phoenix Indexed Universal Life

Face Amount ..... \$ 50,000

Features/Riders

[x] Monthly Transfer Strategy ]

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

Table with 2 columns: Allocation Option and Percentage. Includes Fixed Account (100%), Indexed Account A, B, and Other.

Acknowledgements Relating to Indexed Universal Life Insurance

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.



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]

Simplified Universal Life Application Part II

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 A. Doe

Section 2 Medical History

To the best of your knowledge and belief, have you:

- 1. For a reason other than intentional weight loss, have you lost 10 pounds or more in the past 2 years?
2. Other than above, have you had any other physical or psychological disorder or been treated by a physician or other health care provider...
3. In the past two years, have you been prescribed medications or have you been scheduled or advised to have any diagnostic tests...

Table with 4 columns: Medication Prescribed, Frequency and Dosage, Date Prescribed (mm/dd/yyyy), Condition Treated

Table with 4 columns: Physician Consulted - Name, Address, Reason for Visit, Date last seen (mm/dd/yyyy)

- 4. Ever had or been treated for: bipolar disease, cancer, connective tissue disease, depression, diabetes, gastrointestinal disease, high blood pressure...
5. Have you ever been diagnosed or treated by a member of the medical profession for specified symptoms such as; immune deficiency, anemia...

Additional Medical History. Applicants older than 65 years answers questions below:

- 6. Are you using any of the following: cane, catheter, electric scooter, oxygen, walker or wheelchair?
7. In the past year, have you required the assistance of another person for: bathing, dressing, eating, toileting, or the management of bowel or bladder problems?
8. In the past year, have you had any falls, received or been advised to have any of the following: care in an adult day care facility...

**Section 3- Non - Medical Information**

Provide full details for all "Yes" answers below. Use Section 4 - Additional Information to record additional details.

- 1a. Have you traveled or resided in the past 2 years outside of the United States or Canada?  Yes  No
- 1b. Do you plan to do so within the next 2 years? (If "Yes," state where, how long and purpose.)  Yes  No  
 Location City, Country: \_\_\_\_\_ Purpose: \_\_\_\_\_ How Long: (Specify weeks, months, years) \_\_\_\_\_
- 2a. Have you flown during the past 3 years as a pilot, student pilot or crew member? (If "Yes", complete [Aviation Application Supplement.])  Yes  No
- 2b. Do you plan to do so within the next 2 years? (If "Yes", complete [Aviation Application Supplement.])  Yes  No
- 3a. Have you participated in the past 3 years in ATV (all-terrain vehicle), motorized vehicle racing, stunt driving, motorcycle, motorboat, horse, or truck racing, rodeo, jet ski, scuba/skin diving, spelunking (cave exploration), heleskiing, hang gliding, cliff diving, bungee jumping, snowmobile, bobsled, skeleton, luge, skydiving/sport parachuting, ultralight flying, ballooning, mountain climbing, big game hunting, boxing, martial arts? (If "Yes," complete [Avocation Questionnaire.])  Yes  No
- 3b. Do you plan to do so within the next 2 years? (If "Yes," complete [Avocation Questionnaire.])  Yes  No
- 4. Are you currently, or have you ever been on probation?  Yes  No  
If "Yes", provide details. **Details:** \_\_\_\_\_
- 5. Have you ever been convicted of driving under the influence of alcohol or drugs, or had your driver's license been suspended or revoked, or had greater than 2 moving violations in the past 3 years?  Yes  No  
If "Yes", provide details. **Details:** \_\_\_\_\_
- 6. Have you ever filed bankruptcy?  Yes  No  
If "Yes", provide details. **Details:** \_\_\_\_\_

Use space below for additional information and/or special requests.  
Use [Application Part II Addendum] if additional space required.

**Section 4- Additional Information**

Use space below to record all additional information.

Section # \_\_\_\_\_ Question # \_\_\_\_\_ **Details:** \_\_\_\_\_

**Section 5- Signature**

I, the Proposed Insured, hereby represent that all statements and answers given above are true, complete, and correctly recorded, to the best of my knowledge and belief.

Proposed Insured's Signature 	State Signed In CT	Date (mm/dd/yyyy) 2/1/2010
---	-----------------------	-------------------------------

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 misrepresentation 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) Alan Agent	Licensed Producer's Signature 	State Signed In CT	Date (mm/dd/yyyy) 2/1/2010
--	---	-----------------------	-------------------------------

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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification		
<b>Comments:</b>		
<b>Attachment:</b> AR certification - OL4348.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application		
<b>Bypass Reason:</b> Not applicable since this is an application filing		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Outline of Coverage		
<b>Bypass Reason:</b> Not applicable		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Cover Letter		
<b>Comments:</b>		
<b>Attachment:</b> AR - Cover Letter.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of Variability		
<b>Comments:</b>		
<b>Attachment:</b>		

*SERFF Tracking Number:* TPCI-126464075      *State:* Arkansas  
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*Product Name:* Simplified Issue Application  
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**Statement of Variability - Generic.pdf**

**ARKANSAS  
CERTIFICATION**

FORM NO.	<b>OL4348</b>
FORM TITLE	<b>Simplified Universal Life Insurance Application Part I</b>
FLESCH SCORE	<b>52.86</b>
FORM NO.	<b>OL4349</b>
FORM TITLE	<b>Simplified Universal Life Product Selection Part I</b>
FLESCH SCORE	<b>*52.52</b>
FORM NO.	<b>OL4361</b>
FORM TITLE	<b>Simplified Universal Life Application Part II</b>
FLESCH SCORE	<b>59.19</b>

\* This form was scored in conjunction with forms OL4348.

**Phoenix Life Insurance Company**

Signature: 

Name: **Jeanie Gagnon**  
Title: **Second Vice President**  
Date: **February 16, 2010**



**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 16, 2010

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 OL4348 – Simplified Universal Life Insurance Application Part I  
Form OL4349 – Simplified Universal Life Product Selection Part I  
Form OL4361 – Simplified Universal Life Application Part II

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. In addition to the customary pre-printing of these forms for use by producers and applicants, these forms may also be produced in an electronic format for use with applicants who provide the legally required consents. The electronically generated application signed by the applicant(s) will be identical in content to the filed form. 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 XX/XX/1010.

The Simplified Universal Life Insurance Application Part 1, form **OL4348**, has been designed for use with our Universal Life products and may be used with any Universal Life Insurance Products that have been previously approved by your department and any Universal Life Insurance Products we may develop in the future. The Application for Life Insurance Part 1 will be used in conjunction with the Simplified Universal Life Product Selection Part I (OL4349) and the Simplified Universal Life Application Part II (OL4361). Form **OL4349**, Simplified Universal Life Product Selection Part I will be used when an applicant is applying for our Indexed Universal Life Product. Form **OL4361**, Simplified Universal Life Application Part II will be used to obtain information relating to an applicant's medical history and lifestyle in order to extend an offer of insurance.

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 including the District of Columbia.

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](mailto: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 right of the word "Sincerely,".

Barbara Slater

## **Statement of Variability – Simplified Universal Life Insurance Application Part I**

This Statement of Variability sets forth the variable information which will appear in brackets in form OL4348 (Simplified Universal Life Insurance Application Part I.) No change in variability will be made which in any way expands the scope of the wording being changed.

Section Numbers – The section numbers have been bracketed to accommodate the insertion of form OL4349 (Simplified Universal Life Product Selection Part I) for selection of product type and form OL4361 (Simplified Universal Life Insurance Application Part II) so as to provide for consecutive numbering.

Page Numbers (all pages) – The page numbers have been bracketed to accommodate the insertion of form OL4349 (Simplified Universal Life Product Selection Part I) for selection of product type and form OL4361 (Simplified Universal Life Insurance Application Part II). This form will be inserted between the sections titled “Authorization To Obtain Information” and “Signature” and exhibited in the “1 of 4,” “2 of 4” format. The page numbers are also bracketed to account for the possibility of additional space being made for answers or special instructions.

### **OL4348, Page 1 of 4**

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

#### **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 this information is no longer required, it will be deleted on a non-discriminatory basis and regardless of the product applied for.

“Non U.S. Citizen Only” has been bracketed to indicate that it may be deleted in the future. If this information is no longer required, it will be deleted on a non-discriminatory basis and regardless of the product applied for.

#### **Section 2 - Ownership**

Certificate of Trust Agreement – OL4132 – The form name and number has been bracketed to indicate that it may either change or an additional form reference may be added in the future.

**OL4348, Page 2 of 4**

Section 4 – 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. If any of the payment options listed are available the text that appears will be identical to the text that appears on the form.

**OL4348, Page 4 of 4**

Address – The address has been bracketed to indicate that it may either change or an additional address may be added in the future.

## **Statement of Variability – Simplified Universal Life Product Selection Part I**

This Statement of Variability sets forth the variable information which will appear in brackets in form OL4349 (Simplified Universal Life Product Selection Part I.) No change in variability will be made which in any way expands the scope of the wording being changed.

Section Numbers – The section numbers have been bracketed to accommodate the insertion of form OL4349 (Simplified Universal Life Product Selection Part I) between the sections titled “Authorization To Obtain Information” and “Signature” of Form OL4348 so as to provide for consecutive numbering. The insertion of this form will be depending on the product type being applied for.

Page Number – The page number has been bracketed to accommodate the insertion of form OL4349 (Simplified Universal Life Product Selection Part I) between the sections titled “Authorization To Obtain Information” and “Signature” of Form OL4348 so as to provide for consecutive numbering. The insertion of this form will be depending on the product type being applied for.

### **OL4349, Page 1 of 1**

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

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

The product, Phoenix Indexed Universal Life, has been bracketed to indicate that it may not be available in the future, or that the additional universal life products may be added. Additionally it has been bracketed to indicate that riders, features or other options may be added to this section.

Premium Allocation – The bracketing of the check boxes and text in this section indicates that if these options are no longer offered, they will not appear on this form. It is also bracketed to indicate that additional options may be added in the future.

## **Statement of Variability – Simplified Universal Life Insurance Application Part II**

This Statement of Variability sets forth the variable information which will appear in brackets in form OL4361 (Simplified Universal Life Insurance Application Part II.) No change in variability will be made which in any way expands the scope of the wording being changed.

Section Numbers: The section numbers have been bracketed to accommodate the insertion of form OL4361 (Simplified Universal Life Insurance Application Part II) between the sections titled “Authorization To Obtain Information” and “Signature” of Form OL4348 so as to provide for consecutive numbering.

Page Numbers – The page numbers have been bracketed to accommodate the insertion of form OL4361 (Simplified Universal Life Insurance Application Part II) between the sections titled “Authorization To Obtain Information” and “Signature” of Form OL4348 so as to provide for consecutive numbering.

### **OL4361, Page 1 of 2**

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

### **OL4361, Page 2 of 2**

Form Names – The bracketing of form names on this page indicates that they may either change (subject to prior review and approval of the forms by your Department, if required) or additional references to approved forms may be added in the future.

SERFF Tracking Number: TPCI-126464075 State: Arkansas  
 Filing Company: PHL Variable Insurance Company State Tracking Number: 44891  
 Company Tracking Number: ICCOL4348  
 TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.101 External Indexed - Single Life  
 Adjustable Life  
 Product Name: Simplified Issue Application  
 Project Name/Number: /

## Superseded Schedule Items

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.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/20/2010	Supporting Document	Flesch Certification	02/16/2010	CT readability cert - OL4368.pdf (Superseded)
02/16/2010	Supporting Document	Cover Letter	02/16/2010	CT - Cover Letter.pdf (Superseded)

Bulletin PF-12

Readability Certification

A certificate of compliance, signed by an officer of the company, must be included with all forms. The information to be included in this certificate must be in the format that follows:

A. Option Selected

1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is \_\_\_\_\_.

2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below:

Forms and Form Numbers to Which Certification is Applicable:

Form	Form Number	Flesch Score
------	-------------	--------------

B. Test Option Selected

\*This form was scored with form OL4348.

1. Test was applied to entire policy form(s)

2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. Standards for Certification

A checked block indicates standard has been achieved

1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.

2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)

- 3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.
- 4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.
- 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.
- 6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.
- 7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)

The certification must be signed by an officer of the insurer.



\_\_\_\_\_  
Officer's Name

\_\_\_\_\_  
Officer's Title

Date: \_\_\_\_\_



**Barbara Slater -**  
**State Compliance Coordinator**  
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Email: Barbara.Slater@phoenixwm.com

February 16, 2010

Mr. Thomas R. Sullivan  
Insurance Department  
State of Connecticut  
P.O. Box 816  
Hartford, Connecticut 06142-0816

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

**For Approval Purposes**

Form OL4348 – Simplified Universal Life Insurance Application Part I  
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