NASSAU RE

Phoenix Remembrance Life
Application for Individual Whole Life Insurance
Part 1

PHL Variable Insurance Company (the Company)
Regular Mail: PO Box 219361, Kansas City, MO 64121-9361
Express Mail: 430 W 7th Street, Suite 219361, Kansas City, MO 64105-1407
Email: life.newbusiness@nsre.com
Fax: 816-527-0053

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. Agent Acknowledges ☒ Client Acknowledges ☒

Please print and use black ink. Any changes should be initialed by the Proposed Insured and Owner.

1. Proposed Insured *Note: If residing at present address for less than 6 months, complete Prior Address form.*

First Name	Middle Name	Last Name	Gender	Date of Birth	SSN/Tax ID
[redacted]		[redacted]	M ☐ F ☒	[redacted]	[redacted]

Residence Street Address/Apt #	City	State	ZIP Code	State of Birth
[redacted]	[redacted]	FL	[redacted]	[redacted]

Email Address	Preferred Phone	Driver's License/ID #	State or Country	Expiration Date
[redacted]	[redacted]	[redacted]	FL	[redacted]

U.S. Citizen Yes ☒ No ☐ ***If "No", please complete the questions below.***

Permanent Resident Card Holder	If "Yes", Permanent Resident/Green Card No.	Issue Date	Expiration Date	Country of Birth	Country of Citizenship	Years in U. S.
Yes ☐ No ☐	If "No", do not proceed.					

2. Coverage Applied For

Note: If any optional Riders are being applied for, complete the Supplemental Rider Application

Base Policy Death Benefit	Amount Paid or Amount For Initial Draft	Pay Mode (If Monthly Bank Draft complete Section 8)
$ 10,000.00	$ 58.93	Monthly Bank Draft ☒ Semi-Annual ☐ Annual ☐ Quarterly ☐

3. Screening Questions

IF ANY OF THE FOLLOWING ARE ANSWERED "YES" THE APPLICATION SHOULD NOT BE COMPLETED OR SUBMITTED.
To the best of your knowledge and belief:

1. Are you currently hospitalized or do you require the assistance of another person in performing any of the following activities of daily living: bathing, dressing, toileting, eating, walking or continence?	Yes ☐ No ☒
2. In the past 12 months, have you been confined to a nursing facility or receiving hospice care, or using oxygen equipment to assist in breathing?	Yes ☐ No ☒
3. Have you been diagnosed by a licensed member of the medical profession as having a terminal illness or life expectancy of 12 months or less?	Yes ☐ No ☒
4. Have you ever been diagnosed, treated, tested positive for, taken medications or been prescribed medications for, or been given medical advice by a licensed physician or other health care provider for:	
a. Alzheimer's, Parkinson's disease, muscular dystrophy, schizophrenia, dementia, Lou Gehrig's disease (ALS), Huntington's disease, or Down syndrome?	Yes ☐ No ☒
b. Aneurysm, stroke/TIA, cirrhosis, cystic fibrosis, hemophilia, systemic lupus, amputation due to disease, hepatitis B or C, organ transplant, non-Hodgkin's lymphoma, or had kidney (renal) failure or dialysis?	Yes ☐ No ☒
c. Angina (chest pain), coronary artery disease, heart attack/myocardial infarction, congestive heart failure (CHF), cardiomyopathy, pulmonary hypertension, pulmonary fibrosis, heart disease, heart surgery (including bypass, angioplasty, heart valve replacement, or defibrillator) or any other type of heart or circulatory disease?	Yes ☐ No ☒
d. Leukemia, multiple myeloma, or more than one occurrence or metastasis (spreading) of cancer (excluding basal cell or squamous cell skin cancer)?	Yes ☐ No ☒
5. Have you ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	Yes ☐ No ☒
6. In the past 2 years, have you been diagnosed, treated, tested positive for, taken medications or been prescribed medications for, or been given medical advice by a licensed physician or other health care provider for:	
a. Any form of cancer (excluding basal cell or squamous cell skin cancer)?	Yes ☐ No ☒
b. Insulin shock, diabetic coma, eye or kidney (renal) problems due to complications from diabetes?	Yes ☐ No ☒
7. In the past 5 years, have you received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	Yes ☐ No ☒
8. In the past 5 years, have you been convicted or pled guilty to any felony, or are you currently on probation or parole?	Yes ☐ No ☒

9.	In the past 12 months, have you been scheduled or advised by a licensed member of the medical profession to have any diagnostic tests (excluding Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome test) or surgery that has:	
	a. Not yet been performed?	Yes ☐ No ☒
	b. Been performed but for which the results have not been received?	Yes ☐ No ☒
	c. Resulted in abnormal results but for which no diagnosis has been received?	Yes ☐ No ☒
10.	In the past 5 years, have you used heroin, cocaine, a narcotic, a barbiturate, a hallucinogen, methamphetamine or any other illegal drug except as prescribed by a licensed physician or medical practitioner?	Yes ☐ No ☒
11.	Are you currently involved in a bankruptcy that has not yet been discharged?	Yes ☐ No ☒

4. Ownership (Complete ONLY if other than the Proposed Insured)

Note: If the owner is a trust, complete the Certification of Trust

First Name	Middle Name	Last Name	SSN/Tax ID	Date of Birth
[redacted]		[redacted]	[redacted]	[redacted]

Residence Street Address/Apt #	City	State	ZIP Code	Phone Number
[redacted]	[redacted]	FL	[redacted]	[redacted]

Relationship to Proposed Insured	Email Address	Trust Name (if applicable)
Self	[redacted]	

U.S. Citizen Yes ☒ No ☐ ***If "No", please complete the questions below.***

Permanent Resident Card Holder	If "Yes", Permanent Resident/Green Card No.	Issue Date	Expiration Date	Country of Birth	Country of Citizenship	Years in U. S.
Yes ☐ No ☐	If "No", do not proceed.					

5. Policy Beneficiary Designation

Note: If there are additional Beneficiaries to be named, or if the beneficiary is a trust, use the Additional Policy Beneficiary form. Only the Owner has the right to change beneficiaries.

	First Name	Middle Name	Last Name	Date of Birth	% Share
1. ☒ **Primary** ☐ **Contingent**	[redacted]		[redacted]	[redacted]	100
Relationship to Proposed Insured: Other — Cousin	Country of Residence (if outside U.S.)		SSN/Tax ID		
2. ☐ **Primary** ☒ **Contingent**	[redacted]		[redacted]	[redacted]	100
Relationship to Proposed Insured: Other — Cousin	Country of Residence (if outside U.S.)		SSN/Tax ID		
3. ☐ **Primary** ☐ **Contingent**					
Relationship to Proposed Insured	Country of Residence (if outside U.S.)		SSN/Tax ID		
4. ☐ **Primary** ☐ **Contingent**					
Relationship to Proposed Insured	Country of Residence (if outside U.S.)		SSN/Tax ID		

6. Premium Payor Information (Complete ONLY if premium is paid by someone other than Owner)

First Name	Middle Name	Last Name	SSN/Tax ID
[redacted]		[redacted]	[redacted]

Residence Street Address/Apt #	City	State	ZIP Code	Phone Number
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Relationship to Proposed Insured/Owner

Self

The USA PATRIOT Act requires insurance companies to obtain all relevant customer-related information necessary to establish an effective anti-money laundering program. In accordance with the USA PATRIOT ACT and the Company's anti-money laundering program, the Company will ask individuals for identifying information including their name, address, date of birth, and a driver's license or other government issued identification that will allow us to verify their identity. For certain entities, such as trusts, estates, corporations, partnerships, or other organizations, identifying documentation is also required. For both individuals and legal entities, the Company may include the use of third party sources to verify the information provided.

7. Secondary Addressee (Complete ONLY if designating another person to receive notification of possible lapse in coverage)

First Name	Middle Name	Last Name	Relationship to Owner

Residence Street Address/Apt #	City	State	ZIP Code

8. Bank Draft Authorization (Complete ONLY if Bank Draft is requested)

Please attach a voided check OR provide the banking information below for Electronic Funds Transfer.

Account Information:

Routing Number: [redacted] 9 positions in Routing Number

Account Number: [redacted] Can have up to 17 positions in Account Number

Name of Financial Institution: [redacted]

Please select one of the following. If selecting a draft date, select any date between the 1st and the 28th of the month.

☐ Draft my initial premium on the issue date of my policy and draft subsequent premiums approximately every 30 days thereafter.

☐ Draft my initial premium on the issue date of my policy. Draft my ***SUBSEQUENT*** premiums on _____ of each month.

☒ Hold issue of my policy until 05/03/2019 and draft my initial premium on that date. Draft subsequent premiums approximately every 30 days thereafter.

Authorization Agreement for Preauthorized Payments

I, the bank account owner, authorize the Company to initiate Electronic Funds Transfers (EFT) for the above named bank and bank account in an amount not to exceed my scheduled premium. I understand that I must contact you at least three business days before a scheduled withdrawal to change or cancel this authorization. I understand that for the initial draft, multiple payments may be withdrawn when the EFT date selected is after the contract date. I understand that the Company will only consider a premium paid if the EFT is honored by my bank. I further understand that if the account has insufficient funds to pay the premium or if the EFT cannot be successfully made, for any reason, the policy may lapse. I understand that any bank fees are my responsibility.

Bank Account Owner – First Name	Middle Name	Last Name
[redacted]		[redacted]

Bank Account Owner Signature

eSigned By FireLight [redacted]

2019-04-11T20:58:37 [redacted] 23c

Date (mm/dd/yyyy) 4/11/2019

9. Insurance History

1. Do you plan to replace any existing insurance or utilize values from any existing life insurance policy or annuity (through loans, surrenders or otherwise) to pay the initial premium for this policy? (If "Yes", complete appropriate replacement form)	Yes ☐ No ☒
2. Are there any life insurance policies or annuity contracts owned by, or on the life of, the applicant, or the insured, or the owner, or the annuitant? (If "Yes", complete appropriate replacement form)	Yes ☐ No ☒

3. Total insurance inforce and applied for with all companies $ 10,000.00

10. Authorization to Obtain Information

"Affiliates" means reinsurers, insurance agents and agencies and those performing services in relation to an application for insurance, insurance product or benefit claim. For purposes of assessing insurance coverage eligibility, coverage continuation and/or benefit claim, I, the Proposed Insured, authorize the Company and its affiliates to obtain information, including previously restricted information, about me from any: physician, medical practitioner, hospital, clinic, or medical facility; employer; benefit plan; other insurer or institution; consumer reporting agency; public records; pharmacy, pharmacy benefits manager, or other pharmacy related services organization; or MIB, Inc. This includes records or other information as to past, current, or future: diagnosis, treatment and prognosis of a physical or mental condition; drug, physical and mental health, and alcohol-related information that may be protected by federal or state laws and regulations. I, the Proposed Insured, authorize the Company and its affiliates to make a brief report of my personal and/or protected health information to MIB, Inc. Information may be disclosed: between and among the Company and its affiliates; companies that I have applied or may apply to for life or health insurance, or benefits; as required or permitted by law. Obtained or disclosed information may no longer be protected by federal privacy laws. This authorization is valid for two years from the date of this application. A copy of this authorization shall be as valid as the original. This authorization may be revoked at any time by written notice to the Company, except that action(s) taken before receipt of notice will not be affected. A copy of this authorization will be provided upon request. I have been provided the Privacy Statement.

11. Signature

As the Proposed Insured and / or the Owner, if other than the Proposed Insured, ("I"), understand that the Application for life insurance consists of two parts, a Part 1 and Part 2. All statements made in the Application are full, complete and true to the best of my knowledge and belief. I understand that the Company will rely upon the information provided in the Application and that the statements and answers made therein are the basis for any policy issued by the Company, and that no information about them will be considered to have been given to the Company unless it is stated in the application. Before issuing an insurance policy, the Company may require and obtain information about me to validate my identity.

I understand that 1) no statements made to or information acquired by any Licensed Producer who takes this Application shall bind the Company unless stated in this Application, and 2) no Licensed Producer has authority to make, modify, alter or discharge any contract hereby applied for, and 3) if there is any change in health or personal history that would alter the answers to any of the questions in the Application between now and when the policy is delivered, I will inform the Company in writing as soon as possible at PO Box 219361, Kansas City, MO 64121-9361.

I understand and agree that the insurance applied for shall not take effect unless each of the following has occurred: 1) the policy has been issued by the Company; 2) the premium required for issuance of the policy has been paid in full; 3) the Insured is alive when the premium is paid and when the policy is delivered; 4) all representations made in the Application remain full, complete and true as of the date the policy is delivered; 5) a policy is issued on this application and delivered to and accepted by the owner; and 6) any required forms or amendments to the Application are signed and returned to the Company.

I understand this policy may be structured so that it is classified as a modified endowment contract (MEC) under the Internal Revenue Code; if so, loans or distributions may result in taxable income when taken. If the policy is a MEC, this will be noted on the policy schedule page. Once a policy is issued, MEC classification cannot be changed.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information, is guilty of a felony of the third degree.

☒ ***I confirm that I have received a copy of the Accelerated Death Benefit Rider disclosure form.***

Proposed Insured's Signature	State Signed In	Date (mm/dd/yyyy)
eSigned By FireLight: [redacted] 2019-04-11T20:58:37	FL	4/11/2019
Owner's Signature (Only if Owner is other than the Proposed Insured)	State Signed In	Date (mm/dd/yyyy)

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12. Producer Certification

1. Will this policy replace any existing insurance or utilize values from any existing life insurance policy or annuity (through loans, surrenders or otherwise) to pay the initial premium for this policy?	Yes ☐ No ☒
2. Are there any life insurance policies or annuity contracts owned by, or on the life of, the applicant, or the insured, or the owner, or the annuitant?	Yes ☐ No ☒
3. If applicable, was the customer given the state required replacement disclosures?	Yes ☒ No ☐
4. Was a copy of the Buyer's Guide provided to the owner at the time of sale?	Yes ☒ No ☐
5. Was a copy of the Accelerated Death Benefit Rider disclosure form provided to the owner?	Yes ☒ No ☐
6. Is the Owner/Insured an active duty service member of the United States Armed Forces, including Reserves? If yes, I have provided the Military Disclosure form to my client.	Yes ☐ No ☒
7. Are you related to the proposed insured? If yes, how are you related? _____	Yes ☐ No ☒

8. Select a policy delivery method: ☒ Deliver to the Owner
☐ Deliver to Agent for delivery to Owner

Please certify one of the following:

☒ I certify that I personally met with the Proposed Insured and reviewed the identification documents. To the best of my knowledge, it accurately reflects the identity of the Proposed Insured.

☐ I was unable to personally review the identification documents for the reason stated below. I certify that, to the best of my knowledge, the information provided by the Proposed Insured is true and accurate.

Reason for not reviewing documents: ☐ Application was completed via phone
☐ Other _____

I certify that the information provided by the Proposed Insured is accurately recorded on the application and I am not aware of any discrepancies or misrepresentation in the recorded information. I am qualified and authorized to discuss the contract herein applied for.

Writing Agent – First Name	Middle Name	Last Name
[redacted]		[redacted]

Initials/Last 4 SSN #	Agent's FL License ID #	Agent Phone #	Agent Email
********	[redacted]	[redacted]	[redacted]

Agent Signature
eSigned By FireLight [redacted]
2019-04-11T20:59:20

Date (mm/dd/yyyy): 4/11/2019

Note: *Complete ONLY if the Second Agent was present at the time of sale.*

Second Agent – First Name	Middle Name	Last Name	Agent Email

Agent Signature | Date (mm/dd/yyyy)

Split Commissions

Note: *Complete ONLY if more than one agent will receive commission on this sale. Unless otherwise specified, commissions will be shared equally between all agents listed below.*

Writing Agent Name	Agent's FL License ID #	% Split
[redacted]	[redacted]	100
Second Agent Name	Agent's FL License ID #	% Split

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Part 2

PHL Variable Insurance Company (the Company)
Regular Mail: PO Box 219361, Kansas City, MO 64121-9361
Express Mail: 430 W 7th Street, Suite 219361, Kansas City, MO 64105-1407
Email: life.newbusiness@nsre.com
Fax: 816-527-0053

1. Proposed Insured

Name – First	Middle	Last	Gender	Date of Birth
[redacted]		[redacted]	M ☐ F ☒	[redacted]

2. Medical Questions

Section A:

To the best of your knowledge and belief:

1. Name of Personal Care Physician / Health Care Provider: First Name	Middle Name	Last Name	Date of Last Visit: (mm/yyyy)	Date of Last Physical: (mm/yyyy)
Doctor		[redacted]	03/2019	03/2019

2. Physician Address: Street Address	City	State	ZIP Code
	[redacted]	FL	

3. What is your current height and weight?	Height: [redacted] ft. [redacted] in.	Weight: [redacted] lbs.

4.	In the past 12 months, have you used tobacco or nicotine in any form (excluding occasional cigar or pipe use)?	Yes ☐ No ☒
5.	In the past 12 months, have you been a patient in any hospital, emergency room or similar facility for any reason?	Yes ☒ No ☐
6.	In the past 10 years, have you been diagnosed, treated, tested positive for, taken medications or been prescribed medications for, or been given medical advice by a licensed physician or other health care provider for: High blood pressure, high cholesterol, heart murmur, irregular heart beat, carotid disease, or peripheral vascular disease?	Yes ☐ No ☒
7.	In the past 5 years, have you been diagnosed, treated, tested positive for, taken medications or been prescribed medications for, or been given medical advice by a licensed physician or other health care provider for:	
	a. Cancer of any type, tumor, malignancy, polyp, leukemia, multiple myeloma, swelling or lump?	Yes ☐ No ☒
	b. Diabetes, or a disorder or a disease of the thyroid, pituitary, pancreas, or endocrine system?	Yes ☐ No ☒
	c. Asthma, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, pulmonary fibrosis, sleep apnea, disease or disorder of the lung or respiratory system?	Yes ☐ No ☒
	d. Anxiety, bipolar disorder, depression, or other mental or nervous disease or disorder?	Yes ☐ No ☒
	e. Anemia, bleeding or clotting disorder, other disease or disorder of the blood (excluding Human Immunodeficiency Virus) or lymphatic system?	Yes ☐ No ☒
	f. Convulsion, epilepsy, seizure, multiple sclerosis, or disease or disorder of the brain or neurological system?	Yes ☐ No ☒
	g. Ulcer, colitis, crohn's disease, liver disease, pancreatitis, or gastrointestinal disease?	Yes ☐ No ☒
	h. Blood, protein, albumin, or sugar in the urine, disease or disorder of the prostate, bladder, or genitourinary organs?	Yes ☐ No ☒
	i. Connective tissue disease, rheumatoid arthritis, psoriatic arthritis, disorder of the back, neck or musculoskeletal?	Yes ☐ No ☒
8.	Within the past 3 years, have you been unable to work at your regular job for more than 30 consecutive days, or perform the normal activities of like age and gender, or been confined at home, or are you currently unable to work at your regular job?	Yes ☐ No ☒
9.	In the past 12 months, have you consulted, been diagnosed or treated by a licensed member of the medical profession for any of the following symptoms: chronic fatigue, unexplained weight loss, loss of appetite, diarrhea, unexplained bleeding, recurrent fever, fever of unknown origin, severe night sweats, unexplained or unusual infections, skin lesions, or unexplained swelling of the lymph glands?	Yes ☐ No ☒
10.	In the past 2 years, have you been convicted of any misdemeanor, of 2 or more moving violations or driving under the influence of alcohol or drugs or had a driver's license suspended or revoked?	Yes ☐ No ☒

eSigned [redacted]
2019-04-11T20:58:37

eSigned By Firel[redacted]
2019-04-11T20:59:20

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