

SERFF Tracking Number: TPCI-128506389 State: Arkansas
Filing Company: Phoenix Life and Annuity Company State Tracking Number:
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: OL4374 Reinstatement Application PLAC
Project Name/Number: /

Filing at a Glance

Company: Phoenix Life and Annuity Company

Product Name: OL4374 Reinstatement SERFF Tr Num: TPCI-128506389 State: Arkansas

Application PLAC

TOI: L08 Life - Other

SERFF Status: Closed-Approved-
Closed State Tr Num:

Sub-TOI: L08.000 Life - Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Scott Zweig, Joseph

Disposition Date: 06/26/2012

Bonfitto, Barbara Slater, Elizabeth

Stevens, Colleen Lyons, Marlene

Burghardt

Date Submitted: 06/22/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Form is being
submitted to our state of domicile concurrent
with this filing.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 06/26/2012

State Status Changed: 06/26/2012

Deemer Date:

Created By: Elizabeth Stevens

Submitted By: Elizabeth Stevens

Corresponding Filing Tracking Number:

Filing Description:

For Approval Purposes

Form OL4374 - Application for Reinstatement

We are filing the above-referenced form for approval. The form is filed in accordance with the applicable statutes and

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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, to make a written application for the reinstatement of a life insurance policy.

Duplicate filings of this form are being submitted as well for PHL Variable Insurance Company (NAIC # 93548) and Phoenix Life Insurance Company (NAIC#67814).

Please refer to the attached Statement of Variability for a complete description of the bracketing that appears in the form.

A Flesch certification has been included if required.

Your attention to this submission is appreciated. Should you have any questions regarding any of the materials in this filing, please do not hesitate to contact Barbara Slater at (860) 403-5607, or by e-mail at barbara.slater@phoenixwm.com.

State Narrative:

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

Phoenix Life and Annuity Company	CoCode: 93734	State of Domicile: Connecticut
One American Row	Group Code: 403	Company Type: Life and Annuities
Hartford, CT 06102	Group Name:	State ID Number:
(860) 403-5000 ext. [Phone]	FEIN Number: 43-1240953	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$0.00
Retaliatory?	No
Fee Explanation:	1 application submitted at \$50 per application = \$50
Per Company:	No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Phoenix Life and Annuity Company	\$50.00	06/22/2012	60358575

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/26/2012	06/26/2012

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Disposition

Disposition Date: 06/26/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Form Schedule

Lead Form Number: OL4374

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	OL4374	Application/ Enrollment Form Application for Reinstatement	Initial		51.740	OL4374_JOH N DOE_FINAL_ 6-11-12.pdf



Phoenix Life Insurance Company (Phoenix)
 PHL Variable Insurance Company (Phoenix)
 Phoenix Life and Annuity Company (Phoenix)

Application for Reinstatement

Regular Mail: [PO Box 8027, Boston MA 02266-8027]
 Overnight Mail: [30 Dan Rd., Suite 8027, Canton MA 02021-2809]

Reinstatement of Policy Number(s) 123456789

Section 1 - Proposed Insured Information

Name (First, Middle, Last) Jane D. Doe				Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	Date of Birth (mm/dd/yyyy) 02/01/1960	Social Security Number 987-65-4321	
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Civil Union Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Federal Spouse <input type="checkbox"/> Single <input checked="" type="checkbox"/> Widowed		Birth State TN	Birth Country U. S.	U.S. Citizen <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No [If "No", complete Non U.S. Citizen ONLY questions.]			
Non U.S. Citizen ONLY	Country of Citizenship	Green Card / Visa Type	Expiration Date (mm/dd/yyyy)	Country of Permanent Residence	ID Number	Years in U.S.	
Driver's License # 4067-8895423	State TN	Earned Income \$ 86,000.	Unearned Income \$ -	Net Worth \$ 625,000.			
Residence Street Address (include Apt #) 123 Street			City Anycity	State TN	ZIP Code 12345	Preferred Telephone Number (868) 522-0311	
Have you used tobacco or nicotine products in any form in the last 10 years? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
a. If "Yes", check the product(s) used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars, Pipes, Snuff, Smokeless or Chewing Tobacco, <input type="checkbox"/> Nicotine Patch, Gum, Lozenge or Other _____							
b. If "Yes", check where appropriate: <input type="checkbox"/> Use Currently <input type="checkbox"/> Date Quit (mm/yyyy) _____							

Section 2 - Insurance History

- 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? Yes No
If "Yes", provide date, company and reason. _____
- Are you negotiating for other life insurance? Yes No
If "Yes", provide company, and the total amount of coverage to be placed in force. _____
- Has the insured or the owner participated in a transaction involving the sale or transfer of a life insurance policy on the life of the insured? .. Yes No
If "Yes", provide details in the grid below.
- Has the insured or owner or any individual, or any entity received or been promised cash or other financial or non-financial inducements in connection with this policy or this reinstatement application? Yes No
If "Yes", provide details. _____
- Are there any life insurance policies on the life of the insured including policies that have been previously settled or sold? Yes No
If "Yes", provide details in the grid below.

Schedule of In Force Coverage

If no coverage in force, check here:

Company	Insurance Personal Business	Issue Date mm/yyyy	Amount Including Riders	Indicate if Sold, Assigned, Transferred or Settled and Transaction Date
	<input type="checkbox"/> <input type="checkbox"/>		\$	
	<input type="checkbox"/> <input type="checkbox"/>		\$	
	<input type="checkbox"/> <input type="checkbox"/>		\$	
	<input type="checkbox"/> <input type="checkbox"/>		\$	

Section 3 - Medical History

Current Height: 5'6"		Current Weight: 147		If your weight has changed by 10 pounds or more in the past 2 years, 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 type="checkbox"/> Alive <input checked="" type="checkbox"/> Deceased		71	Construction accident	Mother <input checked="" type="checkbox"/> Alive <input type="checkbox"/> Deceased	68		None
Personal Physician: Please provide the name and address of your personal physician or health care provider, date of most recent visit, reason for visit, and results of treatment (if any): John J. Jones, MD 101 4th Avenue Anycity, TN 12343 12/6/2011 - Routine physical				Has anyone in your immediate family developed any hereditary condition, cancer, or heart disease before age 60? <input type="checkbox"/> Yes (Please provide details below.) <input checked="" type="checkbox"/> No			

To the best of your knowledge and belief, have you ever had, or been told by a physician or other health care provider that you have: (Please provide **details** of "Yes" answers below.)

1. High blood pressure or hypertension? Yes No
2. Pain, pressure, or discomfort in the chest, angina pectoris, palpitations, swelling of the ankles, or undue shortness of breath? Yes No
3. Heart disease, coronary artery disease, cardiomyopathy, heart failure, atrial fibrillation, heart rhythm abnormality, heart murmur, congenital heart disease or valvular heart disease? Yes No
4. Peripheral vascular disease, claudication, narrowing or blockage of arteries or veins? Yes No
5. Asthma, pulmonary fibrosis, chronic cough, emphysema, pneumonia, or any other lung disease? Yes No
6. 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
7. Depression, bipolar disorder, schizophrenia, anxiety, or other psychiatric illness? Yes No
8. Arthritis, lupus, or any musculoskeletal or skin disorder? Yes No
9. Ulcers, abdominal pain, colitis, Crohn's disease, gall bladder disease, liver disease, hepatitis, jaundice, pancreatitis, or any other disease of the gastrointestinal system? Yes No
10. Diabetes, kidney disease, kidney stones, bladder disorder, prostate disorder, protein or blood in the urine? Yes No
11. Endocrine disorder, including disorder of the thyroid, parathyroid, adrenal, or pituitary glands? Yes No
12. Anemia, bleeding or clotting disorder, or any other disorder of the blood or bone marrow? Yes No
13. Cancer of any type, tumor (benign or malignant), leukemia, lymphoma, or Hodgkin's disease? 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, marijuana, 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 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 applied for or received sickness or accident benefits or a disability payment from any source? Yes No

Applicants Age 65 and older answer questions below:

21. Are you using any of the following: cane, catheter, electric scooter, oxygen, walker or wheelchair? Yes No
22. In the past year, have you required the assistance of another person for: bathing, dressing, eating, toileting, transferring, or management of bowel or bladder problems? Yes No
23. 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, assisted living facility, home health care, nursing home care or physical, occupational or speech therapy? Yes No

Details of "Yes" answers (include question number, condition, date of occurrence, testing performed, current status, hospital or treating physician's name and address.)

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

Section 4 - Non - Medical Information

Provide full details for all "Yes" answers below in Section 5 - Additional Information.

- 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? Yes No
 If "Yes", to either questions 1a or 1b state where, how long, purpose and dates.
 Location: City, Country: _____
 How Long: (Specify weeks, months, years) _____
 Purpose: _____
 Dates: _____
- 2a. Have you flown during the past 3 years as pilot, student pilot or crew member? Yes No
 If "Yes", complete Aviation Application Supplement.
- 2b. Do you plan to do so within the next 2 years? Yes No
 If "Yes", complete Aviation Application Supplement.
- 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? Yes No
 If "Yes", complete Avocation Questionnaire.
- 3b. Do you plan to do so within the next 2 years? Yes No
 If "Yes", complete Avocation Questionnaire.
- 4. Have you ever been convicted of a felony? Yes No
- 5. Are you currently, or have you ever been on probation? Yes No
- 6. 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
- 7. Have you ever filed bankruptcy? Yes No

Section 5 - Additional Information

Use space below for additional information.

Empty rectangular box for additional information.

Section 6 - Fraud Notices

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Arkansas, Rhode Island – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia – 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, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Kentucky, Pennsylvania – Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Ohio – 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.

Oklahoma – Warning; Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of any insurance policy/contract containing any false incomplete or misleading information is guilty of a felony.

Tennessee – It is a crime to provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas – Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Virginia – 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 false or deceptive statement may have violated the state law.

Section 7 - 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 Alaska, Colorado, Iowa, Kansas, Kentucky, Montana, New Hampshire, North Dakota, 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.

Section 8 - Signatures

I have reviewed this Reinstatement Application and the statements made herein are those of the Proposed Insured and all such statements made by the Proposed Insured have been correctly recorded and are full, complete and true to the best of the Proposed Insured's knowledge and belief. Further, I understand that the company will rely upon the information provided in this Reinstatement Application. The statements and answers in the Reinstatement Application are the basis for the reinstatement and no information about them will be considered to have been given to Phoenix unless it is stated in the Reinstatement Application.

I understand that if there is any change in my health that would change the answer to any of the questions on this application between now and when I am notified that my reinstatement has been approved, I will notify Phoenix at [PO Box 8027, Boston MA 02266-8027]

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 this reinstatement application reinstatement 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. This reinstatement application and any underwriting requirements are complete and approved by the Home Office of the Company; and
2. All past due premiums and interest payments have been received by the Company during the proposed insured's lifetime;
3. The representations made in the reinstatement application are full, complete and true at the time payment is received by the Company.

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 the insured, I hereby affirm that I have reviewed this Reinstatement Application and that: 1) all statements made by the Owner in this Reinstatement Application have been correctly recorded and are full, complete and true to the best of the Owner's knowledge and belief and 2) that to the best of the Owner's knowledge and belief, all statements of the Proposed Insured are full, complete and true.

Proposed Insured's Signature 	State Signed In TN	Witness Signature (Must be signed in presence of Proposed Insured) 	Date (mm/dd/yyyy) 10/31/2012
Owner's Signature	State Signed In	Witness Signature (Must be signed in presence of Owner)	Date (mm/dd/yyyy)
Owner's Signature	State Signed In	Witness Signature (Must be signed in presence of Owner)	Date (mm/dd/yyyy)

SERFF Tracking Number: TPCI-128506389

State: Arkansas

Filing Company: Phoenix Life and Annuity Company

State Tracking Number:

Company Tracking Number:

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Product Name: OL4374 Reinstatement Application PLAC

Project Name/Number: /

Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Attachment:

AR flesch cert OL4374.pdf

Item Status:

Status

Date:

Bypassed - Item: Application

Bypass Reason: Not applicable.

Comments:

Item Status:

Status

Date:

Satisfied - Item: Statement of Variability - OL4374

Comments:

Attachment:

Statement of Variability - OL4374.pdf

**ARKANSAS
CERTIFICATION**

FORM NO.	OL4374
FORM TITLE	Application for Reinstatement
FLESCH SCORE	51.74

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.

Phoenix Life and Annuity Company

Signature: 
Name: Scott Zweig
Title: Director, Product & Regulatory Compliance
Date: June 22, 2012

Statement of Variability

OL4374 – Application for Reinstatement

June 11, 2012

This Statement of Variability sets forth the variable information which will appear in brackets in form OL4374 (Application for Reinstatement). No change in variability will be made which in any way expands the scope of the wording being changed.

Page 1 - Company Logo:

The company logo has been bracketed to indicate that this logo could be changed in the future.

Page 1 - Company Address:

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

Page 1 - 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.

The line of information that begins “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.

Page 4 - Section 8 – Signatures:

Our address has been bracketed to indicate that it may change in the future.