APPLICATION FOR INDIVIDUAL TERM LIFE INSURANCE POLICY

COLUMBIAN LIFE INSURANCE COMPANY
HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: 4704 VESTAL PARKWAY EAST
PO Box 1381, Binghamton, NY 13902-1381
Phone: (800) 423-9765 / Fax: (866) 253-9459 / www.cfglife.com

1. PROPOSED INSURED

First Name	Middle Initial	Last Name	Social Security No./Green Card No.	Sex ☐ M ☐ F

Date of Birth (MM/DD/YYYY)	Age (Last Birthday)	State (USA) / Country of Birth	Phone Number ☐ Home ☐ Work ☐ Cell ( )

Home Address/Apt. #, Street	City	State	Zip Code	Email

HEIGHT _____Ft. _____In.	**WEIGHT _____lbs.**	Are you currently employed? ☐ YES ☐ NO If "NO," please explain:

Occupation	Annual Income	Household Annual Income

2. BENEFICIARY For multiple Primary or Contingent Beneficiaries, provide additional beneficiary information including % share in Section 8 Special Requests/ Remarks on Page 5.

PRIMARY BENEFICIARY First Name	Middle Initial	**Last Name**	**Relationship to Proposed Insured**

Date of Birth (MM/DD/YYYY)	Social Security No./Green Card No.	Phone Number ☐ Home ☐ Work ☐ Cell ( )

Street Address	City	State	Zip Code

CONTINGENT BENEFICIARY First Name	Middle Initial	**Last Name**	**Relationship to Proposed Insured**

Date of Birth (MM/DD/YYYY)	Social Security No./Green Card No.	Phone Number: ☐ Home ☐ Work ☐ Cell ( )

Street Address	City	State	Zip Code

3. POLICY DELIVERY OPTIONS

DELIVER TO: ☐ **Agent** ☐ **Owner**

OWNER (Complete only if Owner is other than Proposed Insured.)

☐ **Individual** ☐ **Corporation** ☐ **Partnership** ☐ **Trust**

Social Security No./Green Card No./Taxpayer Id. No.

First Name, Middle Initial, Last Name / Corporation / Partnership / Trust	**Relationship to Proposed Insured**

Mailing Address (If different from Insured)/Apt. #, Street	City	State	Zip Code

To designate a Contingent Owner, provide information in Section 8 Special Requests / Remarks on Page 5.

SECONDARY ADDRESSEE / THIRD PARTY DESIGNEE *Complete ONLY if Applicant/Owner is designating a Secondary Addressee/Third Party to receive a copy of notifications of a past due premium and possible lapse in coverage*

First Name	Middle Initial	Last Name

Street Address	City	State	Zip Code

4. POLICY INFORMATION

PLAN OF INSURANCE: ☐ 10 Year Term ☐ 15 Year Term ☐ 20 Year Term ☐ 30 Year Term

RATE CLASS: ☐ Non-Tobacco ☐ Tobacco	Face Amount: $	Amount Paid with Application (Indicate $0 if initial premium is to be drafted): $	Total Premium (Including Riders): $

RIDERS

The following riders are available at no additional premium:

- Common Carrier Accidental Death Benefit (automatically included on all policies.)
- Unemployment Premium Waiver (automatically included on all policies where available.)

☐ Accelerated Death Benefit – Terminal Illness (Allows acceleration of up to 95% of death benefit)*
☐ Accelerated Death Benefit – Critical Illness (Allows acceleration of up to 95% of death benefit)*
☐ Accelerated Death Benefit – Chronic Illness (Allows acceleration of up to 24% of death benefit per year)*

*A signed disclosure notice must be submitted to enroll in these riders. The Chronic Illness rider is subject to underwriting.

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.

The following riders are available for additional premium:

☐ Accidental Death Benefit Premium $ _____
☐ Guaranteed Purchase Option Premium $ _____
☐ Waiver of Premium Premium $ _____
☐ Children's Term Insurance Rider Premium $_____ *Complete Supplemental Application for Children's Term Insurance Rider*

5. HEALTH HISTORY

Any person who knowingly presents a false statement in an application for life insurance may be guilty of a criminal offense and subject to penalties under state law.

	ANSWER ONLY IF APPLYING FOR THE CHRONIC ILLNESS ACCELERATED BENEFIT RIDER	**YES**	**NO**
1.	Do you require any assistance or supervision to perform any of the following activities of daily living: bathing, eating, dressing, toileting, walking, transferring to or from bed or chair, or maintaining continence? ……	☐	☐
2.	Have you ever been diagnosed by, or consulted with, a member of the medical profession for any of the following: a. Memory loss, cognitive impairment, organic brain syndrome? …… b. Fractures due to osteoporosis, numbness, tremors, imbalance or any condition which limits motion or mobility? ……	☐ ☐	☐ ☐
3.	In the past five (5) years, have you been tested for, been advised to be tested or treated, by a member of the medical profession for any of the following: a. Memory loss, cognitive impairment, organic brain syndrome? …… b. Fractures due to osteoporosis, numbness, tremors, imbalance or any condition which limits motion or mobility? ……	☐ ☐	☐ ☐

Part 1

TOBACCO USE

Have you smoked marijuana or used any form of tobacco or nicotine products in the past twelve (12) months?..... ☐ YES ☐ NO

	Part 2 (If any question in this section is answered "Yes," DO NOT SUBMIT THE APPLICATION.)	**YES**	**NO**
1.	Have you ever been diagnosed by a member of the medical profession as having or tested positive for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or have you been diagnosed by a member of the medical profession as having a terminal medical condition that is expected to result in death within the next twelve (12) months?.....	☐	☐
2.	Are you currently: a. Using a catheter, bedridden, confined to hospital, nursing home or other medical facility?..... b. Regularly using any of the following: oxygen, walker, wheelchair or electric scooter?……	☐ ☐	☐ ☐
3.	In the past five (5) years, have you been recommended by a member of the medical profession for an organ or bone marrow transplant, or ever had or received treatment or required follow-up for a heart, lung, liver, kidney, or bone marrow transplant, or ever had or received treatment or required follow-up for an amputation due to disease, or within the last twelve (12) months, received kidney dialysis?……	☐	☐
4.	Have you ever been diagnosed by a member of the medical profession or received treatment for a stroke (CVA), transient ischemic attack (TIA), congestive heart failure, mental retardation, Down's Syndrome, Alzheimer's disease or dementia, or received a cardiac defibrillator implant?.....	☐	☐
5.	In the past ten (10) years, have you been diagnosed by a member of the medical profession, received treatment or required follow up for: a. Schizophrenia, bipolar disorder, major depression, or have you attempted suicide?..... b. Parkinson's disease, Multiple Sclerosis, cardiomyopathy, or received a cardiac pacemaker implant?.....	☐ ☐	☐ ☐
6.	Have you: a. Been prescribed insulin by a member of the medical profession for the treatment of diabetes prior to age 50 or have you been advised by a member of the medical profession to use oral medication or diet for the treatment of diabetes prior to age 30? …… b. Have you been diagnosed by a member of the medical profession as having complications of diabetes, including insulin shock, diabetic coma, Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve, circulatory) disorder, leg ulcers, amputation or diabetes not under control with current treatments? ……	☐ ☐	☐ ☐
7.	In the past ten (10) years, have you been diagnosed, received treatment, or required follow-up by a member of the medical profession for Emphysema or Chronic Obstructive Pulmonary Disease (COPD)? ……	☐	☐

Part 2 continued (If any question in this section is answered "Yes," DO NOT SUBMIT THE APPLICATION.)		YES	NO
8.	In the past five (5) years, have you: a. Used cocaine, narcotics, hallucinogens, barbiturates, amphetamines, or other drugs (excluding marijuana) except as prescribed by a physician? …… b. Received treatment or been advised by a member of the medical profession to reduce, stop, or seek treatment for alcohol use or the abuse of prescribed or non-prescribed drugs?……	☐ ☐	☐ ☐
9.	a. In the past ten (10) years, have you been diagnosed by a member of the medical profession, received treatment, or required follow-up for leukemia, lymphoma, liver cancer, lung cancer, or pancreatic cancer? …… b. In the past five (5) years, have you been diagnosed by a member of the medical profession, received treatment, or required follow-up for cancer (other than leukemia, lymphoma, liver cancer, lung cancer, pancreatic cancer, basal cell or squamous cell carcinoma of the skin)? ……	☐ ☐	☐ ☐
10.	In the past ten (10) years, have you been diagnosed by a member of the medical profession, received treatment, or required follow-up for: a. Coronary artery disease, heart attack, coronary bypass surgery (CABG), coronary angioplasty (PTCA), heart valve replacement, angina, heart arrhythmia, congenital heart disease, aneurysm, disease or disorder of the brain, peripheral arteries, heart or circulatory system? …… b. Paralysis, degenerative muscle or nerve disease/disorder, immune system or connective tissue disease/disorder?…… c. In the past five (5) years, have you been hospitalized for hypertension or high blood pressure?……	☐ ☐ ☐	☐ ☐ ☐
11.	In the past three (3) years, have you been convicted of three (3) or more moving violations or been convicted of driving under the influence of alcohol or drugs? ……	☐	☐
12.	In the past three (3) years, have you been on probation, parole, convicted of, or pled guilty to any crime or to possession or distribution of drugs (excluding marijuana) or any other illegal substance?……	☐	☐

Part 3 Please provide details for "Yes" answers in Section 6 on page 4. (If any question in this section is answered "Yes," the Proposed Insured may not qualify for this plan of insurance.)		YES	NO
1.	Have you experienced any unexplained weight loss of more than 10 lbs. in the last year? ……	☐	☐
2.	a. In the past five (5) to ten (10) years, have you been diagnosed by a member of the medical profession, received treatment, or required follow-up for cancer (other than basal cell or squamous cell carcinoma of the skin)? …… b. In the past ten (10) years, have you been diagnosed by a member of the medical profession, received treatment, or required follow-up for: 1. Systemic Lupus, Sarcoidosis, rheumatoid arthritis, Crohn's Disease, Hepatitis B, Hepatitis C or ulcerative colitis? …… 2. Disease or disorder of the peripheral arteries, blood, liver, pancreas, or kidney (other than kidney stones)? …… 3. In the past ten (10) years, have you been diagnosed by a member of the medical profession, received treatment, or required follow-up for chronic asthma or asthma that has required one or more emergency care visits or an inpatient hospitalization or any disease or disorder of the respiratory system?…… 4. Epilepsy and recurring seizures with the last seizure occurring within the past year? ……	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
3.	In the past thirty-six (36) months, have you used marijuana, in any form, for more than four (4) days a week?…… (If "YES," please provide details including frequency and reason in Section 6 on page 4)	☐	☐
4.	Are you awaiting a diagnosis or test result, or in the past five (5) years, been advised by a member of the medical profession to have a surgical operation or any diagnostic test (except for HIV) other than for routine screening that has not been completed?……	☐	☐
5.	Have you ever been diagnosed or treated by a member of the medical profession for diabetes? ……	☐	☐
6.	In the past five (5) years, have you been prescribed medication, or taken any medication prescribed by a physician, or been hospitalized or consulted a physician or medical facility for any reason? ……	☐	☐

Part 4		YES	NO
1.	Are you a US citizen, permanent US resident or holding a current Resident Card ("green card") or a permanent Visa? …… If "NO," please provide details: _____	☐	☐
2.	Do you have a driver's license? If "NO," please provide details: _____ If "YES," provide Driver's License No. and State: _____	☐	☐
3.	In the past three (3) years, have you had a driver's license suspended or revoked? …… If "YES," please provide details: _____	☐	☐
4.	Within the next two (2) years, do you plan to travel outside the US or Canada for more than thirty (30) consecutive days? …… If "YES," please provide details that include what country you will be residing in, the length of time you plan to reside outside of the USA, the reason for your foreign residency, and your occupation/job duties while you are living abroad: _____ _____	☐	☐
5.	In the past three (3) years have you: a. Engaged in hang-gliding, cliff diving, scuba diving with depth over 130 feet, parachuting, skydiving, rock or mountain climbing, ultra-light flying, traveling at speeds (in any vehicle) in excess of 100 mph (land or water) or plan such activity in the next two (2) years? …… b. In the past two (2) years have you flown, or do you intend to fly within the next two (2) years in an aircraft as a student or a private licensed pilot?…… If "Yes" to either question, please provide details_____	☐ ☐	☐ ☐
6.	In the past three (3) years, have you been declined, postponed, rated or denied reinstatement or asked to pay extra premium by any insurance company? If "YES," please provide details:_____	☐	☐

6. MEDICAL INFORMATION SECTION Use for "YES" answers in Part 3

Explanation for Part _____ Question _____

Condition/Diagnosis/Disease		Date of Diagnosis
Medications used to treat this condition (Copy from pharmacy label)		Date last taken
Name of Physician or Medical Facility	Address of Physician or Medical Facility	
Details of treatment/diagnosis (include dates and durations)		

Explanation for Part _____ Question _____

Condition/Diagnosis/Disease		Date of Diagnosis
Medications used to treat this condition (Copy from pharmacy label)		Date last taken
Name of Physician or Medical Facility	Address of Physician or Medical Facility	
Details of treatment/diagnosis (include dates and durations)		

Explanation for Part _____ Question _____

Condition/Diagnosis/Disease		Date of Diagnosis
Medications used to treat this condition (Copy from pharmacy label)		Date last taken
Name of Physician or Medical Facility	Address of Physician or Medical Facility	
Details of treatment/diagnosis (include dates and durations)		

7. REPLACEMENT:	YES	NO
Does any Proposed Insured have any existing life insurance or annuities? ……	☐	☐
Is this application for insurance intended to replace or change any life insurance or annuities now in force? ……	☐	☐
(If "YES," submit any special forms required by the state in which the application is signed.)		

8. SPECIAL REQUESTS / REMARKS:

9. CONDITIONS RELATING TO THE APPLICATION:

I have read the questions and answers in all parts of this application and agree that they are complete and true to the best of my knowledge and belief. I agree that this application shall form a part of any policy issued. I understand and agree that no agent has the authority to waive a complete answer to any question in the application, pass on insurability, make or alter any contract, or waive any of the Company's other rights or requirements; that any policy applied for shall not take effect (except as provided in the Conditional Receipt bearing the same number as this application) unless and until the policy has been issued and delivered and the full first premium, according to the mode of payment selected by the applicant (as permitted by the Company) and stipulated in the policy, has been paid and accepted by the Company during the lifetime and condition of health of the Proposed Insured as stated in the application.

10. AUTHORIZATION & ACKNOWLEDGMENT:

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance company, MIB, Inc., consumer reporting agency, or other organization, institution or person that has any records or knowledge of me or any proposed insured, to give any such information to Columbian Life Insurance Company ("the Company") or its reinsurers for underwriting or claims purposes. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization also includes information about drugs, alcoholism, prescription drug records, or any other medical history information. To facilitate rapid submission of such information, I authorize all said sources, except MIB, Inc., to give such records or knowledge to any agency employed by the Company to collect and transmit such information. **I understand** my information may be subject to redisclosure to a third party and may no longer be protected by federal privacy laws. **I authorize** Columbian Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. **I understand** a telephone interview may be necessary to verify or supplement information given to the Company on this application. This interview may be made from the Administrative Service Office or from a consumer-reporting agency by a trained interviewer acting on the Company's behalf. A photocopy of this form will be as valid as the original; this authorization will be valid for two (2) years from the date shown below, or the time limit permitted by applicable law in the state where the policy is delivered or issued for delivery. You may revoke this authorization by contacting us at PO Box 1381 Binghamton, NY 13902-1381 however, we retain the right to use any information obtained under your authorization prior to your revocation. **I have read and understand** the Conditions Relating to the Application and the Authorization & Acknowledgment. **I acknowledge** receipt and review of the Information Practices Relating to Underwriting Your Application. **I have read and understand the fraud warning in Section 5 of this application.**

_____ **X** _____

Date of Application — Signature of Proposed Insured (Date)

_____ **X** _____

Signed At (City, State) — Signature of Owner (If other than Insured) (Date)

X _____

Officer Signing for Corporation, Partnership, or Trust & Title (Date)

11. REPORT OF LICENSED AGENT:

Does any Proposed Insured have any existing life insurance or annuities?…… ☐ YES ☐ NO

Is this insurance intended to replace, in whole or part, any life insurance or annuities?…… ☐ YES ☐ NO

(If "YES," submit any special forms required by the state in which the application is signed.)

Is the agent related to the Proposed Insured or Owner? If "YES," please provide relationship _____ ☐ YES ☐ NO

I hereby affirm that I personally solicited and completed this application and all answers given above are true and correct to the best of my knowledge. The application was signed in my presence.

_____ **X** _____

Name of Licensed Agent (Print) — Signature of Licensed Agent *(required)* (Date)

Primary Agent Name	Agent Number	% of Commission (Enter 100% if you are NOT splitting commission
Secondary Agent Name	Agent Number	% of Commission (Amount of 1st and 2nd Agent must equal 100%)

PAYMENT INFORMATION & AUTHORIZATION (The premium quoted may change following underwriting review)

PAYOR IS: ☐ PROPOSED INSURED ☐ OWNER (if other than Proposed Insured) ☐ OTHER

OTHER PAYOR (Complete only if the Payor is NOT the Proposed Insured or Owner)

First Name	Middle Initial	Last Name or Company Name if the Payor is a Corporation	Relationship to Proposed Insured

Mailing Address (Apt. #, Street)	City	State	Zip Code

Home Phone:	Cell Phone:	Email:

REQUESTED EFFECTIVE DATE: _____
(Use only for backdating. Initial premium amount must include back premiums to requested effective date.)

PAYMENT FREQUENCY: ☐ Monthly (not available for direct bill) ☐ Quarterly ☐ Semi-Annual ☐ Annual

FIRST PREMIUM PAYMENT:

Amount of First Premium: $ _____

☐ Draft first premium from the account below **immediately upon policy issue**, if there are no pending application requirements.

☐ Draft first premium from the account below **on or after** ____/____/____ . (The first draft must be within 35 days of the application date). **Insurance age will be calculated as of the date the premium is drafted.**

☐ Check, cashier's check or money order. By signing below, you authorize the Company to initiate an electronic funds transfer from your bank account if payment is made by check. **Please note that your bank account may be debited the same day your agent submits this authorization.**

Agent, complete the Conditional Receipt only if premium is paid by check, cashier's check, or money order

ONGOING PREMIUM PAYMENTS:

☐ Direct Bill (Not available for monthly payment mode)

☐ Electronic Funds Transfer (Select option below)

☐ **Choose a specific day (1st -28th)**

_____
Ongoing Premium Draft Day

OR

☐ **Choose a specific week and day of the month**

Select Week: ☐1st Week ☐2nd Week ☐3rd Week ☐4th Week

Select Day: ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday

Beginning in the month of _____ .

BANK ACCOUNT AUTHORIZATION (Complete if first premium or ongoing premiums will be drafted from an account)

I authorize the payment of debits drawn on my account payable to Columbian Life Insurance Company, provided there are sufficient funds in the account. I agree that if any such debit be dishonored the Company shall be under no liability in the event the dishonored debit results in forfeiture of insurance.

☐ **SOCIAL SECURITY BENEFIT AUTHORIZATION:** If checked, I authorize the Company to adjust the date of withdrawal from my bank account to match my Social Security Benefit deposit.

Any requirement for giving notice of premiums due shall be waived as long as this Electronic Funds Transfer plan is in effect. No premium shall be deemed to have been paid until the Company receives actual payment. The use of this plan shall in no way change the provisions of the policy with respect to the termination of such policy upon nonpayment of the premium due.

This plan shall continue in effect until terminated by the Company or by me by thirty days written notice to the other party. The Company may terminate the EFT plan if any check or electronic fund transfer is not paid on presentation. Upon termination of the Electronic Funds Transfer plan, premiums due under the policy after such termination shall be payable directly to the Company at the minimum modal premium available at the time.

Financial Institution _____ ☐ Checking (*Attach Voided check if available*) ☐ Savings

Transit / Routing Number (must have 9 digits)

Account Number (may have up to 17 digits)

I have read and understand the above statements in bold regarding the timing for the initial premium to be drawn from my account. I hereby acknowledge that the Company is not responsible to reimburse me if my account has insufficient funds and overdraft fees are charged by the bank.

_____ _____ _____
Name of Bank Account Holder Date Authorized Signature as it appears on Bank Records

INFORMATION PRACTICES RELATING TO UNDERWRITING YOUR APPLICATION

Thank you for choosing insurance from Columbian Life Insurance Company. This Notice is given to you at the time you apply for life or health insurance to tell you about the kinds of information we may obtain in connection with your application. **We will treat all personal information about you as confidential**.

INVESTIGATIVE CONSUMER REPORT
We may obtain an investigative consumer report and may tell the consumer reporting agency the amount and type of your coverage. The report may contain data about your identity, age, residence, past and present job (including work duties), economic conditions, driving record, personal and business reputation in the community and mode of living, but will not include any information relating directly or indirectly to sexual orientation.

IDENTIFICATION
To obtain the data described above, the insurer may give my name, address and date and place of birth to the above persons or organizations.

ACCESS TO INFORMATION
You may request, in writing, to receive information from Columbian Life Insurance Company about the nature and scope of an investigative consumer report. Within five (5) business days of receipt of a written request, we will provide you with the name, address and phone number of any agency we ask to prepare such a report. By contacting the investigative agency, you may inspect or receive a copy of such report.

WHERE TO WRITE US
You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please send your written request to Underwriting Department, Columbian Life Insurance Company, PO Box 1381, Binghamton, NY 13902-1381.

MIB, INC. PRE-NOTICE
MIB, Inc. is a not-for-profit membership organization of life insurance companies. The MIB provides an information exchange for its members. It maintains information of underwriting significance on policyholders and applicants as furnished to it by member companies. Such information is available only to member companies and only when such company has an authorization signed by you to request such information.

We use the MIB to check information of underwriting significance, but only as a guide to identify areas about which we might need additional information before reaching a final underwriting decision. Columbian Life does not rely, in whole or in part, on an MIB report in making a final underwriting decision.

We make a brief report to the MIB on those individuals about whom we have information about underwriting significance. We will not report what action we have taken on your application. The MIB, on request, supplies other member companies with information in its files if an application for life or health insurance, or a claim for benefits, is submitted to such company. MIB rules require that a member company have our authorization before requesting information about you.

If you question the accuracy of information in the MIB file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone Number (866) 692-6901. MIB's website is www.mib.com.

CONDITIONAL RECEIPT

Complete Only When Full Modal Premium Is Received With Application

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO COLUMBIAN LIFE INSURANCE COMPANY.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Received from (Print) _____, the sum of_____ on the life of (Proposed Insured) _____ _. Columbian Life Insurance Company ("the Company") accepts this payment in connection with your application for insurance and, subject to the terms and conditions of this Conditional Receipt and subject to all the terms and conditions of the policy applied for, agrees to provide coverage under the following conditions:

EFFECTIVE DATE OF COVERAGE: Provided that each of the conditions below is satisfied, coverage under this Conditional Receipt will begin on the later of the Underwriting Date (as defined below) or the specific policy date requested on the application. The Underwriting Date is the later of (1) the date of the application; or (2) the date all underwriting requirements, as required by the Company's underwriting rules, are completed.

CONDITIONS: Insurance coverage under this Conditional Receipt will begin on the Effective Date (as defined above) only if, on that date, all of the following criteria are met:

(1) You had paid the full first modal premium on the policy applied for; and
(2) All Proposed Insureds were insurable at standard rates on the date of the application; and
(3) The Company is able to issue the policy as applied for; and
(4) The amount of insurance applied for, with respect to any Proposed Insured, is not in excess of $500,000.

TERMINATION OF COVERAGE: Any insurance provided under this Conditional Receipt will terminate: (1) Immediately, if the Company refunds your payment or your check was not honored by your Bank; or (2) The date coverage under the policy applied for becomes effective; or (3) Ninety (90) days after the date of the application.

_____ X_____
Date Signature of Licensed Agent

IMPORTANT NOTICE TO THE AGENT: DO NOT SIGN THE CONDITIONAL RECEIPT UNLESS PREMIUM IS TAKEN WITH THE APPLICATION.