Columbian Quick Reference Tips

Min Face Amount $2,500
Max Face Amount $35,000

Age Range 18-85
Does NOT take Direct Express

Filling Out Application
Fill out red highlighted boxes with your signature/agent number/etc. Make copy after filling out red highlighted boxes.
Always make a duplicate copy of file ***BEFORE*** filling out application with client info
Retitle file with clients first and last name
Fill out yellow highlighted boxes with client info
Base plan of insurance is almost always Elite
Section 7 & 10 answers for replacement need to match
If "yes" to existing insurance question, a replacement form needs to be filled out **even if it no replacement is occurring**
When filling out replacement page, you only need to fill out replaced insurance company **IF you are replacing**
If client shows up yellow or red with Columbian and you are trying to get them through be sure to explain in the additional comments box as well as have them sign the authorization to release information. Talk with manager before submitting app for him to walk you through how to properly explain instructions.
If client is approved elite no need to put medications on application

How to Quote with Cardinal Quoting App
Underwriting Type: Full
Product Type: Level

Columbian Mutual Life Insurance C... (1ST FROM THE TOP)

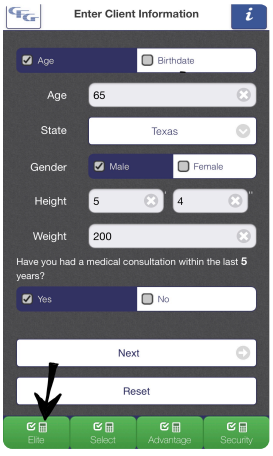
Dignified Choice/Classic Elite	
Premium:	$50.00/mo*
Face Value:	$21,110.00
Annual Fee:	$40.23

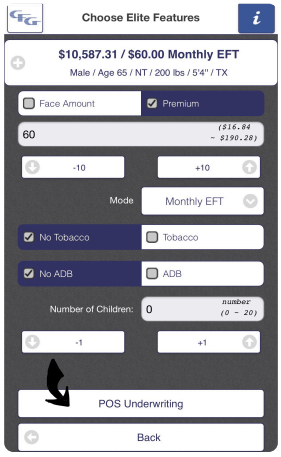
Columbian Mutual Life Insurance C... (2nd FROM THE TOP)

Dignified Choice/Classic Select	
Premium:	$50.00/mo*
Face Value:	$17,259.00
Annual Fee:	$40.23

Columbian App / Health Assessment
1st page fill out details - Click "Next"
2nd page is medications - Click "Next" (NO NEED TO INPUT MEDICATIONS)
3rd pageClick "Elite"
4th Page is to get quotes quickly - Click "POS Underwriting"
Login info plus security questions
Check box and click "continue"
Client Signature
Fill out remaining details - Click "Next"

If client shows up yellow or red with Columbian Elite and you are trying to get them through be sure to explain in the additional comments box as well as have them sign the authorization to release information. Talk with manager before submitting app for him to walk you through how to properly explain medications and health issues. Your manager may suggest you try Oxford, Trinity or another carrier before leaving house. Make sure to get health assessment form signed for any client who shows up as red or yellow for elite that you believe should get through.





Male or Female Ages 25-44				
Height	Decline	Elite	Select	Decline
4'8"	<74	173	189	>190
4'9"	<77	180	196	>197
4'10"	<79	186	203	>204
4'11"	<82	193	210	>211
5'0"	<85	199	217	>218
5'1"	<88	206	224	>225
5'2"	<91	213	232	>233
5'3"	<94	220	239	>240
5'4"	<97	227	247	>248
5'5"	<100	234	255	>256
5'6"	<103	241	263	>264
5'7"	<106	249	271	>272
5'8"	<109	256	279	>280
5'9"	<112	264	287	>288
5'10"	<115	271	296	>297
5'11"	<119	279	304	>305
6'0"	<122	287	313	>314
6'1"	<126	295	322	>323
6'2"	<129	303	331	>332
6'3"	<133	312	340	>341
6'4"	<136	320	349	>350
6'5"	<140	328	358	>359
6'6"	<143	337	367	>368
6'7"	<147	346	377	>378
6'8"	<151	355	386	>387
6'9"	<154	363	396	>397

Male or Female - Ages 45 and up						
Height	Decline	Elite	Select	Advantage	Security	Decline
4'8"	<74	178	189	207	216	>217
4'9"	<77	184	196	214	224	>225
4'10"	<79	191	203	222	232	>233
4'11"	<82	198	210	230	240	>241
5'0"	<85	204	217	238	248	>249
5'1"	<88	211	224	246	256	>257
5'2"	<91	218	232	254	265	>266
5'3"	<94	225	239	262	273	>274
5'4"	<97	233	247	270	282	>283
5'5"	<100	240	255	279	291	>292
5'6"	<103	247	263	288	300	>301
5'7"	<106	255	271	296	309	>310
5'8"	<109	263	279	305	318	>319
5'9"	<112	270	287	314	328	>329
5'10"	<115	278	296	324	338	>339
5'11"	<119	286	304	333	347	>348
6'0"	<122	294	313	342	357	>358
6'1"	<126	303	322	352	367	>368
6'2"	<129	311	331	362	377	>378
6'3"	<133	320	340	372	388	>389
6'4"	<136	328	349	382	398	>399
6'5"	<140	337	358	392	408	>409
6'6"	<143	346	367	402	419	>420
6'7"	<147	355	377	412	430	>431
6'8"	<151	364	386	423	441	>442
6'9"	<154	373	396	433	452	>453

How to Submit App
Delete instruction page before submitting
If using a tablet/notability for application, create a folder labeled Columbian clients in drop box. Send completed application to Columbian Clients folder in drop box.
Login to "CFG" website.
Click on "Resources", then click "Document Upload"
Fill out page, be sure to check box, send to "new business", product: "final expense", insurance company: "Columbian Life", first name, last name, new application: yes, attach file, browse, from drop box.
-OR-
Cardinal Senior Benefits Submission Link:
https://www.cognitoforms.com/Access15/cardinalseniorbenefitsapplicationsubmissionform

For E-App, login to CFG Agent portal and follow this image ➡➡

After Submitting
Moving file from "Applications" folder to "Client" folder
Log client into Senior Agent Tools

APPLICATION FOR INDIVIDUAL WHOLE LIFE INSURANCE POLICY

COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: PO Box 1381, Binghamton, NY 13902-1381

MAIL POLICY TO: ☐ **Owner** ☐ **Agent** **Reference ID:** _____

1. PROPOSED INSURED

First Name	Middle Initial	Last Name	Social Security No./Green Card No.

Sex ☐ M ☐ F	Age (Last Birthday)	Date of Birth (MM/DD/YYYY)	State (USA) / Country of Birth	Home Phone: Cell Phone: Email:

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

Answer only for ages 25-35: Do you have a Driver's License? ☐ YES ☐ NO
If YES, please provide your Driver's License No. and State.
If NO, please provide details in Section 6 Special Requests / Remarks on Page 3.

Driver's License No.	State

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

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

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

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

To designate a Contingent Owner, provide information in Section 6 Special Requests / Remarks on Page 3.

3. BENEFICIARY For multiple Primary or Contingent Beneficiaries, provide additional beneficiary information including % share in Section 6 Special Requests/ Remarks on Page 3.

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

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

Mailing Address/Apt. #, Street	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.	Home Phone: Cell Phone: Email:

Mailing Address/Apt. #, Street	City	State	Zip Code

4. POLICY INFORMATION ☐ Check here if you are willing to accept any plan shown below, for which you qualify based on this application. The insurance for which you qualify may have a return of premium death benefit for the first two (2) or three (3) years, a face amount less than indicated on this application and riders may not be available. Adjust the face amount to match premium? ☐ Yes ☐ No

Requested Effective Date / Draft Date		Base Plan of Insurance
____ / ____ / _____		☐ Full Benefit Whole Life - Dignified Choice **Classic Elite** ☐ Full Benefit Whole Life - Dignified Choice **Classic Select** ☐ Graded Benefit Whole Life – Dignified Choice **Classic Advantage** ☐ Graded Benefit Whole Life – Dignified Choice **Classic Security**

TOBACCO USE
Have you used any form of tobacco or nicotine products, including cigarettes, cigars, pipes, e-cigarettes, chewing tobacco, snuff, nicotine patches or nicotine gum, within the last 12 months? ☐ YES ☐ NO

Amount Paid / Received with Application (Indicate $0 if initial premium is to be drafted.)	Amount of Insurance (Face Amount)	Amount of Base Modal Premium (Minus Riders)	Riders (If available)	Rider Premium	Automatic Premium Loan (**MUST select Yes or No**)
$_____	$_____	$_____	☐ Accidental Death Benefit ☐ Children's Term Insurance Rider ☐ Accelerated Benefit Rider – Terminal Illness	$_____ $_____ (No Charge)	☐ Yes ☐ No

Payment Frequency ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

Payment Method ☐ Draft 1st Premium* ☐ Automated Electronic Funds Transfer * ☐ Direct Bill (Annual, Semi-Annual or Quarterly only)
*If selecting Draft 1st Premium or EFT, please complete authorization on Page 4. ☐ List Bill / Group Bill (if available)

Dignified Choice®

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.

What is your current height and weight? HEIGHT _____Ft. _____In. WEIGHT _____lbs.

PART 1 (If any question in this section is answered "YES," DO NOT SUBMIT THE APPLICATION)	**YES**	**NO**
1. Are you currently hospitalized, confined to a nursing home, hospice, bed, assisted living facility, convalescent home, institutionalized, receiving home health care, or confined to a wheelchair due to illness or disease?	☐	☐
2. Have you ever been diagnosed by a member of the medical profession as having or tested positive for Human Immunodeficiency Virus (HIV), or having an Immune Deficiency Disorder, 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?	☐	☐
3. Have you ever been recommended by a member of the medical profession, for an organ or bone marrow transplant, or ever had a heart, lung, liver or bone marrow transplant, or ever had an amputation due to disease or, within the last twelve (12) months, received kidney dialysis?	☐	☐
4. Are you awaiting a diagnosis or test result, or been advised by a member of the medical profession to have a surgical operation, a diagnostic test (except for HIV) other than for routine screening, that has not been completed?	☐	☐
PART 2 (If any question in this section is answered "YES," the Proposed Insured will be considered for the Classic Security Graded Benefit plan.)	**YES**	**NO**
1. Have you ever been diagnosed by a member of the medical profession with, or received treatment for: mental retardation, Down's Syndrome, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, sickle cell anemia, or Huntington's Disease?	☐	☐
2. Have you ever been diagnosed or treated (including taking medication) by a member of the medical profession with congestive heart failure, Alzheimer's disease, dementia or Lou Gehrig's disease (ALS), or received a cardiac defibrillator implant (except pacemaker implant)?	☐	☐
3. During the last twenty-four (24) months, have you been diagnosed or treated (including taking medication) by a member of the medical profession for any form of cancer, including, leukemia, melanoma or any other internal cancer (other than basal cell skin cancer)?	☐	☐
4. During the last six (6) months have you been diagnosed by a member of the medical profession as having a heart attack?	☐	☐
PART 3 (If any question in this section is answered "YES," the Proposed Insured will be considered for the Classic Advantage Graded Benefit plan. If two or more questions are answered "YES," the Proposed Insured will be considered for the Classic Security Graded Benefit plan.)	**YES**	**NO**
1. Have you ever been diagnosed, treated, (including taking medication), tested positive for, or been advised by a member of the medical profession to seek treatment for chronic lung disease, chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, black lung disease, chronic respiratory disorder (excluding asthma or sleep apnea), or used oxygen to assist with breathing (except for sleep apnea)?	☐	☐
2. During the last thirty-six (36) months, have you been diagnosed or received treatment (including taking medication) by a member of the medical profession for:		
a. Kidney disease, kidney failure, liver disease, chronic hepatitis, drug or alcohol abuse or dependency, sarcoidosis or Systemic Lupus?	☐	☐
b. Multiple Sclerosis, Parkinson's Disease, schizophrenia, brain tumor or have you been hospitalized or institutionalized for a mental or nervous disorder?	☐	☐
3. In the past thirty-six (36) months, have you:		
a. Been on probation, parole, been convicted of, or pled guilty to any crime or to possession or distribution of drugs or any other illegal substance?	☐	☐
b. Been convicted of three (3) or more moving violations, or been convicted of driving under the influence of alcohol or drugs?	☐	☐
4. During the last twenty-four (24) months, have you been diagnosed by a member of the medical profession as having: A stroke (including TIA), aneurysm, enlarged heart, angina, peripheral vascular disease, pacemaker implant, stent, angioplasty, bypass surgery, or any procedure to improve the circulation to the brain?	☐	☐
5. During the last thirty-six (36) months, 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), Peripheral Artery Disease (PAD) or Peripheral Vascular Disease (PVD), or diabetes not under control with current treatment, or have you used insulin for the treatment of diabetes prior to age 50?	☐	☐
6. During the last seven to twenty-four (7–24) months have you been diagnosed by a member of the medical profession as having a heart attack?	☐	☐
PART 4 (If any question in this section is answered "YES," the Proposed Insured will be considered for the Classic Select Full Benefit Plan. If two or more questions are answered "YES," the Proposed Insured will be considered for the Classic Advantage Graded Benefit plan.) If all questions in all sections are answered "NO," the Proposed Insured will be considered for the Classic Elite Full Benefit plan.	**YES**	**NO**
1. In the past five (5) years, have you been diagnosed, treated, (including taking medication), tested positive for, or been advised by a member of the medical profession to seek treatment for cancer, leukemia, melanoma or any other internal cancer (except basal cell carcinoma)?	☐	☐
2. Have you ever been diagnosed, treated, (including taking medication), tested positive for, or been advised by a member of the medical profession to seek treatment for chronic asthma or atrial fibrillation?	☐	☐
3. Are you currently requiring the assistance of another person in performing any ADL's (Activities of Daily Living) including eating, bathing, dressing, toileting, continence, transferring in and out of a bed or chair, or taking medications?	☐	☐

PART 5 Please provide the following details for your most recent consultation with a physician or medical facility.

Date of last visit	Name & Address of Physician or Medical Facility	Reason Consulted	Treatment / Diagnosis

6. SPECIAL REQUESTS / REMARKS / CONTINGENT OWNER DESIGNATION / ADDITIONAL BENEFICIARY INFORMATION

7. REPLACEMENT **YES** **NO**

Does any Proposed Insured have any existing life insurance or annuities?..... ☐ ☐

Is this application for insurance intended to replace 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. 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. No information about the Proposed Insured will be considered to have been given to the Company unless it is stated in this application. 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 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.

9. 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 person proposed for insurance, to give any such information to Columbian Life Insurance Company ("the Company") or its reinsurers for underwriting or claims purposes. 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, 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. **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 (Parent/Guardian if 15 or under) — (Date)

_____ X _____

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

10. 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.)

HAS THE TELEPHONE INTERVIEW BEEN COMPLETED? ..... ☐ YES ☐ NO

Primary Agent Name	Agent Number	Agent % Split
Secondary Agent Name	Agent Number	Agent % Split

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)

SECONDARY ADDRESSEE / THIRD PARTY DESIGNEE

(The Applicant/Owner may designate a Secondary Addressee/Third Party to receive a copy of notifications of a past due premium and possible lapse in coverage.)

☐ Not Designating A Secondary Addressee/Third Party At this Time; or

☐ Designating a Secondary Addressee / Third Party (include full name and address of the designee):

_____

PAYOR (Complete only if the Payor is not the Owner.)

First Name	Middle Initial	Last Name or Company Name if the Payor is a Corporation		
Mailing Address (Apt. #, Street)		City	State	Zip Code
Home Phone: Cell Phone:		Email:		

INITIAL PREMIUM PAYMENT

Amount of Initial Premium: $ _____

☐ Draft initial premium from the account below at a future date. **If you select an initial premium draft date in the future, you will not have potential coverage until that date under the Conditional Receipt.**
- When specifying a day of the month (the 1st through the 28th), the first draft must be within 30 days of the application date.
- When specifying a day of the week and week of the month (e.g., the third Wednesday of the month), the first draft must be within 35 days of the application date.

☐ Draft initial premium **upon receipt** of the application at Columbian's office, from the account below. **Please note that your bank account may be debited the same day your agent submits this application.**

☐ 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.**

ONGOING PREMIUM PAYMENTS

☐ Direct Bill (not available for monthly payment mode)

☐ Electronic Funds Transfer

I request withdrawal of payments on: (CHOOSE ONE) Date (1st through 28th) _____ (OR) Week (1st - 4th) _____ / Day (Mon - Fri) _____

beginning in the month of _____ .

BANK ACCOUNT AUTHORIZATION (Complete if initial 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, you shall be under no liability in the event the dishonored debit results in forfeiture of insurance.

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 of issue.

Financial Institution _____ Account Type: ☐ Checking **(attach voided check if available)** or ☐ Savings

Transit / Routing Number ☐☐☐☐☐☐☐☐☐ Must have 9 digits in routing number.

Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ May have up to 17 positions in account number.

_____ _____ X _____

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

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

COLUMBIAN MUTUAL LIFE INSURANCE COMPANY • HOME OFFICE: BINGHAMTON, NY
COLUMBIAN LIFE INSURANCE COMPANY • HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICES:
VESTAL PARKWAY EAST • PO BOX 1381 • BINGHAMTON, NY 13902-1381
507 PLUM STREET • PO BOX 1056 • SYRACUSE, NY 13201-1056

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES ___ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name Date

_____ _____
Producer's Signature and Printed Name Date

I do not want this notice read aloud to me. _____ *(Applicants must initial only if they do not want the notice read aloud.)*

SUPPLEMENTAL APPLICATION FOR CHILDREN'S TERM INSURANCE RIDER

COLUMBIAN LIFE INSURANCE COMPANY
HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: PO Box 1381, Binghamton, NY 13902-1381

This application supplements Application Form No. _____, dated _____.

CHILDREN'S TERM INSURANCE RIDER AMOUNT OF INSURANCE APPLIED FOR: _____

You can apply for coverage on a maximum of 20 children as defined below.

Please attach a 2nd Supplemental Application for Children's Term Insurance to list more than 10 Proposed Insured children.

1. CHILDREN PROPOSED FOR INSURANCE

Name natural born children, stepchildren, legally adopted children, grandchildren, step grandchildren, legally adopted grandchildren, great grandchildren, step great grandchildren and legally adopted great grandchildren proposed for insurance. Insurance will not be provided on newborn children less than 15 days of age or children that are not US citizens.

Full Name of Proposed Insured Child	Address and Telephone Number	Date of Birth MM/DD/YYYY	Age Last Birthday	Social Security No.
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

2. BENEFICIARY (If a trust, give Trustee Name, Trust Name & Trust Date. If no Beneficiary is named for any child, the Beneficiary Designation defaults to the Insured of the base policy.) Attach a separate sheet if necessary.

Primary Beneficiary Designation (Full name and address)	Relationship to Insured	Social Security No.
	Telephone Number	Date of Birth
Contingent Beneficiary Designation (Full name and address)	Relationship to Insured	Social Security No.
	Telephone Number	Date of Birth

3. HEALTH HISTORY

	YES	NO
1. Has any child proposed for insurance ever been diagnosed as having or been treated by a member of the medical profession for an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or has any Proposed Insured Child tested positive for Human Immunodeficiency Virus (HIV)?.....	☐	☐
2. Has any child proposed for insurance ever used or received treatment, advice or counseling from a physician or other practitioner relating to the usage of alcohol, heroin, cocaine, narcotics, hallucinogens, tranquilizers, barbiturates, amphetamines, or other similar drugs except as prescribed by a physician?.....	☐	☐
3. Has any child proposed for insurance ever been diagnosed or treated (including taking medication) for high blood pressure, heart or circulatory disorder, cancer, mental disorder, mental retardation, Down's Syndrome, muscular dystrophy, spina bifida, cystic fibrosis, kidney or liver disease, diabetes, sickle cell anemia, seizures, cerebral palsy, paralysis, had or been recommended for an organ transplant or been hospitalized for asthma or any respiratory disorder in the past twelve (12) months?.....	☐	☐

If any of these questions are answered "YES" that child will be excluded from coverage. Please list the children for which "YES" answers were given:

_____

4. ACKNOWLEDGEMENT & SIGNATURES

I declare and represent that the foregoing statements and answers have been correctly recorded and that they are full, complete and true to the best of my knowledge and belief and shall constitute a part of the application.

_____ X _____
Date — Signature of Primary Insured

_____ X _____
Date — Signature of Licensed Agent — Agent Number

FORM NO. A613TX-CL

COLUMBIAN MUTUAL LIFE INSURANCE COMPANY • HOME OFFICE: BINGHAMTON, NY
COLUMBIAN LIFE INSURANCE COMPANY • HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICES:
4704 VESTAL PARKWAY EAST • PO BOX 1381 • BINGHAMTON, NY 13902-1381
507 PLUM STREET • PO BOX 1056 • SYRACUSE, NY 13201-1056

AUTHORIZATION TO RELEASE INFORMATION TO MY INSURANCE AGENT OR AGENCY

I authorize Columbian Mutual Life Insurance Company or Columbian Life Insurance Company ("the Company") to disclose personal and medical information about me to my insurance agent and/or agency.

Information that the Company may disclose includes medical information and other personal information as it relates to actions the Company may have taken based on this information. These include changing benefits or riders to something other than I applied for, ordering requirements, or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that I may refuse to sign this authorization. If I refuse to sign, it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time by writing to the Company at: Columbian Financial Group, Attn: Underwriting, PO Box 1381, Binghamton, NY 13902.

I realize that my right to revoke this authorization is limited to the extent that the Company has taken action in reliance on the authorization.

I understand that I can request a copy of this authorization.

Signature of Applicant:_____ Date:_____

Signature of Agent:_____ Date:_____