PHOENIX

Phoenix Life Insurance Company and its subsidiaries
PO Box 8027
Boston MA 02266-8027

Application Part II

Examination to be made in private. Please read all questions to applicant. Answers to be recorded in the examiner's own handwriting.

NAME OF PROPOSED INSURED	SEX	DATE OF BIRTH	OCCUPATION

1. Family Record	Age	Health	Age At Death	Cause of Death
Father				
Mother				
Brothers&Sisters No. Living ____ No. Dead ____				

Please Check (✓) Appropriate	Yes	No
2. To your knowledge, have any of your parents, brothers or sisters had diabetes?	☐	☐
3. A. Have you ever been treated for alcoholism or any drug habit?	☐	☐
B. Have you ever used narcotics, barbiturates, amphetamines, hallucinogens or any prescription drug except in accordance with a physician's instructions?	☐	☐
4. Have you sought treatment or consulted a physician for any reason in the last 5 years, including routine examinations or check-ups? (Give full details.)	☐	☐
5. To the best of your knowledge have you ever had, or been told by any physician or other practitioner that you had:		
A. High blood pressure?	☐	☐
B. Pain, pressure, or discomfort in the chest, palpitation, swelling of the ankles, or undue shortness of breath?	☐	☐
C. Heart disease, heart murmur, angina pectoris, or coronary disease?	☐	☐
D. Rheumatic fever, chorea, rheumatism, or arthritis?	☐	☐
E. Pneumonia, pleurisy, asthma, tuberculosis, chronic cough, or any other disease of the lungs?	☐	☐
F. Epilepsy, fainting spells, concussion, skull fracture, severe headaches, dizziness, mental disorder or nervous breakdown?	☐	☐
G. Indigestion, stomach or duodenal ulcer, colitis, or other disease of the intestines or rectum, gall bladder disorder, jaundice, hepatitis, or liver disorder?	☐	☐
H. Kidney disease, nephritis, kidney stone, bladder trouble, or albumin, sugar, pus, or blood in the urine?	☐	☐
I. Disease of the reproductive organs, prostate trouble, abnormal menstruation, complicated pregnancies or disease of the breasts?	☐	☐
J. Diabetes, venereal disease, gout, thyroid disease, enlarged glands, tumor, polyp, cancer or skin disease?	☐	☐
K. Disease or disorder of blood or blood formation?	☐	☐
L. Acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), or any other immunological disease or disorder?	☐	☐
M. Paralysis, deformity, or any injury or disorder of the muscles, bones, joints, spine or back?	☐	☐
N. Other than above, any physical or mental disorder, operation, or injury within the past 5 years?	☐	☐

6. NAME OF PERSONAL PHYSICIAN (IF NONE, SO STATE) _____
ADDRESS _____
DATE LAST SEEN, REASON AND OUTCOME _____

	YES	NO
7. A. Have you ever had a surgical operation or been a patient in any hospital, sanatorium, or similar institution?	☐	☐
B. Have you had, or been advised to have, any surgical operations, X-rays, electrocardiograms, blood studies, or other tests within the last 5 years?	☐	☐
C. Has a physician ever advised you to diet?	☐	☐
D. Is there any kind of medicine which you take regularly or at frequent intervals?	☐	☐
8. Have you ever applied for or received sickness or accident benefits or a disability pension from any source?	☐	☐
9. A. Have you ever been declined, postponed, rated, or ridered for insurance?	☐	☐
B. Are you negotiating for other insurance? (If "yes" name companies and amounts.)	☐	☐

10. DETAILS of all questions answered "yes." Include **Dates, Names,** and **Addresses** of all doctors consulted, **Duration, Treatment,** and **Results.** Please indicate question # you are responding to:

Question #

_____

_____

_____

_____

_____

_____

The foregoing statements are full, complete, and true to the best of my knowledge and belief.

DATED AT (City and State)	DATE
WITNESS (Examiner)	PROPOSED INSURED (SIGN FULL NAME)

PHOENIX®
PO Box 8027
Boston MA 02266-8027

Application Part II Addendum

Company is defined as Indicated: ☐ Phoenix Life Insurance Company ☐ PHL Variable Insurance Company

PROPOSED INSURED NAME (First, Middle, Last)

Please continue details of all yes answers (reference question #) including dates, names of doctors consulted, treatment, duration, diagnosis and results.

The foregoing statements are full, complete, and true to be best of my knowledge and belief. 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.

DATE	PROPOSED INSURED (Sign full name)

PARAMEDICAL EXAMINATION – Complete questions 1-11.

MEDICAL EXAMINATION BY PHYSICIAN – Complete all questions.

1. How did you identify applicant? ☐ Driver's license (Please provide number and state)_____
☐ Other (Specify) _____

2. Height: ☐ measure ☐ not measured If not measured, indicate reason below.	**3. Weight:** ☐ measured ☐ not measured If not measured, indicate reason below.	**4. Change in Weight:** Has applicant's weight changed by 10 pounds or more in the past year? ☐ Yes ☐ No If "yes", how much: _____ pounds ☐ Gain ☐ Loss Reason for weight change:
5. Pulse Rate: ☐ regular ☐ irregular If pulse is irregular, give details below.	**6. Blood Pressure:** If systolic BP above 140 or diastolic BP above 90, record 2 additional BP readings at least 5 minutes apart.	**1st BP Reading:** / **2nd BP Reading:** / **3rd BP Reading:** Size of BP cuff used: ☐ Standard cuff ☐ Large cuff ☐ Small cuff

7. Is applicant pregnant? If "yes," please provide due date	☐ Yes ☐ No	**Please provide details of any "YES" answers, abnormal findings, or additional remarks:**
8. Does applicant appear unhealthy or older than stated age?	☐ Yes ☐ No	
9. Does applicant use a wheelchair, cane, crutches, walker, or any other assistive device for walking?	☐ Yes ☐ No	
10. Is there any indication of confusion or forgetfulness?	☐ Yes ☐ No	
11. Are you aware of any other information that is pertinent to the applicant's life expectancy?	☐ Yes ☐ No	
PHYSICIAN EXAMINATION ONLY:		
12. On examination, is there any abnormality of the following:		
(a) HEENT (include thyroid exam)	☐ Yes ☐ No	
(b) CNS (gait, tremor, weakness, paralysis)	☐ Yes ☐ No	
(c) Cardiovascular (If abnormal heart sounds or murmurs are present, please describe fully and give your impression. Also check for peripheral edema or any evidence of peripheral vascular disease.)	☐ Yes ☐ No	
(d) Respiratory (breath sounds, wheezing, rales)	☐ Yes ☐ No	
(e) Abdomen (surgical scars, ascites)	☐ Yes ☐ No	
(f) Musculoskeletal (joints, amputations, deformities	☐ Yes ☐ No	
(g) Lymph nodes	☐ Yes ☐ No	
(h) Skin (surgical scars, rash, or any possibly significant skin lesions)	☐ Yes ☐ No	

TESTING PERFORMED IN CONJUNCTION WITH THIS EXAMINATION:

☐ Blood sample (please send samples to Heritage Labs)
☐ Urine specimen (if female applicant currently menstruating, check here ☐)
☐ Electrocardiogram
☐ Chest X-ray

EXAMINER'S STATEMENT:

I certify that I have carefully examined _____ and that the applicant's responses to all questions on both sides of this form are accurately recorded. (print name of person examined)

Examiner's Signature	Date of Examination / Time of Examination ☐ AM ☐ PM
Examiner's Tax ID Number	Name of Producer Requesting Examination
Examiner's Printed Name	Producer & Agency Code
Examiner's Address	Place of Examination (City, State) ☐ Examiner's office ☐ Applicant's business ☐ Applicant's residence

PHOENIX

Phoenix Life Insurance Company and its subsidiaries
100 Bright Meadow Boulevard
PO Box 1900
Enfield CT 06083-1900
Underwriting and Issue

Notice and Consent for HIV-Related Testing

To evaluate your insurability, the Insurer named above (Phoenix Life Insurance Company and its subsidiaries) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Results

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result: _____

Address: _____

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____	_____
Name of Proposed Insured	Signature of Proposed Insured or Parent/Guardian
_____	_____
Address	Date Signed