

State: Arkansas **Filing Company:** PHL Variable Insurance Company
TOI/Sub-TOI: L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life
Product Name: 2012 MIB Filing
Project Name/Number: /

Filing at a Glance

Company: PHL Variable Insurance Company
Product Name: 2012 MIB Filing
State: Arkansas
TOI: L09I Individual Life - Flexible Premium Adjustable Life
Sub-TOI: L09I.001 Single Life
Filing Type: Form
Date Submitted: 12/11/2012
SERFF Tr Num: TPCI-128801152
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: 2012 MIB FILING
Implementation: On Approval
Date Requested:
Author(s): Scott Zweig, Joseph Bonfitto, Barbara Slater, Colleen Lyons, Marlene Burghardt, Lois McGuire
, Erica Scherzer, Hayley Stone
Reviewer(s): Linda Bird (primary)
Disposition Date: 12/17/2012
Disposition Status: Approved-Closed
Implementation Date:
State Filing Description:

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General Information

Project Name: Status of Filing in Domicile: Pending
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: Being filed in domicile state concurrently with this filing.
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 12/17/2012
State Status Changed: 12/17/2012
Deemer Date: Created By: Hayley Stone
Submitted By: Hayley Stone Corresponding Filing Tracking Number:

Filing Description:

PHL Variable Insurance Company (NAIC# 93548, FEIN# 06-1045829)
For Approval Purposes
Form OL4400.1 – Application for Life Insurance Part I
Form OL4406.1 – Other Insured Supplement Part I

We are filing the above-referenced forms for approval. The form is filed in accordance with the applicable statutes and regulations of your jurisdiction and is laser printed, subject only to minor variations in paper stock, color, fonts, duplexing, and pagination. The form is new and is not intended to replace any existing form. The form will be effective on the date of approval and will be used by the insured, on an individual basis for use in our general market.

Form OL4400.1 – Application for Life Insurance Part I

Form OL4400.1 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 future. This form is substantially similar to Form OL4400 (Application for Life Insurance Part I) which was approved by your Department on 2/09/2009 (SERFF Tracking #TPCI-126017168). The changes made to this application impact only Section 13 (Authorization To Obtain Information) and are meant to bring the application into compliance with the new Medical Information Bureau (MIB) standards.

Form OL4406.1 – Other Insured Supplement Part I

Form OL4406.1 allows for the addition of an additional insured on a life policy approved for multiple lives. This form is substantially similar to Form OL4406 (Other Insured Supplement Part I) which was approved by your Department on 2/09/2009 (SERFF Tracking #TPCI-126017168). The changes made to this application impact only Section 13 (Authorization To Obtain Information) and are meant to bring the application into compliance with the new Medical Information Bureau (MIB) standards.

Please see the enclosed Statement of Variability for a description of the bracketing that appears in the forms.

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.

State: Arkansas **Filing Company:** PHL Variable Insurance Company
TOI/Sub-TOI: L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life
Product Name: 2012 MIB Filing
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Thank you in advance for your immediate attention.

Sincerely,

Barbara Slater

Company and Contact

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
Hartford, CT 06102	Group Name:	Insurance and Annuities
(860) 403-5000 ext. [Phone]	FEIN Number: 06-1045829	State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: \$50.00 multiplied by two forms
 Per Company: No

Company	Amount	Date Processed	Transaction #
PHL Variable Insurance Company	\$100.00	12/11/2012	65623879

State: Arkansas Filing Company: PHL Variable Insurance Company
TOI/Sub-TOI: L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/17/2012	12/17/2012

State: Arkansas **Filing Company:** PHL Variable Insurance Company
TOI/Sub-TOI: L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life
Product Name: 2012 MIB Filing
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Disposition

Disposition Date: 12/17/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	Statement of Variability		Yes
Form	Application for Life Insurance Part I		Yes
Form	Other Insured Supplement Part 1		Yes

State: Arkansas

Filing Company:

PHL Variable Insurance Company

TOI/Sub-TOI: L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life

Product Name: 2012 MIB Filing

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Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Application for Life Insurance Part I	OL4400.1	AEF	Initial		57.130	OL 4400.1_JOHN DOE.pdf
2		Other Insured Supplement Part 1	OL4406.1	AEF	Initial		59.260	OL 4406.1_JOHN DOE.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



PHL Variable Insurance Company (Phoenix)

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

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

Application for Life Insurance Part 1

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
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? 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)
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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) 1/2/2013	2. Date of examination (mm/dd/yyyy) 1/2/2013
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)			

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

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

Any information will be used only for the purpose of risk evaluation and determining eligibility for benefits under any policies issued. Phoenix, its affiliates or service providers may disclose information it has obtained to others as permitted or required by law, including MIB, our reinsurers and other persons or entities performing business or legal services in connection with this application, any contract issued pursuant to it or in connection with the determination of eligibility for benefits under an existing policy. Information that is not personally identifiable may be used for insurance statistical studies.

To facilitate rapid submission of information, I authorize all of the above sources, except MIB, to give such records or knowledge to any agent, agency or producer authorized to do business with Phoenix, its affiliates or service providers to collect and transmit such information.

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

This authorization shall continue to be valid for 30 months (24 months for Colorado, Iowa, Kansas, Kentucky, New Hampshire, Oklahoma, West Virginia and Wyoming) from the date it is signed unless otherwise required by law. A copy of this signed authorization shall be as valid as the original. This authorization may be revoked by writing to Phoenix prior to the time the insurance coverage has been placed in force. I understand my authorized representative or I may receive a copy of this authorization on request.

Check one:

I do I do not require that I (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.

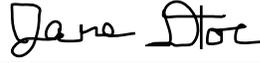
I understand that if there is any change in health or physical condition of any Proposed Insured, or if any Proposed Insured visits a physician or is hospitalized, subsequent to the date I complete the Application or provide any information to be contained in the Application, I will inform Phoenix in 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) 2/1/2013
Proposed Insured's (Life Two) Signature 	State Signed In CT	Date (mm/dd/yyyy) 2/1/2013
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)

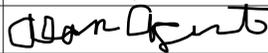
[Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of competent jurisdiction. (Not applicable in AR, DC, 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	Date (mm/dd/yyyy)
Alan Agent	Alan.Agent@phoenixwm.com	12-56598-2001	(860) 403 - 5000		2/1/2013
			() -		
			() -		



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.

- Name of the insurance company for which examination(s) was completed. Insurion Associates
- Date of examination (mm/dd/yyyy) 8/10/2013
- 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

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 _____ pounds <input type="checkbox"/> Gain <input type="checkbox"/> Loss	
Current Weight <u>203</u>	Reason _____	
Family History:	Age if Alive	Age at Death
Father <input checked="" type="checkbox"/> Alive <input type="checkbox"/> Deceased	75	
Mother <input checked="" type="checkbox"/> Alive <input type="checkbox"/> Deceased	72	
If alive, indicate health problems or if deceased, indicate cause of death:		
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) 8/12/2013	* 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.

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

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

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Check one:

I do I do not require that I (we) 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.

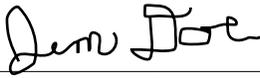
I understand and agree that the insurance applied for shall not take effect unless and until each of the following has occurred: 1) the policy has been issued by Phoenix; 2) the premium required for issuance of the policy has been paid in full during the lifetime of the Insured(s); 3) all the representations 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) 2/2/2013
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.

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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	Date (mm/dd/yyyy)
Alan A. Agent	alan.agent@phoenixwm.com	12-565-1212	(860) 757 - 4242		2/2/2013
			() -		
			() -		

SERFF Tracking #:

TPCI-128801152

State Tracking #:

Company Tracking #:

2012 MIB FILING

State:

Arkansas

Filing Company:

PHL Variable Insurance Company

TOI/Sub-TOI:

L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life

Product Name:

2012 MIB Filing

Project Name/Number:

/

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR readability certification.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):			
AR - OL4400.1 - SOV.pdf			

**ARKANSAS
CERTIFICATION**

FORM NO.	OL4400.1
FORM TITLE	Application for Life Insurance Part 1
FLESCH SCORE	60.07
FORM NO.	OL4406.1
FORM TITLE	Other Insured Supplement Part 1
FLESCH SCORE	59.26

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: December 11, 2012

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 OL4400.1 (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, which were previously approved by your Department on 2/09/2009 (SERFF Tracking #TPCI-126017168): 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.

OL4400.1, 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.

OL4400.1, 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.

OL4400.1, 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.

OL4400.1, 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.

OL4400.1, 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.

OL4400.1, Page 10 of 11

Section 13 – Authorization to Obtain Information – This section has been bracketed to indicate that it may change in the future if the Medical Information Bureau updates the required disclosure language.

OL4400.1, 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 – Other Insured Supplement Part 1

This Statement of Variability sets forth the variable information which will appear in brackets in form OL4406.1 (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, which was previously approved by your Department on 2/09/2009 (SERFF Tracking #TPCI-126017168): 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 8," "2 of 8" 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.

OL4406.1, 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.

OL4406.1, 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.

OL4406.1, Page 8 of 8

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