



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 all sections and pages required for the change requested.

- **Apply for Non-smoker Rates** – Policy with face amount of \$500K or above, no cigarettes for the past 12 months. Must complete Sections 1, 2, 3B, 4 and 10, **AND** OL348 and HIPAA form.
- **Apply for Never Smoke** – (no tobacco for the past 15 years) requires evidence of insurability. Must complete Sections 1, 2, 3B, 4, 5, 6 and 10) **AND** HIPAA form.
- **Apply for Preferred Rates** – Requires evidence of insurability. Must complete Sections 1, 2, 3A, 4, 5, 6 and 10 **AND** HIPAA form.
- **Apply for review of Substandard Rating** – Requires evidence of insurability. Must complete Sections 1, 2, 3A, 4, 5, 6 and 10 **AND** HIPAA form.
- **Apply for Option Exercise** – Must complete Sections 1, 2, 3C, 4, 5 and 10.
- **Apply for Non-Underwritten Policy Change** – Complete section 2 (Insured's name only) 3A, B, C, D, E, and/or that applies to the changes you are requesting and Section 10. For non-underwritten changes, owner and Collateral Assignee signatures are required.

#### 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 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

PO Box 22012  
Albany, NY 12201-2012

##### Phone

- (800) 628-1936 (Traditional Life)
- (800) 541-0171 (Variable Life)

##### FAX

- (321) 400-6318 (Traditional Life)
- (321) 400-6316 (Variable Life)



Nassau Life and Annuity Company (the Company)

Nassau Life Insurance Company (the Company)

PHL Variable Insurance Company (the Company)

**Regular Mail:** PO Box 22012, Albany, NY 12201-2012

**Overnight Mail:** 15 Tech Valley Drive, Suite 201, East Greenbush, NY 12061-4142

## Application for Policy Change Requiring Underwriting

**Print and use black ink.** Complete all applicable sections for the type of policy change requested.

**Policy Number(s) for the requested change:** \_\_\_\_\_

### Section 1 - Select Policy Change type

Face amount increases require the completion of a fully underwritten application versus this form.

These changes require evidence of insurability. Complete all sections and a HIPAA form unless otherwise indicated.

- ☐ Apply for Non-smoker rates (no cigarettes for the past 12 months). (Omit Sections 4, 5 & 6)
- ☐ Apply for Never Smoke rates (no tobacco for the past 15 years and requires evidence of insurability).
- ☐ Apply for Preferred rate classes (requires evidence of insurability).
- ☐ Apply for review of substandard rating (requires evidence of insurability).
- ☐ Apply for Life Plan Option exercise (increase). (Omit Sections 4, 5 & 6)
- ☐ Policy Change (not previously listed information).

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)                                                                                                                                                                                                    |                        |                                                                                                                             |                              | Sex <input type="checkbox"/> M<br><input type="checkbox"/> F | Date of Birth (mm/dd/yyyy) | Social Security Number                                                                                                   |  |
| Marital Status<br><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Civil Union Partner                            |                        |                                                                                                                             |                              |                                                              |                            |                                                                                                                          |  |
| <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.                                                                                                            |  |
| Birth State                                                                                                                                                                                                                   | Birth Country          | U.S. Citizen<br><input type="checkbox"/> Yes <input type="checkbox"/> No If "No", complete Non U.S. Citizen ONLY questions. |                              | Driver's License #                                           |                            | State                                                                                                                    |  |
| Residence Street Address (include Apt #)                                                                                                                                                                                      |                        |                                                                                                                             | City                         | State                                                        | ZIP Code                   |                                                                                                                          |  |
| Home Phone #<br>( ) -                                                                                                                                                                                                         |                        | Work Phone #<br>( ) -                                                                                                       |                              | Cellular Phone #<br>( ) -                                    |                            | Best # to reach Insured<br><input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cellular |  |
| Current Occupation                                                                                                                                                                                                            |                        | Current Employer                                                                                                            |                              | Years of Service                                             | Email Address              |                                                                                                                          |  |
| Employer Street Address                                                                                                                                                                                                       |                        |                                                                                                                             | City                         | State                                                        | ZIP Code                   | Employer's Phone #<br>( ) -                                                                                              |  |
| Have you used tobacco or nicotine products in any form? <input type="checkbox"/> Yes <input 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. Smoking Status

Complete if applying for Smoking Status change.

The **Nonsmoker 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

#### B. Life Plan Option

Complete if applying for Life Plan Option.

#### Life Plan Option

#### Additional Information Required

☐ Increase in Face Amount Option . . . . . Amount \$ \_\_\_\_\_

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

## Section 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<br><input type="checkbox"/> Deceased                                                                                                                                                                                                                                                                |              |                 |                                                                             | Mother <input type="checkbox"/> Alive<br><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 consulted, or been diagnosed or treated by a licensed physician or a licensed member of the medical profession for:                                                                                                                                                               |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| 1. High blood pressure or hypertension, within the past 10 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                          |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| 2. Pain, pressure, or discomfort in the chest, angina pectoris, palpitations, swelling of the ankles, or undue shortness of breath, within the past 10 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                              |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| 3. Heart disease, coronary artery disease, cardiomyopathy, heart failure, atrial fibrillation, heart rhythm abnormality, heart murmur, congenital heart disease or valvular heart disease, within the past 10 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                                       |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| 4. Peripheral vascular disease, claudication, narrowing or blockage of arteries or veins, within the past 10 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                        |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| 5. Asthma, pulmonary fibrosis, chronic cough, emphysema, pneumonia, or any other lung disease, within the past 10 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> 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, within the past 10 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| 7. Depression, bipolar disorder, schizophrenia, anxiety, or other psychiatric illness, within the past 10 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                           |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| 8. Arthritis, lupus, or any musculoskeletal or skin disorder, within the past 10 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> 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, within the past 10 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| 10. Diabetes, kidney disease, kidney stones, bladder disorder, prostate disorder, protein or blood in the urine, within the past 10 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                 |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| 11. Endocrine disorder, including disorder of the thyroid, parathyroid, adrenal, or pituitary glands, within the past 10 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                            |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| 12. Anemia, bleeding or clotting disorder, or any other disorder of the blood or bone marrow, within the past 10 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                    |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| 13. Cancer of any type, tumor (benign or malignant), leukemia, lymphoma, or Hodgkin's disease, within the past 10 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                   |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| 14. Are you taking any kind of medicine, therapy, or treatment regularly or at frequent intervals? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                         |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| 15. Have you been treated for alcoholism or been advised to limit or stop your use of alcohol, within the past 10 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                   |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| 16. Have you used narcotics, barbiturates, amphetamines, hallucinogens, marijuana, or any prescription drug except in accordance with a physician's instructions, within the past 10 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| 17. Have you been a patient in any hospital, treatment center, or similar facility within the last 10 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> 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? .... <input type="checkbox"/> Yes <input type="checkbox"/> 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? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                       |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| 20. Have you applied for or received sickness or accident benefits or a disability payment from any source? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| <b>Applicants Age 65 and older answer questions below:</b>                                                                                                                                                                                                                                                                                |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| 21. Are you using any of the following: cane, catheter, electric scooter, oxygen, walker or wheelchair? ..... <input type="checkbox"/> Yes <input type="checkbox"/> 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? ..... <input type="checkbox"/> Yes <input type="checkbox"/> 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? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                        |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| <b>Details</b> of "Yes" answers (include question number, condition, date of occurrence, testing performed, current status, hospital or treating physician's name and address.)                                                                                                                                                           |              |                 |                                                                             |                                                                                                                                                                                                                 |              |              |                                                                             |
| The Company 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 7 - 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 2 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 2 years in motorized vehicle racing, stunt driving, motorcycle, motorboat, horse, or truck racing, rodeo, scuba/skin diving, spelunking (cave exploration), heli-skiing, hang gliding, cliff diving, bungee jumping, 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 Notice**

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.

## 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, LLC (formerly Medical Information Bureau, LLC), having any records or knowledge of me or my health or prescription history to provide any such information to the Company, 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 the Company, its affiliates, service providers or its reinsurers any of my information relating to alcohol use, drug use and mental health care. Further, I authorize the Company, its affiliates, service providers or its reinsurers to make a brief report of my personal health information to MIB, LLC.

I authorize consumer reporting agencies, insurance companies, motor vehicle departments, my attorneys, accountants and business associates, pharmacy or pharmacy benefit manager, and MIB, LLC to provide any information to the Company, 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. The Company, its affiliates or service providers may disclose information it has obtained to others as permitted or required by law, including MIB, LLC., 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, LLC to give such records or knowledge to any agent, agency or producer authorized to do business with the Company, its affiliates or service providers to collect and transmit such information.

I acknowledge that I have received a copy of the Privacy Statement, including information about Investigative Consumer Reports and MIB, LLC. 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 24 months 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 the Company 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 Insured and all such statements made by the Insured have been correctly recorded and are full, complete and true to the best of the 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 the Company 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 the Company at PO Box 22012, Albany, NY 12201-2012.

I understand that 1) no statement made to or information acquired by any licensed producer who takes this application shall bind the Company unless stated in this policy change application 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 Insured are full, complete and true.

|                                        |                                 |                 |                   |
|----------------------------------------|---------------------------------|-----------------|-------------------|
| Insured's Signature                    |                                 | State Signed In | Date (mm/dd/yyyy) |
| Print full name of Collateral Assignee | Collateral Assignee's Signature |                 | Date (mm/dd/yyyy) |
| Owner's Signature                      |                                 | State Signed In | Date (mm/dd/yyyy) |
| Owner's Signature                      |                                 | State Signed In | Date (mm/dd/yyyy) |



Effective Date: 9/10/2018

This Privacy Statement is provided on behalf of Nassau Life and Annuity Company, Nassau Life Insurance Company, Nassau Life and Annuity Insurance Company, and PHL Variable Insurance Company ("The Company," "we," "our," "us").

The Company respects your concerns about privacy and values the relationship we have with you. This Privacy Statement describes the types of information we collect about you, how we use the information, with whom we share it, the choices available to you regarding our use of the information, and how you can contact us about our privacy practices.

## 1. What Information Does This Privacy Statement Apply To?

This Privacy Statement applies to the collection, use, and disclosure of information from and about you by The Company in order to offer you products and services, determine whether you qualify for our products and services, and administer your account. This Privacy Statement also applies to the collection, use, and disclosure of information from and about you by The Company on our website ([www.nfg.com](http://www.nfg.com)), through our mobile application, through telephone communications, email communications, joint marketing agreements, and through agreements with nonaffiliated third parties.

## 2. What Information Does The Company Collect?

We may obtain information about you when you choose to provide it to us and when we collect it from third parties.

### Information That You Or Others Provide

You may choose to provide information to us in a number of ways, such as when you request a quote, apply for a policy, sign up for promotions or newsletters, purchase our products, register on our website, post or provide content, or otherwise interact with us. The types of information you may provide to us include:

- Information we receive from you on applications or other forms or in order to provide you with a quote or illustration (such as name, address, city, state, ZIP code, email address, telephone number, birth date, household information, marital status, information about beneficiaries, and education);
- Information about your transactions and relationships with us, our affiliated companies, and others (such as products or services purchased, account balances, your policy coverage, premiums, and payment history). Financial and payment information (such as social security number, net worth, assets, income, payment card number, expiration date, account number, and billing address);

- Medical information (such as information about your health status or condition, payment for health care, etc.);
- Product preferences, advertisement preferences, and other information about how you use our website;
- Content you submit or post on our website (such as photographs, videos, reviews, articles, comments, or any other information you provide to us or post);
- Employment information;
- Records and copies of your correspondence (including email addresses), if you contact us.

We also may collect information about you from third parties, such as:

- Information we receive from a consumer reporting agency (such as information about your creditworthiness and credit history);
- Information we receive from third parties in order to issue and service your policies (such as motor vehicle reports and medical information);
- Information we receive from third party social media sites.

### Investigative Consumer Reports

In some cases, we may request an independent reporting agency to prepare an investigative consumer report which contains information related to your personal characteristics, finances, general reputation, character, and mode of living. Information obtained primarily through personal interviews with friends, neighbors or associates. You have the right to be interviewed in connection with the preparation of such a report. Upon written request, a complete disclosure of the nature and scope of such a report, if one is made, will be provided as well as the name, address and phone number of the reporting agency so that you may request a copy of your report. If the information in a consumer report leads us to not approve your application or to charge an extra premium we will notify you and provide the reporting agency's name, address and phone number. We will never use the information we receive from an investigative consumer

report for marketing purposes. You should be aware that when an independent consumer reporting agency prepares such a report, they may keep it and disclose it to other companies upon request.

### **Medical Information Bureau**

Information regarding your insurability will be treated as confidential. The Company, or its reinsurers may, however, make a brief report thereon to MIB, LLC, which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. You may contact MIB at 866-692-6901 or go to its website at [www.mib.com](http://www.mib.com) to request disclosure online. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

The Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

If you have questions or you wish to have a more detailed explanation or copies of the information we collect, please contact your producer or write to The Company directly. Write to: Nassau, Chief Underwriter, PO Box 22012, Albany, NY 12201-2012.

### **3. How Does The Company Use My Information?**

We may use your information for the following purposes:

- offering you products and services, deciding if you qualify for our products and services, and servicing your account;
- establishing and verifying the identity and eligibility of website users;
- opening, maintaining, administering, managing, and servicing website user profiles, accounts or memberships;
- processing, servicing or enforcing transactions (including EFT, ACH, credit or debit card transactions);
- providing products, content, content suggestions, services, and support;
- conducting special events, sweepstakes, surveys,

programs, contests, and other offers (and communicating with you about such events);

- analyzing and improving our products, services, or website (including developing new products and services; improving safety; managing our communications; analyzing our products; performing market research; performing data analytics; and performing accounting, auditing and other internal functions);
- providing users with product, service, or company updates;
- marketing and advertising our products or services as well as products and services of third parties (such as affiliates, subsidiaries, and business partners);
- responding to your inquiries or comments, or contacting you as necessary;
- operating and communicating with you about or through external social networking platforms;
- maintaining the security and integrity of our systems, including maintaining internal records;
- conforming to legal requirements or industry standards, complying with legal process, detecting and preventing fraud or misuse, defending our legal rights, or protecting others;
- as part of a merger, acquisition, bankruptcy, transfer, sale, corporate change, or any other transaction involving all or a portion of The Company's assets.

All information we collect may be aggregated and merged or enhanced with data from third party sources.

### **4. How Does The Company Share My Information?**

We may disclose all of the information we collect (including your nonpublic personal financial information), as described in Section 2 above, to both affiliated and non-affiliated third parties, such as:

- To companies that perform marketing services on our behalf or to other financial institutions with which we have joint marketing agreements;
- To financial services providers, such as life insurers, automobile insurers, mortgage bankers, securities broker-dealers, and insurance agents. We may also make such disclosures to an insurance institution, agent, insurance support organization, or self-insurer without your prior authorization, but only for purposes of (i) detecting or preventing fraud or other criminal activity; (ii) allowing the recipient to perform its function in connection with our insurance transactions; or (iii) as otherwise permitted by law;



- To a group policyholder for reporting claims experience or for audit purposes;
- To a medical care institution or medical professional for purposes of verifying your insurance coverage or benefits, to inform someone of a medical condition of which that person might not be aware, or for conducting operations or services audit to verify the individuals treated by the medical professional or at the medical care institution;
- To non-financial companies, such as retailers, direct marketers, airlines, and publishers;
- To third parties who help us with our business functions, such as service providers or suppliers. Examples of these service providers include entities that process credit card and other types of payments, help us moderate content posted on the Website, provide web hosting or analytics services, or who assist with marketing functions;
- To third parties involved in servicing and administering products and services on your behalf such as:
  - Your agent, broker or producer;
  - Banks;
  - Reinsurance companies;
  - Firms that assist us in the servicing of your policies;
  - Firms that assist in the printing or delivering of statements and notices;
- To other third parties for their own marketing purposes;
- To third parties for specific purposes permitted by law, such as:
  - If necessary to protect the safety, property, or other rights of us, our customers, or employees;
  - To comply with any court order, law, or legal process, including to respond to any government or regulatory request, or as otherwise required by law;
  - To State or federal regulators;
  - To auditors;
  - To law enforcement or another governmental authority for purposes of preventing or prosecuting fraud, or to report activities we reasonably believe are illegal;
  - With your consent in certain circumstances;

We may disclose information about our customers and our former customers to these third parties for the purposes described above.

We reserve the right to transfer information we have about

you in the event we sell, transfer, or engage in another transaction involving all or a portion of our business or assets, or undertake another form of corporate change, including bankruptcy. Following such a sale, transfer, or transaction, or corporate change, you may contact the entity to which we transferred your information with any inquiries concerning the processing of that information.

Your information may be stored in databases maintained by The Company (including local storage) or third parties, and may be disclosed to third parties for the purposes stated in this Privacy Statement, that are located within and outside the United States, including countries where privacy rules differ and may be less stringent than those of the country in which you reside.

## 5. Is My Information Secure?

The Company will take reasonable precautions to protect your information from loss, misuse or alteration. For example, we have procedures in place that limit internal access to personal information to only those employees who need to access it in order to perform business services or market products on behalf of The Company and our affiliates. We educate our employees on the importance of protecting the privacy and security of your information. We also maintain physical, electronic and procedural safeguards that comply with federal and state regulations to guard your personal information.

Please be aware, however, that any email or other transmission you send through the Internet cannot be completely protected against unauthorized interception. As a result, we ask that you not send any confidential information to The Company via e-mail.

## 6. What Choices Do I Have?

**If you prefer that we not disclose nonpublic personal financial information about you to nonaffiliated third parties, you may opt out of those disclosures, that is, you may direct us not to make those disclosures (other than disclosures permitted by law). If you wish to opt out of disclosures to nonaffiliated third parties, you may opt out by sending us an email request to opt out to [corporate.compliance@nfg.com](mailto:corporate.compliance@nfg.com) or by calling us at 1-800-813-8180. Note that you can only opt out of sharing your nonpublic personal financial information with nonaffiliated third parties for certain purposes; you cannot opt out of sharing such information with nonaffiliated third parties who are service providers to us, who engage**

**in joint marketing efforts with us, who assist us with processing and servicing transactions, or as otherwise permitted by law.**

You may also “opt-out,” or unsubscribe, from our newsletters, special offers or discounts, or other marketing communications by following the unsubscribe instructions in any e-mail or other communication you receive from us. After doing so, you will not receive future promotional emails unless you open a new account, enter a contest, or sign up to receive newsletters or emails. Please note that even after unsubscribing we may still disclose information as permitted or required by law including, but not limited to, service related announcements, important information about your policy, state required notices, and other non-marketing communications about your account or purchases that you have made. Please allow up to 2 weeks for us to process your request.

You may access personal information we have recorded about you by submitting a written request which reasonably describes the information requested. This information will be provided to you within thirty (30) business days from the date your written request is received so long as it is reasonably locatable and retrievable by us. You may also request the correction, amendment or deletion of any recorded personal information that we have in our possession. We will notify you of our decision to comply with your request or our reasons for refusal within thirty (30) business days from the date your written request is received. In the event we refuse your request, you will be provided with the opportunity to file a concise statement setting forth what you believe to be the correct, relevant or fair information and the reasons you may

disagree with our determination.

We store data for as long as it is necessary to provide the products and services described in this Privacy Statement and for our internal business purposes. If you would like us to delete information, you may contact us using the information below and we will take reasonable efforts to delete your information from our records, but may need to keep a copy for administrative purposes (such as documenting that a transaction occurred).

This policy is meant for general use in every state. Any provision in this policy that is in conflict with the laws of your state is hereby amended to conform with the standards in your state.

**Residents of California, New Mexico, Vermont:**

We will not disclose personal information about you to any unaffiliated third party without first obtaining your affirmative, opt-in consent, except as expressly permitted by law.

## **7. How Can I Contact The Company?**

The Company is committed to working with you to obtain a fair and rapid resolution of any queries, complaints, or disputes about privacy. If you have submitted information to The Company and you would like to have it deleted from our databases or corrected, or if you have any other questions or comments regarding our privacy practices, please email us at [corporate.compliance@nfg.com](mailto:corporate.compliance@nfg.com) for more information.