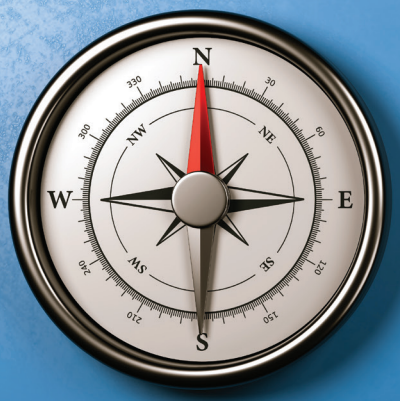
COLUMBIAN FINANCIAL GROUP

Safe Shield®

Simplified Issue Term



Agent Guide

- Plans and Riders
- Underwriting Guidelines
- Completing the Application

COLUMBIAN LIFE INSURANCE COMPANY
HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: BINGHAMTON, NY

Table of Contents

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Mail to	P.O. Box 1381 Binghamton, NY 13902-1381
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Base Plan	
Initial Term Periods	10, 15, 20, or 30 years
Issue Ages (age last birthday)	10-Year Term 18 - 70 15-Year Term 18 - 70 20-Year Term 18 - 65 30-Year Term 18 - 55
Issue Amounts	Ages 18 - 55 $20,000 - $350,000 Ages 56 - 70 $20,000 - $250,000
Benefit	Level death benefit all years.
Renewability	Policy may be renewed at annual renewable term premiums to the first policy anniversary on or after the Insured's 100th birthday.
Life Event Requirement	None
Simplified Issue Underwriting	– Application health questions – Height/Weight – Milliman check, which includes MIB, Prescription Drug Database, Medical Billing Records, and Motor Vehicle Report (for ages 18-35) – If Milliman does not return any prescription information, an Exam One prescription drug database check is run – Information obtained through Milliman or MIB may result in additional underwriting checks being conducted, such as a criminal background check through ExamOne. These additional checks, if performed, are focused solely on the underwriting risks listed on the application. – Telephone Interview if needed to clarify information
Underwriting Classes	– Male/Female – Non-Tobacco/Tobacco – Issued Standard through Table D
Modal Factors	Monthly EFT .087 Quarterly .265 Semi-Annual .52 Annual 1.00
Annual Policy Fee	$48.00 (fully commissionable)
Dividends	Non-participating
Convertibility	May be converted to a permanent plan of insurance after the second policy year and before the earlier of: – The end of the initial term period less five years; and – The policy anniversary on which the Insured is age 65

Benefits and Riders Available With *No Additional Premium*	
Common Carrier Accidental Death Benefit	
Benefit	An additional benefit is payable if the Insured dies within 180 days of an accidental bodily injury that occurred while a fare-paying passenger on a common carrier.
Benefit Amount	Equal to the face amount of the base policy, not to exceed $250,000 aggregate limit for all Columbian Common Carrier Accidental Death Benefit Riders combined.
Availability	Automatically included on all policies at no additional premium.
Coverage Period	To the first policy anniversary on or after the Insured's 85th birthday.
Unemployment Premium Waiver (not available in MA, PA, TN or WA)	
Benefit	Waives premiums for the base policy and all riders for up to six months if the Insured becomes unemployed after the second policy anniversary and collects unemployment benefits for at least four consecutive weeks.
Benefit Limits	The lifetime benefit under the policy is six months.
Availability	Automatically included on all policies (where allowed) at no additional premium.
Coverage Period	Rider coverage remains in force as long as the policy remains in force.
Living Benefit Riders (not available in CA)	
Benefit	The Terminal Illness, Critical Illness and Chronic Illness Riders allow for acceleration of up to 95% of the original face amount if the Insured is diagnosed with a qualifying condition. – **Terminal Illness:** Terminal condition and life expectancy of 12 months or less. – **Critical Illness:** Life threatening cancer, ALS, kidney failure, heart attack, major organ failure or stroke. – **Chronic Illness:** Severe cognitive impairment or the Inability to perform at least two of the six activities of daily living (bathing, continence, dressing, eating, toileting and transferring) for a period of at least 90 days. The acceleration benefit is reduced by a $250 Administrative Charge (may vary by state) and a discount factor based on the Insured's life expectancy.
Benefit Limits	– Maximum lifetime benefit: 95% of base policy death benefit – Chronic Illness benefit amount: Maximum 24% base policy benefit per year – Minimum face amount accelerated = $5,000 – Minimum residual face amount = $5,000 – Minimum acceleration benefit amount = $1,000
Effects of Acceleration	– Face amount and base policy premiums are reduced by the acceleration percentage. – Payment of the benefit will have no effect on any Children's Term Insurance or Accidental Death Benefit under the policy. – Any Waiver of Premium coverage and associated premiums will reduce due to the reduction in face amount. – Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.
Availability	– Available at the time of policy issue. May not be added after policy issue. – Available at all issue ages – Two application health questions required to qualify for Chronic Illness Rider
Coverage Period	– Riders terminate when the total accelerated amount under all accelerated death benefit riders equals the maximum accelerated death benefit amount. – Terminal Illness Rider terminates after any accelerated benefit has been paid under the rider.

Benefits and Riders Available With *Additional Premium*	
Accidental Death Benefit Rider	
Benefit	Additional benefit payable for death due to bodily injuries which are the direct and independent cause of death occurring within 180 days after the date of an accident.
Availability	Available at the time of policy issue for all issue ages
Benefit Amount	Equal to base policy death benefit. Maximum Accidental Death Benefit payable for all Columbian policies combined is $250,000.
Coverage Period	To the first policy anniversary on or after the Insured's 95th birthday
Children's Term Insurance Rider	
Benefit	Level term coverage on an individual child, grandchild or great grandchild of the insured. Natural born, step, and legally adopted children, grandchildren, or great grandchildren may be covered. Riders issued with the policy include a "paid-up" benefit. If the policy insured dies while the rider is in effect, rider coverage will remain in force without further payment of premiums. This benefit is not provided if the insured commits suicide within two years of policy issue and does not apply to riders added to a policy after policy issue.
Issue Ages	Base Insured: same as base policy Child: 15 days through 18 years (less than 19)
Availability	Available at time of policy issue and may be added after issue.
Issue Limits	$2,500 - $15,000 (issue amount must be the same for all child riders) Maximum 20 riders per policy
Coverage Period	To the policy anniversary on or after the child's 25th birthday
Conversion	Rider may be converted without evidence of insurability to a permanent policy then offered by the Company for conversion purposes subject to our rules as to amount, age and rating: – Up to the amount of the rider between the ages of 22 and 25. – Up to 5 times the amount of the rider on the date rider coverage ends. – **For riders issued with the policy** - Up to 5 times the amount of the rider on the date of the base insured's death *if the insured commits suicide within two years of the date of issue of the policy*. – **For riders added after policy issue** - Up to 5 times the amount of the rider on the date of the base insured's death.
Guaranteed Purchase Option Rider	
Benefit	Provides an opportunity to increase coverage on an option date by an amount up to the rider benefit amount without further evidence of insurability. If an election is made at an option date, a new term policy will be issued with a new term period. Premiums will increase accordingly.
Issue Ages	18 - 37
Maximum Benefit	The lesser of the policy face amount or $30,000 per option
Scheduled Option Dates	Within 90 days prior to the policy anniversary on which the insured is 25, 28, 31, 34, 37 and 40 years old.
Special Option Dates	Within 90 days after marriage, purchase of a home, or birth or adoption of a child. Exercising a Special Option Date eliminates the next Scheduled Option date.
Coverage Period	To the first policy anniversary on or after the insured's 40th birthday. Rider coverage will terminate prior to age 40 if all available options are used.
Waiver of Premium - Disability	
Benefit	Waives all premiums for the base plan and riders after six months of total and continuous disability occurring while rider coverage is in effect.
Issue Ages	18 - 55
Rider Availability	Available at time of policy issue. May not be added after policy issue.
Coverage Period	Rider benefit terminates at the first anniversary on or after the insured's 65th birthday; however, if the insured is totally and continuously disabled prior to age 60, premiums will continue to be waived until such disability ceases.

Underwriting Guidelines

Underwriting Basis

- Application health questions
- Height/Weight (see chart)
- Milliman Irix, which includes checks on MIB, prescription drugs, medical billing records and Motor Vehicle check (for ages 18-35). ExamOne prescription drug check if no Rx history is returned. Additional ExamOne checks may be run based on information received. The additional checks, if performed, are focused solely on the underwriting risks listed on the application.
- Telephone interview if needed to clarify information
- If the Proposed Insured has existing coverage with Columbian, the prior file will be reviewed.

Underwriting Criteria

- Standard through Table 4. Higher than Table 4 will be declined.
- Height and Weight
- Non-Tobacco = no tobacco or nicotine product use or smoked marijuana in the past 12 months

Build Chart

Height	Minimum	Maximum	Height	Minimum	Maximum
4'8"	74	189	5'9"	112	287
4'9"	77	196	5'10"	115	296
4'10"	79	203	5'11"	119	304
4'11"	82	210	6'0"	122	313
5'0"	85	217	6'1"	126	322
5'1"	88	224	6'2"	129	331
5'2"	91	232	6'3"	133	340
5'3"	94	239	6'4"	136	349
5'4"	97	247	6'5"	140	358
5'5"	100	255	6'6"	143	367
5'6"	103	263	6'7"	147	377
5'7"	106	271	6'8"	151	386
5'8"	109	279	6'9"	154	396

Weight is only one factor in the underwriting assessment. A build that is within the parameters does not guarantee acceptance. Weight exceeding the maximum will be declined.

Motor Vehicle Report A Motor Vehicle Report (MVR) is run on all applicants age 18-35 who have a valid driver's license. An MVR may be requested on applicants age 36+ if the application question regarding moving violations or driving under the influence is answered "yes" or if we receive confidential information that indicates the question should have been answered "yes."

The following will be a decline:

- DUI within 3 years
- 3 or more moving violations within 3 years

Violations considered:
1. Speeding 15 mph or more over posted limit
2. Accident (at fault)
3. Reckless driving
4. Driving without a license, insurance, or registration

Financial Underwriting Guidelines An income replacement factor is used in determining the total amount of insurance the applicant is eligible for (see chart). A non-income earning spouse with minor children is eligible for up to 50% of the total coverage (in force and applied for) on the income earning spouse. Others with no earned income will be given individual consideration.

Age	Earned Income Factor
≤ 40	25
41 - 50	20
51 - 60	15
61 - 70	10
71 +	5

Foreign Nationals A valid and long-term interest in the United States must be established and the proposed insured must have a Social Security Number, Green Card (Resident Card) or TIN.

Unacceptable Risks

The following is provided to help you determine whether a client may be eligible for SafeShield® coverage. Consideration for some risks may be possible with medical records provided at the client's expense.

- AIDS/ARC: Has been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) (Symptomatic or Asymptomatic) or been treated for AIDS or ARC by a physician or healthcare provider. See Human Immunodeficiency Virus listing for HIV guidelines.
- ALCOHOL ABUSE: Decline if within 5 years
- ALZHEIMER'S DISEASE/DEMENTIA
- AMPUTATIONS: If due to disease
- ASTHMA: Decline if moderate and smoker. Decline if severe.
  - Moderate Asthma = Asthma with daily symptoms and exacerbations two or more times per week, some restrictions of activities, daily use of bronchodilator, up to two weeks of missed time from work in the past 12 months.
  - Severe Asthma = Asthma with daily symptoms, could have a hospital admission within the past year, symptoms frequently not relieved with treatment, could have history of life-threatening attack, greater than two weeks of work missed due to asthma in the past 12 months.
- ATTEMPTED SUICIDE: Within the past 10 years
- BEDRIDDEN: Currently bedridden or confined to any hospital, nursing home, or other medical facility.
- BIPOLAR DISORDER
- BRAIN DISEASE / DISORDER
- CANCER:
  - Decline if within five years for all internal cancer other than superficial basal cell skin cancer.
  - Decline if within ten years for leukemia, lymphoma, liver cancer, lung cancer, or pancreatic cancer.
  - If cancer was any type other than those listed above for decline, consideration is possible with medical records provided by the proposed insured at the time of application.
- CEREBRAL PALSY
- CHRONIC BRONCHITIS: Considered a form of COPD. Clinically, it is defined as a chronic productive cough for more than three months in each of the last two successive years.
- CHRONIC PAIN:
  - Non-opioid treatment - If severe (functional limitations such as physical mobility or multiple medications)
  - Opioid treatment including Methadone, OxyContin, Hydromorphone and Fentanyl. Other opioid treatment will be given individual consideration.
- CIRCULATORY SYSTEM: Diagnosis, treatment or follow-up for disease or disorder past 10 years
- CONGESTIVE HEART FAILURE
- CORONARY ARTERY/HEART DISEASE OR DISORDER/HEART ATTACK/HEART SURGERY: In the past 10 years, received diagnosis of or required follow-up for Aneurysm, Angina, Heart Arrhythmia, Cardiomyopathy, Congenital Heart Disease, Coronary Angioplasty (PTCA/Stent), Coronary Bypass Surgery (CABG), Heart Attack, Heart Valve Replacement, Valve Disorder, Pacemaker, or Defibrillator. Heart disease diagnosed or treated more than 10 years ago may be considered, but medical records may be required to help in the determination of acceptable risk.
- CRIMINAL HISTORY: In the past 3 years, been on probation or parole, or been convicted of or pled guilty to any crime or to possession or distribution of drugs or other illegal substance.
- CROHN'S: Decline if moderate or severe, meaning less than one year since last attack or flare-up, symptoms include fever, anemia, severe colic, dehydration, weight loss and/or hospitalization, surgery being contemplated or surgery less than six months ago. Moderate to severe Crohn's could also include recurrence of symptoms after surgery.

Unacceptable Risks

- CVA (Stroke) & TIA (Transient Ischemic Attack or Mini Stroke)
- COPD / EMPHYSEMA
- CYSTIC FIBROSIS
- DEGENERATIVE MUSCLE or NERVE DISEASE/DISORDER
- DEPRESSION: Moderate or severe. Can include multiple medications for depression, more than one week of work missed in the past 12 months due to depression, history of hospitalizations for depression, history of suicidal ideation or attempt.
- DIABETES – See Diabetes Field Underwriting Guidelines
- DOWN'S SYNDROME
- DRUGS: In the past 5 years, used or been treated for amphetamines, cocaine, narcotics (other than marijuana), hallucinogens, or barbiturates. See Marijuana listing for marijuana guidelines.
- EPILEPSY/SEIZURES: With seizure within the past year.
- GASTRIC BYPASS OR SLEEVE SURGERY: Postpone six months from time of surgery
- HEMOPHILIA
- HUMAN IMMUNODEFICIENCY VIRUS (HIV): Diagnosed as having HIV Infection (Symptomatic or Asymptomatic) or been treated for HIV by a physician or healthcare provider.*
- HYPERTENSION / HIGH BLOOD PRESSURE: If hospitalized within the past 5 years
- IMMUNE SYSTEM or CONNECTIVE TISSUE DISEASE/DISORDER
- KIDNEY DISEASE / DISORDER (other than kidney stones)
- LIVER DISEASE / DISORDER
- MARIJUANA: If smoked within past 12 months, tobacco rates apply. If ingested, tobacco rates do not apply.
- MENTAL RETARDATION
- MOBILITY ISSUES: Regularly using a walker, wheelchair or electric scooter
- MULTIPLE SCLEROSIS
- OXYGEN (using regularly)
- PANCREATIC DISEASE / DISORDER
- PARALYSIS: Any paraplegia or quadriplegia.
- PARKINSON'S DISEASE
- PERIPHERAL ARTERIAL AND VASCULAR DISEASE
- RHEUMATOID ARTHRITIS: If severe. Can include marked deformities in joints, rheumatoid nodules, restrictions in movement, needs assistance with some ADLs, chronic daily pain, involvement widespread in multiple joints.
- SARCOIDOSIS: If active disease and/or residual pulmonary impairment.
- SCHIZOPHRENIA
- SICKLE CELL ANEMIA
- SYSTEMIC LUPUS: If moderate or severe. Can include swollen joints, pleuritic chest pain and pleural effusion and or complications with kidneys.
- TERMINAL CONDITION: Terminal diagnosis expected to result in death within twelve months
- TRANSPLANT: Has received or been recommended for an organ or bone marrow transplant.
- TRANSPORTATION ASSISTANCE: Permanent usage of the following: walker, wheelchair, electric scooter, oxygen, or catheter.
- ULCERATIVE COLITIS: If moderate to severe.

*In California, the Proposed Insured will not be declined solely on the basis of a positive HIV test. An Attending Physician's Statement (APS) will be required.

Diabetes Field Underwriting Guidelines

General Guidelines

- **Insulin** guidelines apply if diabetes is controlled with insulin (may also be using oral medication in combination). The following are not eligible:
  - Insulin diabetics under age 50
  - Insulin diabetics who use tobacco or nicotine products
- **Non-insulin** guideline applies if diabetes is controlled with oral medication or diet only. The following are ineligible for coverage:
  - Non-insulin diabetics under age 30
  - Non-insulin diabetics age 30-49 who use tobacco or nicotine products
  - Non-insulin diabetics age 50-70 who use tobacco or nicotine products and have had diabetes for more than 15 years
- Complications such as nerve pain, kidney disease and/or retinopathy (eye disease) will result in ineligibility.
- Calculate points as below to determine whether an application should be submitted.

STEP ONE

Add points based on age, length of time the Proposed Insured has had diabetes.

Age	0 to 15 years	Greater than 15 years
30-39	4	Decline
40-49	3	Decline
50-59	2	4
60-70	1	3

STEP TWO

Add points based on Diabetes Height/Weight Chart on the next page.

STEP THREE

Add 2 points if the Proposed Insured has used nicotine in the past 12 months.

STEP FOUR

Add 2 points if the Proposed Insured uses insulin.

POINTS

	Step 1	Step 2	Step 3	Step 4
Total	Age & time	Height/Weight	Tobacco Use	Insulin use
_____ =	_____ +	_____ +	_____ +	_____

DECISION

- **If total is less than or equal to 4 points,** submit the application for underwriting.
- **If greater than 4 points,** do not submit application. The client is ineligible for this product.

Download the SafeShield® Software from cfglife.com/illustrations-calculators-and-quotes/ for a convenient Diabetes Calculator. The Diabetes Calculator is available in the Resources section of the software.

Diabetes Field Underwriting Guidelines

Diabetes Height/Weight Chart

Points to add	0	1	2	3
4'8"	83-140	141-167	168-176	177-185
4'9"	86-145	146-173	174-182	183-191
4'10"	89-150	151-179	180-188	189-198
4'11"	92-155	156-185	186-195	196-205
5'0"	95-161	162-191	192-202	203-212
5'1"	98-166	167-198	199-209	210-219
5'2"	102-172	173-205	206-215	216-226
5'3"	105-177	178-211	212-222	223-234
5'4"	108-183	184-218	219-230	231-241
5'5"	112-189	190-225	226-237	238-249
5'6"	115-195	196-232	233-244	245-257
5'7"	119-201	202-239	240-252	253-264
5'8"	122-207	208-246	247-259	260-272
5'9"	126-213	214-253	254-267	268-280
5'10"	129-219	220-261	262-275	276-289
5'11"	133-225	226-268	269-283	284-297
6'0"	137-232	233-276	277-291	292-305
6'1"	141-238	239-284	285-299	300-314
6'2"	145-245	246-292	293-307	308-323
6'3"	148-251	252-299	300-315	316-331
6'4"	152-258	259-308	309-324	325-340
6'5"	156-265	266-316	317-333	334-349
6'6"	161-272	273-324	325-341	342-359
6'7"	165-279	280-332	333-350	351-368
6'8"	169-286	287-341	342-359	360-377
6'9"	173-293	294-349	350-368	369-387

Any weight above the range in the last column shown for the Proposed Insured's height is a decline.

Medication Guide

The following list is provided to help identify medical conditions that may be associated with health questions on the application. The presence of a medication does not mean that an applicant will be declined, but should be used to ensure that any associated question is answered accurately. This list is not all-inclusive and is subject to change as new drugs become available and existing drugs are used for additional conditions.

Medication	Medical Condition
Abilify	Major Depression likely
Amantadine HCL	Parkinson's
Ambisome	HIV Treatment likely
Anastrozole	Cancer
Antabuse	Alcoholism
Aptivus	HIV Treatment likely
Aranesp	Kidney Disease
Aricept	Alzheimer's/Dementia
Arimidex	Cancer
Aromosin	Cancer
Atamet	Parkinson's
Atgam	Organ/Tissue Transplant likely
Atripla	HIV Treatment likely
Avonex	Multiple Sclerosis
Belbuca	Drug Abuse
Betaseron	Multiple Sclerosis
BiDil	Congestive Heart Failure likely
Buprenex	Drug Abuse
Calcijex	Kidney Disease
Calcitriol	Kidney Disease
Calcium Acetate	Kidney Disease
Campath	Cancer
Campral	Substance Abuse
Carbidopa	Parkinson's
Carnitor	Kidney Disease / CHF / Cardiomyopathy
Casodex	Cancer
Chlorpromazine	Schizophrenia likely
Clopidogrel	Stroke, TIA or CAD
Clozapine	Schizophrenia
Clozaril	Schizophrenia
Cognex	Alzheimer's/Dementia
Combivir	HIV treatment likely
Copaxone	Multiple Sclerosis
Crofelemer	HIV treatment likely
Cyclosporine	Organ Transplant

Medication	Medical Condition
Cystagon	Kidney Disease
Cytogam	Organ Transplant
Daliresp	COPD
Digoxin	Congestive Heart Failure likely
Disulfiram	Alcoholism
Donepezil	Alzheimer's/Dementia
Dornase Alpha	Cystic Fibrosis
Emend	Cancer
Emsam	Major Depression likely
Emtriva	HIV treatment likely
Epivir	HIV treatment likely
Epzicom	HIV
Evzio	Alcohol or Drug Abuse
Exelon	Alzheimer's / Dementia
Fentanyl	Severe chronic pain
Femara	Cancer
Filgrastim	Cancer likely
Flutamide	Cancer
Foscavir	HIV treatment likely
Fosrenol	Kidney Disease
Fulyzaq	HIV treatment likely
Galantamine	Alzheimer's/Dementia
Ganciclovir	HIV Treatment likely / Organ Transplant
Gengraf	Organ Transplant
Geoden	Schizophrenia likely
Haldol	Schizophrenia likely
Haloperidol	Schizophrenia likely
Halperidone	Schizophrenia likely
Harvoni	Hepatitis C
Hectorol	Kidney Disease
Hydrea	Cancer
Hydromorphone	Severe chronic pain
Hydroxyurea	Cancer
Insulin prior to age 50	Diabetes
Interferon	Hepatitis likely
Intron-A	Cancer or Hepatitis C
Invega	Schizophrenia likely
Invirase	HIV treatment likely
Isosorbide	Heart Disease
Lamivudine-Zidovudine	HIV treatment likely

Medication	Medical Condition
Lanoxin	Congestive Heart Failure possible / Arrhythmia
Larodopa	Parkinson's
Latuda	Bipolar / Schizophrenia likely
Levodopa	Parkinson's
Lexiva	HIV treatment likely
Lupron	Cancer
Megestrol	Cancer or HIV
Memantine	Alzheimer's / Dementia
Mercaptopurine	Cancer
Methadone	Severe chronic pain
Namenda	Alzheimer's / Dementia
Narcan	Alcohol / Drugs
Naloxone	Alcohol / Drugs
Naltrexone	Alcohol / Drugs
Navane	Schizophrenia likely
Neupogen	Cancer likely
Nintedanib	Pulmonary Fibrosis likely
Nitrostat	Angina / Cardiac Chest Pain
Nitro	Angina / Cardiac Chest Pain
Nitroglycerin	Angina / Cardiac Chest Pain
Norvir	HIV treatment likely
Ofev	Pulmonary Fibrosis likely
OxyContin	Severe chronic pain
Oxymorphone	Severe chronic pain
PegIntron	Hepatitis / Melanoma
Peginterferon	Hepatitis / Melanoma
Perphenazine	Schizophrenia likely
PrismaSol	Kidney Disease
Prograf	Organ Transplant
Pulmozyne	Cystic Fibrosis
Quetiapine	Schizophrenia possible
Rapamune	Organ Transplant
Razadyne	Alzheimer's / Dementia
Rebif	Multiple Sclerosis
Reminyl	Alzheimer's/Dementia
Renagel	Kidney Disease
Renvela	Kidney Disease
Retrovir	HIV treatment likely
Ribapak	Liver disease

Medication	Medical Condition
Ribasphere	Liver Disease
Ribavirin	Hepatitis C
Riluzole	ALS likely
Rilutek	ALS likely
Risperdal	Schizophrenia likely
Risperidone	Schizophrenia likely
Roferon-A	Cancer or Hepatitis C
Sensipar	Kidney Disease/Failure
Seroquel	Schizophrenia likely
Sofosbuvir	Chronic Hepatitis
Sovaldi	Chronic Hepatitis
Spiriva	COPD likely
Stalevo	Parkinson's likely
Stelazine	Schizophrenia likely
Stribild	HIV
Suboxone	Substance abuse possible
Subutex	Substance abuse possible
Sustiva	HIV treatment likely
Tamoxifen	Cancer
Targretin	Cancer
Thiothixene	Schizophrenia likely
Tivicay	HIV
Trilafon	Schizophrenia likely
Trizivir	HIV treatment likely
Viracept	HIV treatment likely / Hepatitis
Viramune	HIV treatment likely / Hepatitis
Viread	HIV treatment likely / Hepatitis
Zemplar	Kidney Disease / Failure
Zidovudine	HIV
Zyprexa	Psychotic Disorder likely
Zytiga	Cancer

Electronic Application (eApp) Instructions

Columbian's electronic application includes risk qualifying features to help you quickly determine whether your client may qualify for a SafeShield® plan before you complete the entire application. Using eApp helps eliminate errors and gets your applications submitted faster, and the Point of Sale (POS) Underwriting option delivers a decision in under three minutes, while you're with the client.

Completing an eApp:

1. Select the application state. The application state must match the Proposed Insured's state of residence. If the application state differs from the state where you are completing the application, you must be licensed in both states.
2. Select the product and click the Create button.
3. The interactive questions on the Health History and Policy Information screen will help determine whether the Proposed Insured may qualify for a SafeShield® plan. As you answer the questions, the status bar updates to show the client's risk level of green, yellow or red.
   - Green = Eligible to apply for immediate POS Underwriting approval
   - Yellow = Underwriting review will be needed. Click the question mark in the status bar for details regarding the yellow status.
   - Red = Client is not eligible for the product
4. If the client is eligible to apply, click the "Next" button to complete the rest of the application. As each screen is completed, the status bar will show a green checkmark for the page.

Signing the eApp:

Please note that the full first and last name is required for all electronic signatures.

On the Finish screen, answer the question "Was the application completed by phone?"

- If answered "No," you have the option to sign and submit the application for underwriting or sign and get an immediate Point of Sale (POS) underwriting decision.
  - An image of the completed application and any additional forms will be displayed for review. If corrections are needed, select the Edit button to return to the application.
  - If all information is correct, have the Proposed Insured and any additional parties apply their signature at each signature flag, then apply your signature as Agent.
  - If you selected POS Decision, you may submit or withdraw the application after the decision is delivered.
- If answered "Yes," you have the option to send for remote signatures and get an immediate POS underwriting decision or send for remote signatures and submit for underwriting upon receipt of the application.
  - Enter an email address and assign an Access Code for each recipient, then click the Send Email button.
  - Each recipient will receive an email asking them to review and sign the application through DocuSign. They will need to provide the Access Code you assigned.
  - When all signatures have been applied, the POS decision will be delivered (if applicable) and the application will be submitted for processing.

A PDF of the completed application will be available on your eApp Home Page after submission. For applications signed remotely, each signer will receive an email from DocuSign with a PDF of the completed and signed application.

Paper Application Instructions

Be sure to use the application and any other required forms for the Proposed Insured's primary state of residence. If the application state differs from the state where the application is being taken, you must be licensed in both states.

1. PROPOSED INSURED

Fill this out completely, being sure to include the Social Security number and phone number of the Proposed Insured. When calculating the Proposed Insured's age, if a specific effective date is requested for backdating or if the first premium is to be paid by bank draft, calculate the age as of the effective date or draft date, not the application date.

2. BENEFICIARY

Be sure to include the Beneficiary's relationship to the Proposed Insured.

3. POLICY DELIVERY OPTIONS

Check the appropriate box to indicate whether the policy will be mailed to you or to the Policyowner. If neither box is checked, the policy will be mailed to the Policyowner. Policies with outstanding delivery requirements will be mailed to the agent regardless of which box is checked.

If a delivery receipt is included with the policy, it must be signed by the Policyowner and returned to the Company.

OWNER

Complete this section if the Proposed Insured will not be the owner of the policy. Be sure to include the owner's Social Security number. The Policyowner must have an insurable interest in the life of the Proposed Insured. The insurable interest requirement is satisfied if the individual is an immediate family member or would suffer an economic loss by the death of the Proposed Insured. The relationship must be stated on the application.

SECONDARY ADDRESSEE

Complete this section if the Applicant/Owner is designating an additional party to receive a copy of any notifications of past due premium and possible lapse in coverage.

4. POLICY INFORMATION

- Select the plan of insurance, tobacco class and any desired riders.
  - If any of the applicable Accelerated Death Benefit Riders (Terminal Illness, Critical Illness and/or Chronic Illness) are selected, provide Disclosure Statement Form No. 5419CFG or appropriate state variation.
  - If applying for the Chronic Illness Accelerated Benefit Rider, answer the two health questions related to the rider.
- Enter the face amount of the base policy and the total premium, including riders. Indicate the amount of premium paid with the application. If the initial premium will be drafted, enter a zero for the amount paid with application. If backdating, the initial premium must be calculated from the requested effective date of the policy.

5. HEALTH HISTORY

- **Part 1** - If the proposed insured has smoked marijuana or used any tobacco or nicotine product in the past 12 months, Tobacco rates will apply. Please note that the marijuana question pertains only to smoked marijuana.
- **Part 2** - If any question in this part is answered "Yes," do not submit the application.
- **Part 3** - If any question in this part is answered "Yes," provide details on page 4.
- **Part 4** - Provide details for any "Yes" answers. If the applicant has a driver's license, be sure to include the Driver's License Number and state of issue in question 2.

6. MEDICAL INFORMATION SECTION

Provide details for any "Yes" answers in Part 3 of the Health History. The information you provide will help avoid a telephone interview to determine whether the proposed insured qualifies for a SafeShield® plan.

7. REPLACEMENT

Answer both replacement questions on the application.

- If the application is signed in a state that has adopted the Model Replacement Regulation:
  - If the Applicant *does not have* any existing life insurance or annuities, your duties with respect to replacement are complete.
  - If the Applicant *does have* existing life insurance or annuities, you must complete the appropriate replacement notice for your state, even if the existing insurance or annuities are not being replaced. The notice must be read aloud to the Applicant, unless he or she initials the bottom of the form indicating that they have declined to have it read aloud.
- If the application is signed in a state that has not adopted the Model Regulation, complete the appropriate replacement notice if the Applicant answers "yes" to the second replacement question: *"Is this application for insurance intended to replace any life insurance or annuities now in force?"*

A replacement should be recommended only when it is in the best interest of the Applicant. Columbian does not condone unwarranted or unsuitable replacements. Any time that you complete a replacement notice, you must submit a copy with the application and leave a copy with the Applicant, as well as copies of all sales materials used in the presentation.

8. SPECIAL REQUESTS/REMARKS

Use this space to add any details regarding the application. *If the proposed insured will need an interpreter in case a telephone interview is needed, please include a note and indicate the language needed.*

10. AUTHORIZATION & ACKNOWLEDGEMENT

The Proposed Insured must sign the application. A Power of Attorney signature will not be accepted. If the Owner will be other than the Insured, the Owner must sign as well. Signatures are to be witnessed by the Agent. If the signature is not witnessed by the Agent, the reason must be noted under "Special Requests/Remarks." Be sure to include the city and state where the application was signed. *Note:* The application must be received by the Company within 30 days of signature.

11. REPORT OF LICENSED AGENT
Answer both replacement questions and indicate whether you are related to the Proposed Insured or Owner. If yes, provide the relationship.

PAYMENT INFORMATION & AUTHORIZATION
Indicate whether the premiums will be paid by the Proposed Insured, Owner, or another party. If they will be paid by another party, provide the requested information for the payor.

Enter a requested Effective Date only if backdating to save age. Backdating up to six months is allowed. The initial premium must include back premiums to the requested Effective Date. If no date is requested, the Effective Date will be the later of the date of the application or the date all underwriting requirements, as required by the Company's underwriting rules, are completed.

FIRST PREMIUM
Indicate the amount of the first premium and check the appropriate box to indicate how the first premium is to be paid.

- If the option to draft the first premium **immediately upon policy issue** is selected, the premium will be drafted when the policy is issued, if there are no pending requirements.
- If the option to draft the first premium **on or after a specified date** is selected, the draft must be within 35 days of the application date.
- If payment is made by check, the premium will be debited electronically when the application is received by the Company.

ONGOING PREMIUM PAYMENTS
Indicate whether ongoing premium payments will be billed or paid by Electronic Funds Transfer (EFT). Direct Bill is not available for monthly payments.

EFT premiums can be drafted on a specific day between the 1st and the 28th of each month, or on a specific day and week of each month to coincide with bank deposits. If the payor checks the Social Security Benefit Authorization, the draft date will be adjusted to coincide with Social Security deposits in months where the deposit date differs due to a holiday.

CONDITIONAL RECEIPT
Complete this section only if premium is paid by immediate draft or by check, cashier's check or money order. Do not complete the Conditional Receipt if the initial premium will be drafted at a future date or drafted on issue of the policy.

Applications may be submitted by mail, fax, or secure upload through the Partners website. For paper applications completed by phone, verbal signatures are obtained through the Voice Signature process. For detailed procedures, please see the Telesale Procedure Guide, Form No. 6085-CL.

Please note that Spanish versions of the application and the Telesale Procedure Guide are provided as reference tools only. Only the English version of the application will be accepted, and the Voice Signature process must be completed in English.

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.cflife.com

1. PROPOSED INSURED

First Name	Middle Initial	Last Name	Social Security No./Green Card No.	Sex
John	M	Doe	999-99-9999	☒ M ☐ F

Date of Birth (MM/DD/YYYY)	Age (Last Birthday)	State (USA) / Country of Birth	Phone Number ☒ Home ☐ Work ☐ Cell
10/14/93	30	GA	(123) 456-7890

Home Address/Apt. #, Street	City	State	Zip Code	Email
123 Peachtree Blvd	Anywhere	GA	12345	johnnyd@speed.net

HEIGHT	WEIGHT	Are you currently employed?
5 Ft. 10 In.	168 lbs.	☒ YES ☐ NO If "NO," please explain:

Occupation	Annual Income	Household Annual Income
Engineer	$90,000	$180,000

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 Na	Relationship to Proposed Insured
Jane	L		Spouse

Be sure to specify the relationship of the beneficiary to the insured.

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

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.)

Complete this section if the owner will be other than the insured. Specify relationship to insured.

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

Social Security

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 o

SECONDARY ADDRESSEE / THIRD PARTY DESIGNEE *Complete ONLY if Applicant/Owner a copy of notifications of a past due premium and possible lapse in coverage*

Complete this section if designating a third party to receive a copy of any notification of past due premium or possible lapse in coverage.

First Name	Middle Initial	

Street Address	City	State	Zip Code

Application may vary by state.

4. POLICY INFORMATION

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

RATE CLASS:	Face Amount:	Amount Paid with Application (Indicate $0 if initial premium is to be drafted):	Total Premium (Including Riders):
☒ Non-Tobacco ☐ Tobacco	$ 100,000	$ 0	$ 29.32

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 ye

Be sure to check the appropriate boxes if Accelerated Benefit Riders are desired.

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

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 $ 4.12
☐ Waiver of Premium	Premium $ _____
☒ Children's Term Insurance Rider	Premium $ 1.04 *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 guil of a criminal offense and subject to penalties under state law.

Answer only if applying for Chronic Illness Rider.

ANSWER ONLY IF APPLYING FOR THE CHRONIC ILLNESS ACCELERATED BENEFIT RIDER		S	NO
1.	Do you require any assistance or supervision to perform any of the following activities of daily living: 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

1.	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 Immunodefici (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or have you been diagnosed by a the medical profession as having a terminal medical condition that is expected to result in death within the next twelve (12)		
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)?	☐	☒

Health questions may vary by state.

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 a 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			O
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: Georgia License No. DL123456789	☒	☐
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:_____	☐	☒

If not a US citizen, applicant must have a Green Card or permanent Visa.

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

Explanation for Part 3 **Question** 6

Condition/Diagnosis/Disease	Date of Diagnosis
Sinus Infection	5/12/2020
Medications used to treat this condition (Copy from pharmacy label)	Date last taken
Amoxicillin	5/22/2020
Name of Physician or Medical Facility	Address of Physician or Medical Facility
Dr. Smith	Anywhere, GA
Details of treatment/diagnosis (include dates and durations)	
Antibiotic for 10 days.	

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.**

12/15/21
Date of Application

X John Doe 12/15/21
Signature of Proposed Insured (Date)

Anywhere, GA
Signed At (City, State)

X _____
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 or forwarded to the applicant for signature.

_____ X _____
Name of Licensed Agent (Print) Signature of Licensed Agent *(required)* (Date)

Frank Agent
Primary Agent Name

123456789
Agent Number

100%
% 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

If backdating, initial premium 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: $ 34.48

☒ 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)**

15th
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 January .

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 January ☒ Checking (*Attach Voided check if available*) ☐ Savings

1	2	3	4	5	6	7	8	9

Transit / Routing Number (must have 9 digits)

1	2	3	4	5	6	7	8	9	8	7	6	5	4	3	2	1

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.

John Doe	12/15/21	John Doe
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 [illegible]PANY
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE [illegible]

Complete only if initial premium is paid by check, cashier's check or money order.

Received from (Print) _____, the sum of_____ [illegible]f
(Proposed Insured) _____ _. Columbian Life Insurance C[illegible]s payment in connection with your application for insurance and, subject to the terms and conditions of this Conditional[illegible]eipt 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.

FORM NO. ICC19 A653-CL-NOTICE **LEAVE WITH PROPOSED INSURED/OWNER**

Conversion Rules & Requirements

The policy may be converted to permanent insurance after it has been in effect for two years. Conversion must be applied for prior to the insured's attained age 65 or five years before the end of the initial term, whichever is earlier.

- Minimum conversion amount is $25,000.
- Maximum conversion amount is equal to the amount of the original term policy.
- For partial conversions, a minimum of $25,000 must remain on the term policy.
- Any premiums due more than 31 days before the date of application must be paid and the first premium for the new policy must be paid.
- The date of conversion must be the same day of the month as the Effective Date of the original policy.
- The effective date of the new policy will be the date to which premiums have been paid on the original policy (paid-to date).
- The new policy will be issued with the same tobacco class as the original policy.

For Children's Term Rider conversions:

- Conversion must be applied for within the conversion period specified in the rider.
- Minimum conversion amount is $2,500
- Maximum conversion amount is subject to the terms of the rider.
- Total insurance for a child age 0 to 15 may not exceed the greater of $50,000 or 50% of the amount of life insurance in force on the parent/applicant.

For questions prior to submitting a conversion request, contact Customer Service at (800) 423-9765 extension 5920.

For questions or status updates after the conversion request has been submitted, contact New Business at (800) 423-9765 extension 5944.

cfglife.com
800-423-9765

This guide is not intended for consumer use, nor is it intended to represent a legal contract. The information contained herein is designed to serve as a general reference source only. The company procedures and practices outlined in this guide are subject to change due to legal or compliance requirements or the needs of the business.

For complete policy and rider terms, please refer to Policy/Rider Form 1F612-CL, 1F613-CL, 1H841-CL, 1H906-CL, 1H907-CL, 1H908-CL, 1H915-CL, 1H916-CL, 1H931-CL, 1H932-CL, 1H933-CL and 1H934-CL or appropriate state variation. Product/Rider specifications and availability may vary by state.

Form No. 6147-CL (Rev. 3/23)

COLUMBIAN LIFE
INSURANCE COMPANY
HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: BINGHAMTON, NY