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**State:** Arkansas **Filing Company:** Phoenix Life and Annuity Company  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** Policy Change Form  
**Project Name/Number:** /

## Filing at a Glance

Company: Phoenix Life and Annuity Company  
Product Name: Policy Change Form  
State: Arkansas  
TOI: L08 Life - Other  
Sub-TOI: L08.000 Life - Other  
Filing Type: Form  
Date Submitted: 01/14/2013  
SERFF Tr Num: TPCI-128828542  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: OL4755  
Implementation: On Approval  
Date Requested:  
Author(s): Scott Zweig, Joseph Bonfitto, Barbara Slater, Jean Bulger, Elizabeth Stevens, Colleen Lyons, Marlene Burghardt, Lois McGuire , Erica Scherzer, Hayley Stone  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 01/18/2013  
Disposition Status: Approved-Closed  
Implementation Date:  
State Filing Description:

**State:** Arkansas  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
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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:  
Explanation for Combination/Other: Market Type: Individual  
Submission Type: New Submission Individual Market Type:  
Overall Rate Impact: Filing Status Changed: 01/18/2013  
State Status Changed: 01/18/2013  
Deemer Date: Created By: Jean Bulger  
Submitted By: Hayley Stone Corresponding Filing Tracking Number:

Filing Description:  
Phoenix Life and Annuity Company (NAIC# 93734, FEIN #43-1240953)

RE: For Approval Purposes  
Form OL4755 Application for Policy Change

Dear Reviewer:

We are filing the above-referenced form 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, to make a written application for one of two types of changes to their in-force life insurance policy. The first being any administrative change and the second any change that would require underwriting.

A duplicate filing of this form is being submitted as well for PHL Variable Insurance Company (NAIC # 93548) and for Phoenix Life Insurance Company (NAIC # 93734).

We are requesting approval of this form for use with all of our life insurance products previously and subsequently approved by your Department.

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 me at (860) 403-5607, or by e-mail at [barbara.slater@phoenixwm.com](mailto:barbara.slater@phoenixwm.com).

Sincerely,  
Barbara Slater

## Company and Contact

### Filing Contact Information

Scott Zweig, Director [scott.zweig@phoenixwm.com](mailto:scott.zweig@phoenixwm.com)

**State:** Arkansas **Filing Company:** Phoenix Life and Annuity Company  
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One American Row 860-403-5951 [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: \$50.00  
 Retaliatory? No  
 Fee Explanation: Each Application fee is \$50.00  
 Per Company: No

Company	Amount	Date Processed	Transaction #
Phoenix Life and Annuity Company	\$50.00	01/14/2013	66515803

State: Arkansas Filing Company: Phoenix Life and Annuity Company  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/18/2013	01/18/2013

SERFF Tracking #:

TPCI-128828542

State Tracking #:

Company Tracking #:

OL4755

State:

Arkansas

Filing Company:

Phoenix Life and Annuity Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Policy Change Form

Project Name/Number:

/

## Disposition

Disposition Date: 01/18/2013

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	Regulation 34 Certification		Yes
Supporting Document	Statement of Variability		Yes
Form	Application for Policy Change		Yes

SERFF Tracking #:

TPCI-128828542

State Tracking #:

Company Tracking #:

OL4755

State: Arkansas

Filing Company:

Phoenix Life and Annuity Company

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other

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## Form Schedule

Lead Form Number: OL4755

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Application for Policy Change	OL4755	AEF	Initial		59.990	OL 4755 bracketed and john doe.pdf

### Form Type Legend:

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



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

Application for Policy Change

Print and use black ink. Any changes must be initiated by the Insured and Owner. Complete all applicable sections that need to describe changes requested. If more than two Insureds use a second copy of form and attach it to this form.

Provide the Policy Number that requires change. \_\_\_\_\_

Section 1 - Type of Transaction

Select one type of change being requested below. If an increase in face amount is requested complete the appropriate life insurance application or one of the appropriate state variations.

- Apply for Non-smoker rates (no cigarettes for the past 12 months). (Must complete Sections 1, 2, 3B, 8, 9 and 10) **AND** HIPAA and OL348 - required
- Apply for Never Smoke rates (no tobacco for the past 15 years and requires evidence of insurability). (Must complete Sections 1, 2, 3B, 5, 6, 8, 9 and 10) **AND** HIPAA - required
- Apply for Preferred rate classes (requires evidence of insurability). (Must complete Sections 1, 2, 3A, 5, 6, 8, 9 and 10) **AND** HIPAA - required
- Apply for review of substandard rating (requires evidence of insurability). (Must complete Sections 1, 2, 3A, 5, 6, 8, 9 and 10) **AND** HIPAA - required
- Apply for Option Exercise. (Must complete Sections 1, 2, 3C, 8, 9 and 10)
- Policy Change (not previously listed information). (Must complete Sections 1, 2, 3, 3A, 3C, 4, 5, 8, 9 and 10)

Describe type of change:

Section 2 - Required Information

Complete required information being requested below in its entirety so that your request can be processed in a timely manner. All fields are required for processing.

Insured Information

Name (First, Middle, Last) John A. Doe				Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	Date of Birth (mm/dd/yyyy) 01/01/1980	Social Security Number 123-45-6789	
Marital Status <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Civil Union Partner		Birth State CT	Birth Country USA	U.S. Citizen <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No [If "No", complete Non U.S. Citizen ONLY questions]			
<b>Non U.S. Citizen ONLY</b>	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 # 0201-259-55885		State CT	Earned Income \$100,000	Unearned Income \$		Net Worth \$ 100,000	
Residence Street Address (include Apt #) 1 State Street			City Anytown		State CT	ZIP Code 11256	
Home Phone # ( 860 ) 555 - 1212		Work Phone # ( 860 ) 444 - 1212		Cellular Phone # ( 860 ) 333 - 1212		Best # to reach Insured <input type="checkbox"/> Home <input type="checkbox"/> Work <input checked="" type="checkbox"/> Cellular	
Current Occupation Sales		Current Employer Eastman Kodak		Years of Service 6	Email Address john.doe@john.com		
Employer Street Address 123 American Ave.			City Hoentown	State CT	ZIP Code 11225	Employer's Phone # ( 860 ) 565 - 1212	
Have you used tobacco or nicotine products in any form? <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 3 - Policy Change**

**A. Type of Policy Change**

Select applicable options to be changed. Complete additional information as required. Certain restrictions may apply.

- Face Amount Reduction  
Indicate new face amount to be placed in force Amount . . . . . \$ \_\_\_\_\_
- Policy Date Date (mm/dd/yyyy) . . . . . \_\_\_\_\_
- Rated Age Age (number of years) . . . . . \_\_\_\_\_
- \*Date of Birth Date (mm/dd/yyyy) . . . . . \_\_\_\_\_
- \*Plan of Insurance Name . . . . . \_\_\_\_\_
- Rate Class reconsider for Preferred Name . . . . . John Doe
- Rate Class reconsider for Substandard Rating Name . . . . . \_\_\_\_\_

**\*Changes require completion of Medical Section 5; certain restrictions may apply. Please note that there may be income tax ramifications as a result of changes to your policy. Please consult your tax advisor for assistance.**

**B. Smoking Status**

Complete if applying for Smoking Status change.

The **Non-smoker rate class requires** no cigarette use in the past 12 months.

- For changes to Non-Smoker rates, no medical questions are required.
- Policies with face amounts of \$500,000 and greater will require a urine specimen.

The **Never Smoker rate class requires** no tobacco use (in any form) in the past 15 years and the insured must currently be a standard risk. The Never Smoker rate class is not available on all products.

- Changes to Never Smoker rates require evidence of insurability.
- Complete the medical questions in Section 5 for all cases.
- Policies with face amounts of \$500,000 and greater will require a urine specimen.
- Additional requirements may be necessary.

Date restrictions may apply to changes occurring only on policy anniversary or monthiversary.

Please check the applicable statement below. By checking one of these statements, the insured attests that the statement selected is true to the best of their knowledge and belief.

**For changes to Non-Smoker rates:**

I do not now smoke cigarettes, nor have I smoked cigarettes for at least the past twelve months. . . . .  Yes  No

**For changes to Never Smoker rates (not available on all products):**

I do not now use tobacco in any form, nor have I used tobacco in any form for the last fifteen years. . . . .  Yes  No

**C. Riders or Features**

Select riders and/or features to be added or cancelled. Complete additional information as required. **Unless indicated, any present riders or features will be retained. Not all riders or changes are available on all products.**

**Death Benefit Option Change**

- Level to Increasing
- Increasing to Level
- Return of Premium to Level

**Life Plan Options**

**Additional Information Required**

- Increase in Face Amount Option . . . . . Amount \$ \_\_\_\_\_
- Reduction of Face Amount Option . . . . . Amount \$ \_\_\_\_\_
- Exchange for Annuity Option
- Alternate Policy Split Option

Section 3 continued on next page.

Select riders and/or features to be added or cancelled. Complete additional information as required. **Unless indicated, any present riders or features will be retained. Not all riders or changes are available on all products.**

**Section 3 - Policy Change continued**

**C. Riders or Features continued**

Rider Exercise	Additional Information Required
<input type="checkbox"/> Acceleration of Death Benefit Rider	
<input type="checkbox"/> Child Term Rider	First, Middle, Last Name _____ Date of Birth (mm/dd/yyyy) _____
<input type="checkbox"/> Exchange of Insured Rider .....	Amount \$ _____
<input type="checkbox"/> Exchange Option Rider	
<input type="checkbox"/> Level Term Protection Rider .....	Amount \$ _____
<input type="checkbox"/> Overloan Protection Rider	
<input type="checkbox"/> Paid-up Additions Purchase Rider for premium of .....	Face Amount \$ _____
<input type="checkbox"/> Purchase Protector Rider	
<input type="checkbox"/> Reduction of Face Amount Rider .....	Amount \$ _____

**Rider Cancel**

<input type="checkbox"/> Acceleration of Death Benefit Rider (Accelerated Benefit Rider) <b>Disclosure Form must be submitted.</b>
<input type="checkbox"/> Accidental Death Benefit
<input type="checkbox"/> Alternate Surrender Value Rider
<input type="checkbox"/> Child Term Rider
<input type="checkbox"/> Cost of Living
<input type="checkbox"/> Disability Benefit Rider
<input type="checkbox"/> Early Crediting Option Rider
<input type="checkbox"/> Increasing Term Protection Rider (Individual Increasing Term Rider)
<input type="checkbox"/> Level Term Protection Rider (Individual Level Term Rider)
<input type="checkbox"/> OptionTerm
<input type="checkbox"/> Paid-up Additions Purchase Rider for premium of
<input type="checkbox"/> Protection Plan - Children's
<input type="checkbox"/> Protection Plan - Family
<input type="checkbox"/> Purchase Protector
If Other(s), print feature name and indicate if cancelling below.
<input type="checkbox"/> _____
<input type="checkbox"/> _____
<input type="checkbox"/> _____

**D. Premiums**

Select the payment mode to which premiums should be changed. The method selected below will determine the due dates with at least one premium payable on policy anniversary.

Annual    Semi-Annual    Quarterly    Monthly Debit ("Check-O-Matic") Minimum Monthly Payment - \$25.00

**E. Additional Changes**

Select applicable change(s) to the Automatic Premium Loan Provision and/or Automatic Nonforfeiture Provision. Complete additional information as required.

Automatic Premium Loan. .... If selected, indicate  Operative or  Non-Operative

Automatic Nonforfeiture Provision. .... If selected, indicate  Extended Insurance (if eligible under policy) or  Paid-up Insurance

**Section 3 continued on next page.**

**Section 3 - Policy Change continued**

Select dividend method to be used. If the intent is to release values from current dividends, skip this section and go to Section G Dividend Release. Non-medical questions must be completed.

**F. Dividend Method**

- Cash    Accumulate    Reduce Premium    Paid-up Additions    Reduce Loan    OptionTerm
- \*Buy One-year term with balance to . . . . .  Cash    Accumulate    Reduce Premium    Paid-up Additions    Reduce Loan
- Buy Deferred Additions with balance (Economaster Plans only) . . .  Cash    Accumulate    Reduce Premium    Paid-up Additions

Unless otherwise provided below, any existing dividends will be retained on present basis.

\*If the current dividend method is Fifth Dividend, OptionTerm, Economaster I or II, Term Additions or Supplemental Term Portion answer the following question:  
I understand that as a result of this change in dividend method, my Death Benefit will be affected. . . . .  Yes

Comments:

**G. Dividend Release**

Select Dividend and Paid-Up values to be released and/or applied. Complete additional information as required for each selection.

- Release Accumulated Dividends
- Surrender Paid-up Additions and apply the cash value thereof as follows (state all or amount needed if dollar amount unknown).
  - \$ \_\_\_\_\_ to TIR on Policy Number . . . . . \_\_\_\_\_
  - \$ \_\_\_\_\_ on premium under Policy Number . . . . . \_\_\_\_\_
  - \$ \_\_\_\_\_ to reduce loan on Policy Number . . . . . \_\_\_\_\_
  - Pay in cash specified dollar amount of . . . . . \$ \_\_\_\_\_
  - Apply existing dividend values to new method shown under 5 above, subject to evidence of insurability if necessary.
  - Other \_\_\_\_\_

Comments:

If the current dividend is OptionTerm or Term Additions answer the following question:  
I understand that the release of Paid-Up Additions may affect my Death Benefit . . . . .  Yes

**Section 4 - Insurance History**

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? .....  Yes  No  
If "Yes", provide date, company and reason. \_\_\_\_\_
2. Are you negotiating for other life insurance? .....  Yes  No  
If "Yes", provide company, and the total amount of coverage to be placed in force. \_\_\_\_\_
3. 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.
4. 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 application? .....  Yes  No  
If "Yes", provide details. \_\_\_\_\_
5. 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		Issue Date mm/yyyy	Amount Including Riders	Indicate if Sold, Assigned, Transferred or Settled and Transaction Date
	Personal	Business			
	<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 5 - Medical History**

Current Height:		Current Weight:		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:			
<b>Family History:</b>	Age if Alive	Age at Death	If alive, indicate health problems or if deceased, indicate cause of death:	<b>Family History:</b>	Age if Alive	Age at Death	If alive, indicate health problems or if deceased, indicate cause of death:
Father <input type="checkbox"/> Alive <input type="checkbox"/> Deceased				Mother <input type="checkbox"/> Alive <input type="checkbox"/> Deceased			
<b>Personal Physician:</b> 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):				Has anyone in your immediate family developed any hereditary condition, cancer, or heart disease before age 60? <input type="checkbox"/> Yes (Please provide <b>details</b> below.) <input 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 6 - Non - Medical Information**

Provide full details for all "Yes" answers below in Section 6 - 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 7 - Additional Information**

Use space below for additional information.

\_\_\_\_\_

**Section 8 - 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.

**New Jersey** – Any person who includes any false or misleading information on an application for an insurance policy is subject 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 9 - Authorization To Obtain Information

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

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

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

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

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

This authorization shall continue to be valid for 30 months (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 10 - Signatures

I have reviewed this Policy Change 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 Policy Change Application. The statements and answers in the Policy Change Application are the basis for the policy change and no information about them will be considered to have been given to Phoenix unless it is stated in the Policy Change 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 policy change 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 policy change 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 changes applied for shall not take effect unless and until each of the following has occurred:

1. This policy change application and any underwriting requirements are complete and approved by the Home Office of the Company; and
2. The representations made in the policy change application are full, complete and true at the time payment is received by the Company.

Under penalties of perjury, I certify that: a) the number provided on this form is my correct taxpayer identification number; and b) I am not subject to backup withholding because: 1) I am exempt from backup withholding; or 2) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends; or 3) the IRS has notified me that I am no longer subject to backup withholding, and c) I am a U.S. citizen or other U.S. person.

If I am an Owner who is not the insured, I hereby affirm that I have reviewed this Policy Change Application and that: 1) all statements made by the Owner in this Policy Change 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.

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

SERFF Tracking #:

TPCI-128828542

State Tracking #:

Company Tracking #:

OL4755

State: Arkansas

Filing Company:

Phoenix Life and Annuity Company

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other

Product Name: Policy Change Form

Project Name/Number: /

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR flesch cert 2 OL4755.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Regulation 34 Certification		
Comments:			
Attachment(s):			
AR certification - OL4755 - Reg 34.pdf			

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

**ARKANSAS  
CERTIFICATION**

FORM NO.	<b>OL4755</b>
FORM TITLE	<b>Policy Change Form</b>
FLESCH SCORE	<b>59.99</b>

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: December 28, 2012

**ARKANSAS  
CERTIFICATION**

FORM NO.	<b>OL4755</b>
FORM TITLE	<b>Policy Change Form</b>

I hereby certify the following:

- To the best of my knowledge and belief, the above form(s) and submission complies with Arkansas Regulation 34.
- The attached forms comply with ACA 23-79-138 and Bulletin 11-83.

Signature:   
Name: Scott Zweig  
Title: Director, Product & Regulatory Compliance  
Date: December 28, 2012

  
Signature: \_\_\_\_\_  
Name: Scott Maramo, FSA, MAAA  
Title: 2nd Vice President, Product and Market Development  
Date: December 28, 2012

## **Statement of Variability**

### **OL4755 - Application for Policy Change**

**December 28, 2012**

This Statement of Variability sets forth the variable information which will appear in brackets in form OL4755 (Application for Policy Change). 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 – Type of Transaction:**

The types of transactions has been bracketed to indicate that it may be deleted in the future

#### **Page 1 - Section 2: Required Information:**

Insured Information – The language that begins with “Non 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.

#### **Page 2- Section 3 – Policy Change:**

A.Type of Policy Change – The bracketing of the checkboxes and text in this section indicates that if certain policy change options are no longer offered, they will not appear on this form. It is also bracketed to indicate that other policy change options may be added to this form. However, no policy change options will be added to this form unless they have been previously approved by your Department, if approval is required.

#### **Page 2- Section 3 – Policy Change:**

C.Riders or Features – Death Benefit Option Change- The bracketing of the checkboxes and text in this section indicates that if certain death benefit option changes are no longer offered, they will not appear on this form. It is also bracketed to indicate that other death benefit option changes may be added to this form. However, no death benefit option changes will be added to this form unless they have been previously approved by your Department, if approval is required.

C.Riders or Features – Life Plan Options- The bracketing of the checkboxes and text in this section indicates that if certain life plan option changes are no longer offered, they will not appear on this form. It is also bracketed to indicate that other life plan option changes may be added to this form. However, no life plan option changes will be added to this form unless they have been previously approved by your Department, if approval is required.

**Page 3- Section 3 – Policy Change:**

C.Riders or Features – Riders of Exercise- The bracketing of the checkboxes and text in this section indicates that if certain rider exercise option changes are no longer offered, they will not appear on this form. It is also bracketed to indicate that other rider exercise option changes may be added to this form. However, no rider exercise option changes will be added to this form unless they have been previously approved by your Department, if approval is required.

**Page 3- Section 3 – Policy Change:**

C.Riders or Features – Rider Cancel- The bracketing of the checkboxes and text in this section indicates that if certain rider changes are no longer offered, they will not appear on this form. It is also bracketed to indicate that other rider changes may be added to this form. However, no rider changes will be added to this form unless they have been previously approved by your Department, if approval is required.

**Page 3- Section 3 – Policy Change:**

D.Riders or Features - Premiums- The different payment options have been bracketed to indicate that either all of the options shown here may not be available (we may discontinue certain options), or that additional payment options may be added.

**Page 3- Section 3 – Policy Change:**

E.Riders or Features – Additional Changes- The bracketing of the checkboxes and text in this section indicates that if certain additional changes are no longer offered, they will not appear on this form. It is also bracketed to indicate that other additional changes may be added to this form. However, no additional changes will be added to this form unless they have been previously approved by your Department, if approval is required.

**Page 4- Section 3 – Policy Change:**

F.Riders or Features – Dividend Method- The bracketing of the checkboxes and text in this section indicates that if certain dividend changes are no longer offered, they will not appear on this form. It is also bracketed to indicate that other dividend changes may be added to this form. However, no dividend changes will be added to this form unless they have been previously approved by your Department, if approval is required.

**Page 4- Section 3 – Policy Change:**

G.Riders or Features – Dividend Release- The bracketing of the checkboxes and text in this section indicates that if certain dividend release changes are no longer offered, they will not appear on this form. It is also bracketed to indicate that other dividend release changes may be added to this form. However, no dividend release changes will be added to this form unless they have been previously approved by your Department, if approval is required.

**Page 7 - Section 6– Non-Medical Information:**

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

**Page 7 – Section 8 – Fraud Notices**

The bracketing of language in this section indicates that the fraud language required by each listed state will appear in this section. Should the states change their required language, those changes will be reflected here.

**Page 8 - Section 10 – Signatures:**

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