

Telephone Application with Voice Signature Wyoming

Dear Insured/Applicant:

Thank you for your application for SafeShield® Term life insurance. Your verbal answers were obtained by phone and used to complete the questions on the life insurance application, and your voice signature was secured by digital recording. The completed application and your voice signature have been submitted to the Company's administrative service office for processing.

To protect the privacy of information collected and transmitted during the application process, the data is encrypted and stored in secured databases. All of the Company's data and systems are secured using current technology standards and procedures that undergo a variety of internal and external audits and reviews of the process and systems to ensure they are kept current.

I am providing you with printed versions of the following documents, which were read to you during the application process. Please keep these documents with your important insurance papers.

- Application Authorization & Acknowledgment
- Information Practices Relating to Underwriting Your Application
- Conditional Receipt
(applicable if initial premium is to be paid by immediate bank draft)
- Living Benefit Rider Disclosures, Form No. 5419CFG
(only if applying for Accelerated Benefit - Terminal Illness, Critical Illness or Chronic Illness Rider(s))
- Important Notice: Replacement of Life Insurance or Annuities, Form No. 4086CFG
(applicable if the applicant has existing life insurance or annuities / a replacement is occurring)

Thank you for giving us the opportunity to serve you and your insurance needs. We appreciate your business and are dedicated to providing you with the highest level of service.

Form No. 5376CFG-WY-SIT (Rev. 11/21)

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

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.**

Date of Application	X	Signature of Proposed Insured		(Date)
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?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is this insurance intended to replace, in whole or part, any life insurance or annuities?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<i>(If "YES," submit any special forms required by the state in which the application is signed.)</i>		
Is the agent related to the Proposed Insured or Owner? If "YES," please provide relationship _____	<input type="checkbox"/> YES	<input type="checkbox"/> 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.

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

INFORMATION PRACTICES RELATING TO UNDERWRITING YOUR APPLICATION

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

INVESTIGATIVE CONSUMER REPORT

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

IDENTIFICATION

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

ACCESS TO INFORMATION

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

WHERE TO WRITE US

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

MIB, INC. PRE-NOTICE

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

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

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

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

CONDITIONAL RECEIPT

Complete Only When Full Modal Premium Is Received With Application

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

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

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

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

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

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

Date X _____
Signature of Licensed Agent

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

COLUMBIAN MUTUAL LIFE INSURANCE COMPANY

Home Office:

Box 1381, Binghamton, NY 13902-1381

COLUMBIAN LIFE INSURANCE COMPANY

Home Office: Chicago, IL

Administrative Service Office:

P.O. Box 1381, Binghamton, NY 13902-1381

Accelerated Death Benefit Rider Disclosure

The insurance contract you are applying for may include one or more of the riders described below. The riders allow the Policyowner to receive a portion of the policy's death benefit during the lifetime of the Insured if the Insured is diagnosed by a physician with a qualifying condition as defined in the Rider. Please read your Policy and Rider(s) carefully and consult your Rider(s) for specific information.

Accelerated Death Benefit - Terminal Illness: This Rider allows the Owner to request payment of a portion of the death benefit of the policy if the Insured is diagnosed with a non-correctable medical condition which, in the best medical judgment of a physician, will result in the death of the Insured within twelve (12) months from the date of the diagnosis.

Accelerated Death Benefit - Critical Illness: This Rider allows the Owner to request payment of a portion of the death benefit of the policy if the Insured is diagnosed with one or more of the following as defined in the rider: Amyotrophic Lateral Sclerosis (ALS), Life Threatening Cancer, End Stage Renal Failure (Kidney Failure), Myocardial Infarction (Heart Attack), Major Organ Failure, or Stroke.

Accelerated Death Benefit - Chronic Illness: This Rider allows the Owner to request payment of a portion of the death benefit of the policy if the Insured is diagnosed with a Chronic Illness. Chronic Illness means the Insured is (a) unable to perform, without substantial assistance from another person, at least two of the activities of daily living for a period of at least 90 days due to a loss of functional capacity or, (b) requires substantial supervision by another person to protect the Insured from threats to health and safety due to the insured's severe cognitive impairment for a period of at least 90 days.

Premium Charge

There is no additional premium charge for the Riders; however, an administrative fee will be deducted from the accelerated benefit payment each time a Rider benefit is exercised.

Accelerated Benefit Payment

The request for a benefit must be made in writing and signed by the Owner. Consent of any assignee or irrevocable beneficiary will be required. A spousal release will be required, if applicable, in community property states.

The Acceleration Amount is chosen by the Owner, subject to minimum and maximum limits. Each Acceleration Amount must be at least \$5,000 and must allow for at least \$5,000 residual face amount. The aggregate maximum for all Acceleration Amounts under all Riders is 95% of the eligible death benefit of the Policy on the date of the first acceleration. Under the Chronic Illness Rider, the maximum amount that may be accelerated in any 12-month period is 24% of the eligible death benefit.

The Acceleration Benefit Amount will be based on the Insured's expected mortality at the time of claim as determined by the Company. **Some qualifying events can impact the Insured's quality of life without having a material impact on their mortality and, therefore, the acceleration benefit may be quite small or there may be no acceleration benefit payable at all.**

Upon receipt of a request for rider benefits, the Company will provide the Owner and any irrevocable beneficiary with a written offer showing the amount of the rider benefit as well as the impact of the acceleration on the death benefit and premium amounts. The Owner may accept or decline the offer. If the offer is accepted, the Owner and any irrevocable beneficiary will be provided a statement demonstrating the effect of the acceleration. The policy will be modified with an endorsement indicating the new death benefit and premium amounts.

Effects of Accelerated Benefit Payment

An accelerated death benefit payment will result in a reduction in face amount and base policy premium. There will be no reduction in the annual policy fee, if applicable. Payment of the benefit will have no effect on any Children’s Term Insurance or Accidental Death Benefit. Any Waiver of Premium coverage and the associated premiums will reduce due to the reduction in face amount.

The following examples are hypothetical and intended only to demonstrate how an individual assessment of mortality could affect an Acceleration Benefit Amount. The examples bear no relationship to any actual claims you may make or benefit amounts you may receive. They demonstrate the effects of acceleration and are provided for illustrative purposes only, and have no relationship to your policy premiums or values. In both examples, the Owner has a term policy and has elected an acceleration of \$60,000, or 60% of the policy’s eligible death benefit. For policies that have cash values, policy loans or dividends at the time of acceleration, those values will typically be reduced proportionately to the reduction in face amount.

In this example, the Insured has a qualifying condition that makes his likelihood of death 3 times what it was without the condition.

	<u>Before Acceleration</u>	<u>After 60% Acceleration</u>
Base Policy Face Amount	\$100,000.00	\$40,000.00
Base Policy Annual Premium (excluding policy fee)	\$979.00	\$391.60
Annual Policy Fee	\$60.00	\$60.00
Total Base Policy Annual Premium (including Policy Fee)	\$1,039.00	\$451.60
Accelerated Benefit Payment (after administrative fee)		\$12,923.20

Same as the above example, except the qualifying condition makes his likelihood of death 8 times what it was without the condition.

	<u>Before Acceleration</u>	<u>After 60% Acceleration</u>
Base Policy Face Amount	\$100,000.00	\$40,000.00
Base Policy Annual Premium (excluding policy fee)	\$979.00	\$391.60
Annual Policy Fee	\$60.00	\$60.00
Total Base Policy Annual Premium (including Policy Fee)	\$1,039.00	\$451.60
Accelerated Benefit Payment (after administrative fee)		\$34,731.11

RECEIPT OF ACCELERATED DEATH BENEFITS MAY BE TAXABLE. YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR TO DETERMINE THE CURRENT TAX CONSEQUENCES PRIOR TO MAKING ANY ELECTION.

These Riders are not long-term care insurance and do not provide long-term care benefits. The benefits are not intended to qualify for favorable tax treatment. The Riders may affect your ability to receive certain government benefits or entitlements. The Accelerated Death Benefit may be considered an asset in determining eligibility. You should contact your local Medicaid Unit and the Social Security Administration for more information.

I hereby acknowledge that I have read and understand these disclosures and have received a copy for my records.

Signature of Applicant/Owner

Date

Printed Name of Applicant/Owner

Social Security Number

I certify that I have provided a copy of this statement to the Applicant/Owner.

Signature of Licensed Agent

License No.

Date

Applicant Copy

**IMPORTANT NOTICE REQUIRED BY
THE COMMISSIONER OF
INSURANCE**

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

REPLACEMENT NOTICE

ASK QUESTIONS - IT'S YOUR MONEY - GET THE FACTS

Whether it is to your advantage to replace or change your existing insurance or annuity program, only you can decide. It is in your best interest to obtain adequate information in order to compare relatively short and long range costs and benefits before a final decision is made.

The producer or insurance company assisting you with this new purchase must notify your existing producer or company so that they may prepare a detailed, current statement concerning your existing program for your comparison. Statements and illustrations should not, however, be used as the sole basis to compare policies or contracts. We want you to understand the effects of replacements before you make your purchase decision, and ask that you review the statements listed under "Items to Consider."

EXISTING INSURANCE WHICH MAY BE REPLACED OR CHANGED

Full Name of Insurance Company Including Home Office Location	Policy or Contract Number*	Name of Insured
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surrender Charge of Policy Being Replaced _____% and \$_____

Sales Charge of Policy Being Purchased (if applicable) \$_____

New Surrender Period and Surrender Charges of Policy Being Purchased.

Years										
% Charge										

Years										
% Charge										

*If a number has not been assigned by the existing insurer, indicate alternative identification, such as an application or receipt number.

ITEMS TO CONSIDER

1. Due to a possible change in insurability status (health, occupation or high risk recreational activities), you might be denied new coverage, or the premium may be higher than a standard premium.
2. The Incontestability and Suicide Clause time periods would probably begin anew in a new policy. This could possibly result in a claim being denied that might otherwise have been paid under an existing policy or contract.
3. Your present insurance company may be able to modify your existing plan on terms which may be more favorable for you than completely replacing it with a new policy or contract.
4. Don't terminate or alter your existing policy until after the new policy has been delivered to you and accepted by you.
5. If you terminate your existing policy, you may incur surrender charges and/or penalties. The new policy you are purchasing may have a new surrender charge period and/or sales charges.
6. There may be tax consequences in replacing an existing policy. Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code? Is this transaction a "tax free" exchange? See your tax advisor for specific tax advice regarding the proposed transaction.
7. Take your time in making your decision about purchasing the new policy. Gather all information about the new policy and compare it to your old policy. Remember, you do not have to make a decision during the first meeting with your sales person.
8. REMEMBER: Following receipt of a new life insurance policy or annuity contract you should immediately examine its contents. If you are not satisfied with it for any reason, you have the right to return it within the thirty (30) day "examination period" to the insurer at its home office or branch office or to the producer through whom it was purchased, for a full refund of premium. If you do return the policy or contract, you should request a dated receipt indicating that it was returned.

DID YOU READ THE "ITEMS TO CONSIDER"?

Applicant's Signature Date

Producer's Signature Date

Applicant's Name (printed)

Producer's Name (printed) & License No.

Address

Address

City, State, Zip Code

City, State, Zip Code

Telephone Number

Telephone Number

COLUMBIAN LIFE INSURANCE COMPANY • HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICES:
PO BOX 1056 • SYRACUSE, NY 13201-1056
PO BOX 1381 • BINGHAMTON, NY 13902-1381

WYOMING DEFINITION OF REPLACEMENT

Wyoming's regulation governing replacement of life insurance policies and annuities requires you to provide the applicant with a completed Replacement Notice, Form No. 4086CFG, if a replacement is occurring.

According to the Wyoming regulation, a replacement is defined as any transaction in which new life insurance or a new annuity is to be purchased, and it is known or should be known to the proposing producer or to the proposing insurer if there is no producer, that by reason of such transaction, existing life insurance or annuity has been or is to be:

- (1) Lapsed, forfeited, surrendered, or otherwise terminated;
- (2) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;
- (3) Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
- (4) Reissued with any reduction in cash value; or
- (5) Pledged as collateral or subjected to borrowing, whether in a single loan or under a schedule of borrowing over a period of time for amounts in the aggregate exceeding twenty-five percent (25%) of the loan value set forth in the policy.

If any of the above has or may occur, you must present to the applicant, not later than the time of application, a completed Replacement Notice, Form No. 4086CFG. The form must be signed by you and the applicant, and you must submit one copy to the Company and leave one copy with the applicant. You must also leave a copy of any written or printed communications used for presentation to the applicant.