COLUMBIAN MUTUAL LIFE INSURANCE COMPANY
HOME OFFICE: 4704 Vestal Parkway East
PO Box 1381, Binghamton, NY 13902-1381
(800) 423-9765 / www.cfglife.com

APPLICATION FOR INDIVIDUAL TERM LIFE INSURANCE POLICY

DATED AT (CITY, STATE)	DATE OF APPLICATION	MAIL POLICY TO: ☐ Agent ☐ Owner

1. PROPOSED INSURED

Name (Last, Middle Initial, First)	Social Security Number	Sex	Age	Date of Birth	State of Birth

Home Address/Apt. No., City, State, Zip Code	Phone Number: ☐ Home ☐ Work ☐ Cell ( )

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

Name of Owner	Social Security Number	Relationship to Proposed Insured

Mailing Address/ (If different from Insured)

3. BENEFICIARY	Name & Address	Relationship	Telephone No.	Social Security No.
Primary				
Contingent				

4. POLICY INFORMATION

Email Address

Plan of Insurance:	Riders:	Amount of Insurance (Face Amount):	Amount Paid with Application:
☐ 15 Year Term ☐ 20 Year Term ☐ 30 Year Term 50% Return of Premium Benefit ☐ 20 Year Term ☐ 30 Year Term	☐ Accidental Death Benefit ☐ Waiver of Premium – Disability ☐ Children's Term Insurance Rider	$_____	$_____

Payment Mode:
☐ Annual $_____ ☐ Semi-Annual $_____ ☐ Quarterly $_____
☐ EFT - Please specify Annual, Semi-Annual, Quarterly or Monthly _____ $_____

☐ Draft 1st Premium? (Draft date must be within 30 days of application date. Please see EFT options on Page 4.)

Requested Effective Date:

Children's Rider Amount: _____ Units (Children are natural, step, and legally adopted children.)

Name	Sex	Date of Birth	Height / Weight	Beneficiary
			/	Applies to all Children, including Children added after Issue Date.
			/	
			/	NAME:
			/	
			/	RELATIONSHIP:

If applying for Children's Term Insurance Rider, please provide the amount of existing insurance on each Proposed Insured Child and the Applicant. Attach a separate sheet if necessary.

Dividend Options: ☐ Cash ☐ Premium Reduction ☐ Dividend Accumulations *If no option is elected, dividends will be used toward Premium Reduction, unless premiums are being paid by Electronic Funds Transfer, in which case, the default election is Cash.

5. AGENT INFORMATION

Agent [1] Name	%	Writing No.	Agent [2] Name	%	Writing No.	GA Name	GA No.

FAMILY SOLUTIONS DIVISION

6. HEALTH HISTORY

SECTION A. YES NO

1. Are all proposed insureds US citizens, permanent US residents or holding a permanent Visa? ☐ ☐
2. Are you currently employed? If "NO," please explain _____ ☐ ☐
   Occupation: _____
   Annual Income: _____ Total Household Income: _____
3. Do you have a Driver's License? If "NO," please provide details: _____ ☐ ☐
   If "YES," Driver's License No. and State: _____
4. In the past three (3) years, has any proposed insured:
   - Been on probation or parole for, convicted of, or pled guilty to any crime or to possession or distribution of drugs or any other illegal substance? ☐ ☐
   - Been convicted of three or more moving violations, been convicted of driving under the influence of alcohol or drugs, or had a driver's license suspended or revoked? ☐ ☐

   If "YES" to above, please provide details: _____
5. Have you used tobacco or any nicotine products in the past twelve (12) months (to include cigarettes, cigars, snuff/chew/dip, pipes, nicotine patch or nicotine gum)? ☐ ☐

SECTION B. If "YES" to questions in Sections B or C, please provide details in chart below. YES NO

1. Has any proposed insured been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infections (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or health care provider? ☐ ☐
2. Has any proposed insured ever received or been recommended by a member of the medical profession for an organ or bone marrow transplant? ☐ ☐
3. Is any proposed insured currently:
   a. Bedridden or confined to any hospital, nursing home, or other medical facility? ☐ ☐
   b. Using any of the following: walker, wheelchair, electric scooter, oxygen or catheter? ☐ ☐

   If "YES," please provide details: _____
4. Current Height: _____ Current Weight: _____
   Any unexplained history of weight loss of more than 10 lbs. in the last year? ☐ ☐
   If "YES," please provide details: _____
5. In the past three (3) years has any proposed insured:
   a. Engaged in: hang-gliding, cliff diving, scuba diving over 130 feet, parachuting, skydiving, rock or mountain climbing, speeds (in any vehicle) in excess of 100 mph (land or water) or plan such activity in the next 2 years? ☐ ☐
   b. Flown as a student pilot, or private pilot with over 250 flight hours per year, used an ultra-light aircraft or plan such activity in the next 12 months? ☐ ☐

SECTION C YES NO

1. In the past three (3) years, has any proposed insured been declined, postponed, rated or denied reinstatement or asked to pay extra premium by any insurance company? ☐ ☐
2. In the past five (5) years, has any proposed insured:
   a. Used cocaine, narcotics, hallucinogens, barbiturates, amphetamines, marijuana or other drugs except as prescribed by a physician? ☐ ☐
   b. Been advised by a healthcare professional to reduce or stop alcohol or drug use or received treatment for alcohol or drug abuse? ☐ ☐
3. Does any proposed insured have or has had a diagnosis by a member of the medical profession of diabetes prior to the age of 35 and/or experienced 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? ☐ ☐
4. In the past ten (10) years, has any proposed insured received a diagnosis by a member of the medical profession of or required follow-up for:
   a. Cancer (other than basal cell or squamous cell carcinoma of the skin), leukemia, or lymphoma? ☐ ☐
   b. Stroke (CVA), transient ischemic attack (TIA), paralysis? ☐ ☐
   c. Systemic lupus, sarcoidosis, rheumatoid arthritis, Crohn's Disease or ulcerative colitis, degenerative muscle or nerve disease/disorder, immune system or connective tissue disease/disorder? ☐ ☐
   d. Schizophrenia, bipolar disorder, major depression, mental retardation, Down's Syndrome, Alzheimer's disease, dementia, Parkinson's disease or Multiple Sclerosis? ☐ ☐
   e. Coronary artery disease, heart attack, coronary bypass surgery (CABG), coronary angioplasty (PTCA), heart valve replacement, angina, heart arrhythmia, congenital heart disease, cardiomyopathy, congestive heart failure (CHF), pacemaker, defibrillator, aneurysm, disease or disorder of the brain, peripheral arteries, blood, liver, pancreas, or kidney (other than kidney stones)? ☐ ☐
   f. Emphysema, COPD or asthma that has required one or more acute emergency care visits or an inpatient hospitalization? ☐ ☐
   g. Epilepsy and recurring seizures with the last seizure occurring within the past year? ☐ ☐
5. Is any proposed insured awaiting a diagnosis by or been advised by a member of the medical profession to have a surgical operation, a diagnostic test, except for HIV, or a medical or mental evaluation that has not been completed? ☐ ☐
6. In the past five (5) years, has any proposed insured been prescribed medication or taken any medication prescribed by a physician or been hospitalized or consulted a physician or medical facility for any reason? ☐ ☐

TABLE FOR "YES" ANSWERS IN SECTIONS B OR C – Attach a separate sheet if necessary.

Person Proposed for Insurance	Medication Name (Copy from Pharmacy Label)	Date last taken	Name & Address of Physician or Medical Facility	Treatment / Diagnosis	Dates & Durations

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. 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 Mutual Life Insurance Company ("the Company") or its reinsurers for underwriting or claims purposes. This authorization also includes information about drug records, or any other medical history information (excluding psychotherapy notes). 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 Home 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, and will survive my death if it occurs during such two (2) year period. 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 _____

Dated At (City, State) — Signature of Owner (If other than Insured) (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.)

I hereby affirm that I personally solicited, witnessed, and completed this application and all answers given above are true and correct to the best of my knowledge.

_____ X _____

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

_____ _____ _____

Agent Number % — Second Agent Number % (If Splitting) — Agent's State License ID No. (in jurisdictions where required)

MISCELLANEOUS — Complete, If Applicable – Not Required In All States

SECONDARY ADDRESSEE / THIRD PARTY DESIGNEE ☐ Not Electing A Secondary Addressee/Third Party At this Time.

(The Applicant/Owner may designate a Secondary Addressee/Third Party to receive a copy of Important Notices.)

Name & Address:

Secondary Addressee / Third Party Authorization

I hereby give permission to accept any Important Notices on behalf of the named Proposed Insured.

X _____

Signature of Secondary Addressee/Third Party (If Required)

INITIAL PREMIUM OPTIONS - DO NOT USE FOR DRAFT 1st PREMIUM

☐ CHECK ENCLOSED

☐ ONE TIME ELECTRONIC FUNDS TRANSFER – IMMEDIATE WITHDRAWAL (Must Complete In Full.)

For the one time Electronic Funds Transfer, your agent will submit your application for insurance and this authorization for payment to Columbian Mutual Life Insurance Company ("the Company"). By signing this form, you authorize the Company to initiate an electronic funds transfer from your bank account.

Please note that your bank account may be debited the same day your agent submits this authorization. The below hereby authorizes the Company to draw an electronic fund transfer from my bank account for payment of new life insurance.

This will be a one time withdrawal from my account in the amount of $ _____ from the account detailed below.

Financial Institution _____ Name of Bank Account Holder: _____

Account Type ☐ Checking or ☐ Savings

Transit / Routing # | | | | | | | | | | Must have 9 digits in routing #

Account Number | | | | | | | | | | | | | | | | | | Can have up to 17 positions in account #

_____ X _____

Date — Authorized Signature as it appears on Bank Records (one time withdrawal)

IF YOU WISH TO CONTINUE MAKING PREMIUM PAYMENTS VIA ELECTRONIC FUNDS TRANSFER, PLEASE COMPLETE THE INFORMATION BELOW AND SIGN. PLEASE NOTE: YOU NEED ONLY INCLUDE THE ACCOUNT INFORMATION IF IT IS DIFFERENT THAN STATED ABOVE.

REQUEST FOR ELECTRONIC FUNDS TRANSFER PLAN

☐ DRAFT FIRST

☐ ONGOING EFT DRAFT

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 _____ ☐ Checking (Attach voided check if available.) or ☐ Savings

Transit / Routing # | | | | | | | | | | Must have 9 digits in routing #

Account # | | | | | | | | | | | | | | | | | | Can have up to 17 positions in account #

I request withdrawal of payments on: Date (1st - 28th)_____ beginning in the month of _____ .

_____ _____ X _____

Name of Bank Account Holder — Date — Authorized Signature as it appears on Bank Records (ongoing withdrawals)

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 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 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 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 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 Full Modal Premium Is Received With Application

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 $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. A582NY-NOTICE

LEAVE WITH PROPOSED INSURED/OWNER