NASSAU RE

Nassau Life and Annuity Company
Nassau Life Insurance Company
PHL Variable Insurance Company

Request for Policy Change
Quick Reference
Non-Underwritten Changes ONLY

Attached is the form you requested. **Please read and follow all instructions carefully** Complete all areas of the form that apply to your situation so that your request can be processed in a timely manner.

Complete as many of Sections 1 through 6 on page 1 only, that you need to describe what you are requesting.

Non-Dividend Sections

1. Indicate basic policy attribute(s) and associated change(s) being requested.
2. Select feature(s) to be added or cancelled.
3. Check the payment mode to which you would like your premiums changed.
4. Indicate change(s) to the Automatic Premium Loan Provision and/or Automatic Nonforfeiture Provision.

Dividend Sections (Please Read CAREFULLY)

5. Change of Dividend Method - If your intent is to release values from your current dividends, do not complete Section 5 and use Section 6 instead.
Check the dividend method to which you would like to change. **Please note:** If your current dividend method is one of these options:
• Fifth Dividend • Optionterm • Economaster I or II • Term Additions • Supplemental Term Portion
Please **write in** comment section:
I understand that as a result of this change in dividend method, my Death Benefit will be affected.

6. Release of Dividends/Paid-Up Values
Indicate the manner in which you wish your dividends and paid-up values released and/or applied.
Please note: If your current dividend method is one of these options:
• Optionterm • Term Additions
Please **write in** comment section:
I understand that the release of Paid-Up Additions may affect my Death Benefit.

Signatures and Dates

Owner signature requirements are based on the owner designation of the policy/contract. Examples are:

- ***Individual:*** Print and sign your full name as it appears on the policy/contract.
- ***Multiple Owners:*** All owners must sign.
- ***Collateral Assignee: Assignees must sign in addition to the Owner, on Owner Signature lines and indicate title as "Collateral Assignee".***
- ***Partnership:*** All partners must sign (unless a form authorizing one partner to sign is on file with us).
- ***Corporation:*** Titled officer must sign. The officer's title must also be indicated.
  NOTE: In general, the insured/annuitant should not sign as officer. We ask that an additional titled officer sign if the signing officer is effecting a change for his or her personal benefit.
- ***Trust:*** The current trustee(s) must sign.

*All **forms must be dated** in order to process your request.*

To Contact Us

US Mail	***Phone***	***FAX***
PO Box 22012 Albany, NY 12201-2012	• (800) 628-1936 (Traditional Life) • (800) 541-0171 (Variable Life)	• (321)400-6318 (Traditional Life) • (321)400-6316 (Variable Life)

NASSAU RE

PO Box 22012
Albany, NY 12201-2012

Request for Policy Change

☐ Nassau Life and Annuity Company (the Company) ☐ Nassau Life Insurance Company (the Company) ☐ PHL Variable Insurance Company (the Company)

POLICY NUMBER	NAME OF INSURED	ASSIGNED AGENT	AGENCY REQUESTING CHANGE

The company is defined as indicated above, is hereby requested to change said policy as indicated below:

1. CHANGE THE FOLLOWING TO:
   - ☐ *Amount _____
   - ☐ *Plan: _____
   - ☐ Policy Date: _____
   - ☐ *Date of Birth: _____
   - ☐ Rated Age: _____

TO BE COMPLETED BY HOME OFFICE
When a copy of this form is attached to and made a part of said policy, the premium shall be as shown below.

Regular Premium	$
Extra Premium	$

2. FEATURES (UNLESS OTHERWISE INDICATED, ANY PRESENT FEATURES WILL BE RETAINED):

Add*	Cancel		
☐	☐	Waiver of Premium	
☐	☐	Accidental Death Benefit	
☐	☐	Level Term, Amount $ _____ ☐ with ADB ☐ without ADB	
☐	☐	Purchase Protector, Units _____	
☐	☐	Family Protection Plan, Units _____	
☐	☐	Children's Protection Plan, Units _____	
☐	☐	Cost of living, Amount $ _____	
☐	☐	Paid-up Additions Purchase Rider for premium of $ _____ bought _____ (Frequency)	
☐	☐	Payor Death	
☐	☐	Payor Disability	
☐	☐	_____	
☐	☐	_____	

3. PREMIUMS SHALL BE: ☐ Quarterly ☐ Semi-Annual ☐ Payroll Deduction ☐ Annual ☐ Check-O-Matic
Above method will determine the due dates with at least one premium payable on policy anniversary.

4. CHANGE THE FOLLOWING TO:
   - ☐ Automatic Premium Loan
     - ☐ Operative ☐ Non-operative
   - ☐ Automatic Nonforfeiture Provision
     - ☐ Extended Insurance (if eligible under policy)
     - ☐ Paid-up Insurance

5. DIVIDEND METHOD SHALL BE:
   - ☐ Cash ☐ Accumulate
   - ☐ Reduce Premium ☐ Paid-up Additions
   - ☐ *Buy One-year term with balance as shown below:
   - ☐ Buy Deferred Additions with balance as shown below: (Economaster Plans only)
     - ☐ Cash ☐ Accumulate
     - ☐ Reduce Premium ☐ Paid-up Additions

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

6. RELEASE DIVIDEND AND PAID-UP VALUES AS FOLLOWS:
   - ☐ Release Accumulated Dividends
   - ☐ Surrender Paid-up Additions**

   and apply the cash value thereof as follows (state All or Amount Needed if dollar amount not known)
   - ☐ $ _____ to TIR on Application No. _____
   - ☐ $ _____ to TIR Policy No./PDF Agreement No. _____
   - ☐ $ _____ on premium under Policy No. _____
   - ☐ $ _____ to reduce loan on Policy No. _____
   - ☐ Pay $ _____ in cash
   - ☐ Apply existing dividend values to new method shown under 5 above, subject to evidence of insurability if necessary
   - ☐ Other _____

** Unless otherwise requested in comments section, a surrender of paid-up additions will also surrender any paid-up additions resulting from the company's 1982 More For Your Money increased insurance amendment.

COMMENTS

*ASTERISKED CHANGES REQUIRE COMPLETION OF NON-MEDICAL APPLICATION ON REVERSE

TO BE COMPLETED BY HOME OFFICE

Premiums shall be _____ thereafter as provided in the policy.

Cost to complete this change and fully pay the policy to _____ is _____ payable in one sum on _____. Allowance for the change with premiums paid to _____ is _____

This allowance shall be applied: _____

MINOR CORRECTIONS (No change will be made in amount or plan of insurance)

These changes will be based upon the statements and representations made in any Non-medical Application and Evidence of Insurability, if any, submitted in connection with this change, a copy of which is attached to the policy.

ANY STATEMENTS CONTAINED IN THE NON-MEDICAL APPLICATION ON THE REVERSE SIDE HEREOF ARE BINDING ON THE UNDERSIGNED.

Signed at _____ (City and State) on _____ (Date)

Insured _____ (Signature of Insured is necessary if Non-medical Application Completed) Owner _____

Spouse of Insured _____ (Signature of spouse needed if spouse to be covered person) Assignee _____

NON-MEDICAL APPLICATION FOR A POLICY CHANGE

This evidence of insurability is submitted in connection with the policy change requested on the reverse side of this form. The change shall not take effect until (A) the evidence of insurability is approved by the Company during the lifetime of the insured, and (B) the required payment for the change is paid in full.

1. This question to be completed by the **insured and all persons to be covered:** (Use second OL180A MO if needed.)

FULL NAME	RELATIONSHIP	SEX	DATE OF BIRTH	HEIGHT	WEIGHT	AMOUNT OF INSURANCE

Please check (✓) the appropriate box and give the details of all "Yes" answers including dates and pertinent names in Question No. 11.	Yes	No
2. Is the insurance intended to replace (in whole or in part) any existing life insurance in this or any other company?	☐	☐
3. Have you or any proposed insured:		
(a) made plans for any future travel or residence outside the U.S.A.?	☐	☐
(b) flown during the past three (3) years as a student pilot, pilot, crew member or with any other duties on any aircraft or contemplated such activity?	☐	☐
(c) participated in motor vehicle or motorboat racing, parachute jumping, skin, scuba or other underwater diving activity or is any contemplated?	☐	☐
4. Have you or any proposed insured had life, accident, health, medical or surgical insurance postponed, rated, or ridered, modified or not issued as applied for?	☐	☐
5. Has any disability required an absence from work for more than three (3) weeks in the last five (5) years?	☐	☐
6. Have you or any proposed insured been hospitalized, sought treatment or consulted a physician or other practitioner for any physical or mental disorder or routine examination or check-up in the last five (5) years?	☐	☐
7. To the best of your knowledge have you or any proposed insured ever had or been told by any physician or practitioner that you had:		
(a) high blood pressure, heart disease, angina, heart murmur, or pain, pressure or discomfort in the chest?	☐	☐
(b) kidney disease, bladder trouble, or albumin, blood, pus, or sugar in the urine?	☐	☐
(c) epilepsy, severe headaches, dizziness, convulsions or paralysis?	☐	☐
(d) diabetes, arthritis, enlarged glands or growth disorders; mental or nervous disorders, alcohol or drug abuse?	☐	☐
(e) ulcers, colitis, or disease of the intestines or rectum; tumor, polyp or cancer?	☐	☐
(f) hepatitis, jaundice, or disease of the liver, asthma, disease of the lungs; or undue shortness of breath?	☐	☐
8. Is there any medication taken on a regular or frequent basis?	☐	☐
9. Has anyone to be insured ever had an abnormal electrocardiogram, x-ray, blood chemistry profile or other medical test?	☐	☐

10. Personal physician (if none, so state): ☐ None

Name _____ Date last seen: _____ Reason: _____

Address: _____

11. Details of all "Yes" answers (if additional space is necessary, use a second OL180A MO and attach it to this form.)

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

Signed at _____ Date _____

Witness _____ Signed by _____
(Insured - Sign Full Name)

Witness _____ Signed by _____
(Spouse Of Insured - If to be Covered Sign Full Name)

Request For Interview

☐ I/We do ☐ I/We do not (check one only) require that I/We be interviewed in connection with any investigative consumer report that may be prepared.

AUTHORIZATION TO OBTAIN INSURANCE (NON-MEDICAL) INFORMATION

I/We hereby authorize any insurance company to which I/we have applied for or inquired about insurance coverage or benefits to give to the Company or its reinsurers any information relating to or obtained in connection with such application or inquiry including the dollar amounts and status of any policies or claims.

AUTHORIZATION TO OBTAIN HEALTH CARE (MEDICAL) INFORMATION

I/We hereby authorize any physician, hospital, clinic or other health care provider or any persons who have health care information about us or our family, including insurance companies and MIB, Inc., to give that information to the Company and its legal representatives. The Company may then redisclose it to other persons, including MIB, Inc., legal representatives, medical consultants, reinsurance companies and consumer reporting agencies, only to the extent required to perform their services for the Company or as otherwise required or permitted. The information may also be redisclosed as otherwise required or permitted by law. The information will not be given, sold or transferred to any other person not mentioned in this authorization. If the record contains information relating to alcohol or drug abuse or mental health care, enough of this information is also to be released to accomplish the purposes for which the information is requested. This information may be used only for the purpose of risk evaluation, the administration of claims and implementation of policy provisions and for insurance statistical studies.

This authorization or a true photocopy thereof shall continue to be valid for 30 months from the date signed below unless otherwise required by law. It may be revoked in writing to the Company at any time until the insurance coverage has been placed in force. I/We may receive a copy of it on request. It is understood that this authorization applies separately to each person applying for insurance.

I acknowledge that I have received a copy of the Pre-Notification to applicants regarding the Medical Information Bureau, Investigative Consumer Reports and the Underwriting Process.

_____ _____

INSURED (SIGN FULL NAME) DATE

_____ _____

SPOUSE OF INSURED (SIGN FULL NAME) DATE

PRE-NOTIFICATION REGARDING MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. The Company may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance, or submit a claim for benefits to such a company, the Bureau, upon request, will supply such company with the information it may have.

The Company may also release information to other life insurance companies to whom you apply for life or health insurance, or to whom you submit a claim for benefits. The Company will not, however, reveal to another company or to the Bureau, the action taken on the basis of your current request for insurance.

Upon request, the Bureau will arrange disclosure of information in your file. (Non-medical information will be disclosed to you and medical information will be disclosed to your attending physician or other medical professional designated by you.) If you question the accuracy of the information, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The Bureau's information office is at P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone 617-426-3660.

SUPPLEMENTARY NOTICE OF INFORMATION PRACTICES

In addition to the information practices described in the pre-notification entitled "What You Should Know About the Underwriting Process," "Investigative Consumer Reports," and "Medical Information Bureau," we and your agent may under limited circumstances disclose certain of the information gathered to third parties without your further authorization. For example, certain necessary items of information may be disclosed to:

- Persons or organizations for purposes of performing a business, professional or insurance function for use in connection with risk evaluation, administration of claims, and implementation of policy provisions;
- a medical professional to inform you of a medical condition of which you may not be aware;
- a state insurance department for purposes of carrying out its regulatory responsibilities;
- an affiliated company so that it can inform you of the availability of an insurance product or service.

Please also note that in the event we ask a consumer reporting agency to gather information for us that the information obtained may be kept by it and later disclosed to other users of reports. You have the right to request to be interviewed in connection with the preparation of any investigative consumer report that may be prepared. You have a right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. A description of these procedures will be sent to you upon request. If you have any further questions about our information practices, please write to the Medical Director, Nassau Re, One American Row, PO Box 5056, Hartford, CT 06102-5056.

Detach; give to proposed insured, if Non-medical or Medical Application is Completed.

PRE-NOTIFICATION OF INVESTIGATIVE CONSUMER REPORT TO INSURANCE/ANNUITY APPLICANT

In compliance with the provisions of the Fair Credit Reporting Act, this notice is to inform you that in connection with your application for insurance an investigative consumer report may be prepared. Such a report, which includes information regarding the consumer's character, general reputation, personal characteristics, and mode of living, is obtained through personal interviews with friends, neighbors and associates of the consumer. Upon written request, a complete and accurate disclosure of the nature and scope of such a report, if one is made, will be provided.

WHAT YOU SHOULD KNOW ABOUT THE UNDERWRITING PROCESS

One of the prime objectives of the Company is to provide insurance at low cost. The underwriting process - the evaluation of risks - is necessary not only to assure this low cost but also to assure that each policyholder contributes his or her fair share of the cost.

Your **application** is the primary source of information in the evaluation process. However, as authorized by you, other sources of information may be used. These include the results of your **physical examination,** if required, and any reports received from **doctors** or **hospitals** who have attended you.

A check of the records of the Medical Information Bureau will be made. The purpose of the Bureau is to protect member companies and their policyholders from bearing the expense created by those who would conceal facts relevant to their insurability. Information furnished by the Bureau serves as an alert to the possible need for further independent investigation, but except in limited circumstances under Bureau rules cannot itself be used as the basis for rating or declination. The Bureau is not a repository of medical reports from hospitals and doctors, and information in the Bureau file does not reveal whether applications for insurance are accepted, rated or declined.

In addition, it is common practice within the insurance business to obtain an **investigative consumer report** as described on the reverse side. While these are not obtained on all cases, in the event that such a report is obtained, the applicant may, on request, be given the name and address of the reporting agency.

In most instances, our applicants are in good health, are not subject to unusual accident hazards, and otherwise meet our underwriting standards. In these cases the applications are rather quickly approved and a policy is issued at standard rates.

Some applicants for insurance, however, present greater insurance risks. This is usually due to an abnormal physical condition, a possibly dangerous occupation or avocation or a history of medical problems. In these cases a higher premium may be charged or coverage may be limited. In this way, each policy owner assumes his or her fair share of the insurance cost.

Occasionally, an applicant is denied coverage, usually because of a past or present medical condition. Whatever cash may have been collected is, of course, promptly returned.

For the benefit of all our policyholders, the Company selects you as carefully as you selected us. The Company's continuing objective is to provide you with low-cost insurance coupled with sound and timely advice, both now and in the years to come.

Thank you for allowing the Company to service your needs.

AGENT'S REPORT

1. If Non-medical Application completed, was it completed by you and signed by the applicant in your presence?
   ☐ Yes ☐ No

2. If Medical examination submitted;
   A. If Non-appointed examiner - Reason used (Complete Form 511)
   B. Medical Fee
   ☐ From allowance on change ☐ Insured paid examiner ☐ $ _____ collected from Insured and sent to H.O.

3. A. For 1 and 2 above, see Application/Policy No. _____

   B. If application is made for increased amount, your estimate of his/her income? Earned $ _____ Independent $ _____

4. Will the change requested replace existing insurance? (If "Yes," a letter of particulars is required from the Agent.)
   ☐ Yes ☐ No ☐ Letter

5. Additional Comments (Re: any past rating, rejection or postponement, physical history, habits or finances, etc.)

Signature of Agent _____ Date _____