# APPLICATION FOR INDIVIDUAL WHOLE LIFE INSURANCE POLICY

## COLUMBIAN MUTUAL LIFE INSURANCE COMPANY

HOME OFFICE: Binghamton, NY
ADMINISTRATIVE SERVICE OFFICE: PO Box 4850, Norcross, GA 30091-4850

**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<br>If YES, please provide your Driver's License No. and State.<br>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**

| **Requested Effective Date / Draft Date** | Payment Options | Base Plan of Insurance |
|---|---|---|
| _____ / _____ / _____ | ☐ Whole Life | ☐ Full Benefit Whole Life - Dignified Choice **Classic Elite**<br>☐ Full Benefit Rated Whole Life – Dignified Choice **Classic Select**<br>☐ Two Year Graded Benefit Whole Life – Dignified Choice **Classic Advantage**<br>☐ Three Year Graded Benefit Whole Life – Dignified Choice **Classic Security** |

**Dividend Option (Choose One):** ☐ Paid in Cash ☐ Paid-Up Additions ☐ Accumulate at Interest ☐ Reduce Premium (Not Available if EFT)

**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<br>☐ Children's Term Insurance Rider | $_____<br>$_____ | ☐ Yes<br>☐ 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. ☐ Family Group Bill (if available)



**Dignified Choice®**

**5. HEALTH HISTORY**

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

| | YES | NO |
|---|---|---|
| **PART 1 (If any question in this section is answered "YES," DO NOT CONTINUE, YOU ARE NOT ELIGIBLE FOR THE PLANS OF INSURANCE ON THIS APPLICATION.)** | | |
| 1. Are you currently hospitalized, confined to a nursing home, hospice, bed, assisted living facility, convalescent home, correctional facility, institutionalized, receiving home health care, or confined to a wheelchair due to illness or disease? | ☐ | ☐ |
| 2. Have you ever been diagnosed by a licensed member of the medical profession as having Human Immunodeficiency Virus (HIV), or having an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? | ☐ | ☐ |
| 3. 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? | ☐ | ☐ |
| 4. 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? | ☐ | ☐ |
| 5. Are you awaiting a diagnosis or test result (except for HIV), 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 may be eligible for the Three Year Graded Benefit Dignified Choice Classic Security plan; please proceed to Section 6 on Page 3.)** | **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 may be eligible for the Two Year Graded Benefit Dignified Choice Classic Advantage plan. If two or more questions are answered "YES," the Proposed Insured may be eligible for the Three Year Graded Benefit Dignified Choice Classic Security plan.)** | **YES** | **NO** |
| 1. Have you ever received care or treatment (including taking medication) 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 may be eligible for the Full Benefit Rated Dignified Choice Classic Select plan. If two or more questions are answered "YES," the Proposed Insured may be eligible for the Two Year Graded Benefit Dignified Choice Classic Advantage plan.) If all questions in all sections are answered "NO," the Proposed Insured may be eligible for the Full Benefit Dignified Choice Classic Elite plan.** | **YES** | **NO** |
| 1. In the past five (5) years, have you received care or treatment (including taking medication) 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 received care or treatment (including taking medication) 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. (Attach a separate sheet if necessary.)**

| 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**

**DISCLOSURE NOTICE IF APPLYING FOR THE TWO YEAR GRADED BENEFIT DIGNIFIED CHOICE CLASSIC ADVANTAGE PLAN OR THE THREE YEAR GRADED BENEFIT DIGNIFIED CHOICE CLASSIC SECURITY PLAN: SINCE THIS POLICY IS ISSUED WITH MINIMAL OR NO MEDICAL UNDERWRITING, THE PREMIUM RATE CHARGED INCLUDES AN EXTRA MORTALITY RISK CHARGE. IF YOU ARE HEALTHY ENOUGH TO QUALIFY AS A "STANDARD" RISK, PREMIUMS WOULD LIKELY HAVE BEEN LOWER IF YOU HAD APPLIED FOR A FULLY UNDERWRITTEN POLICY.**

| **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 of the Proposed Insured.

**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 Mutual Life Insurance Company ("the Company") or its reinsurers for underwriting or claims purposes. This authorization also includes information about prescription drug records, or any other medical history information (excluding psychotherapy notes). Additional authorizations may be required for the release of records pertaining to treatment for drug use or alcoholism. 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 Mutual 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. 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.

_____ **X** _____

Date of Application — Signature of Proposed Insured (Date)

_____ **X** _____

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

**X** _____

Witness Signature (If signed outside the presence of the Agent) (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 Mutual 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

## INFORMATION PRACTICES RELATING TO UNDERWRITING YOUR APPLICATION

Thank you for choosing insurance from Columbian Mutual Life Insurance Company. This Notice is given to you at the time you apply for life 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 persons or organizations listed in the Authorization & Acknowledgement.

**ACCESS TO INFORMATION**
You may request, in writing, to receive information from Columbian Mutual 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 Mutual Life Insurance Company, PO Box 4850, Norcross, GA 30091-4850.

**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 Mutual 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 Payment Received

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

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

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

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

(1) You had paid the full first modal premium on the policy applied for; and
(2) All Proposed Insureds were insurable at standard rates on the date of the application; and
(3) The Company is able to issue the policy as applied for; and
(4) The amount of insurance applied for, with respect to any Proposed Insured, is not in excess of $70,000.

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.**



**LEAVE WITH PROPOSED INSURED/OWNER**