# NEW BUSINESS CHECKLIST

## KANSAS

### SUBMISSION OPTIONS

ELECTRONIC APPLICATION:
If the application is being submitted electronically, provide the Applicant with the applicable required disclosure documents from the eApp Disclosure Packet, Form No. 5354CFG-KS

FAX:
(877)261-3266
Please include completed Application Fax Cover Sheet, Form No. 3969CL-U

MAIL:
PO Box 1381
Binghamton, NY 13902-1381

EXPRESS MAIL:
4704 Vestal Parkway East
Vestal, NY 13850

### CONTACT

PHONE:
(800)423-9765

EXTENSIONS:
New Business – 4902
Underwriting – 5904
Sales Support – 7582

WEBSITE:
www.cfglife.com

### IMPORTANT INFORMATION:

Do not submit the application if any question in Part 1 or any two questions in Part 2 of the Health History are answered "Yes."

### SUBMIT THE FOLLOWING APPLICABLE FORMS:

☐ **Application**
*Form No. ICC21 A745-CL*

☐ **Accelerated Death Benefit Rider Disclosure**
*Form No. 6180-CL (IC)*
A signed and completed Accelerated Death Benefit Rider Disclosure must be submitted with the application when the rider is being applied for.

☐ **Children's Term Insurance Rider (Grandchild Rider)**
*Form No. ICC18 A640-CL*
A signed and completed Supplemental Application for Children's Term Insurance must be submitted with the application when the rider is being applied for.

☐ **Replacement**
*Due to replacement regulations, replacement business is no longer accepted in the state of Kansas.*

☐ **Initial Premium Payment**
If the initial premium is being submitted with the application, submit a personal check, cashier's check or money order from the Applicant made payable to Columbian Life Insurance Company. If premium will be paid by bank draft, include a voided check or deposit slip if available.

# APPLICATION FOR INDIVIDUAL WHOLE LIFE INSURANCE POLICY

**COLUMBIAN LIFE INSURANCE COMPANY**
HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: 4704 VESTAL PARKWAY EAST
PO Box 1381, Binghamton, NY 13902-1381
(800) 423-9765 / www.cfglife.com

## 1. PROPOSED INSURED

| First Name | Middle Initial | Last Name | Social Security No./Green Card No. | Sex ☐ M ☐ F |
|---|---|---|---|---|
| | | | | |

| Date of Birth (MM/DD/YYYY) | Age (Last Birthday) | State (USA) / Country of Birth | Phone Number ☐ Home ☐ Work ☐ Cell ( ) |
|---|---|---|---|
| | | | |

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

**Answer only for ages 18-35:** 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 7 Special Requests / Remarks on Page 3.

| Driver's License No. | State | **WEIGHT** _____**lbs.** |
|---|---|---|
| | | **HEIGHT** _____**Ft.** _____**In.** |

## 2. BENEFICIARY

For multiple Primary or Contingent Beneficiaries, provide additional beneficiary information including % share in Section 7 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. | Phone Number ☐ Home ☐ Work ☐ Cell ( ) |
|---|---|---|
| | | |

| Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| **CONTINGENT BENEFICIARY First Name** | Middle Initial | **Last Name** | **Relationship to Proposed Insured** |
|---|---|---|---|
| | | | |

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

| Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

## 3. POLICY DELIVERY OPTIONS

**DELIVER TO:** ☐ **Agent** ☐ **Owner**

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

| **First Name, Middle Initial, Last Name** | **Social Security No./Green Card No./Taxpayer Id. No.** | **Relationship to Proposed Insured** |
|---|---|---|
| | | |

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

To designate a Contingent Owner, provide information in Section 7 Special Requests / Remarks on Page 3.

**SECONDARY ADDRESSEE** *(Complete ONLY if Applicant/Owner is designating a Secondary Addressee/Third Party to receive a copy of notifications of a past due premium and possible lapse in coverage)*

| First Name | Middle Initial | Last Name |
|---|---|---|
| | | |

| Street Address | 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) 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

| Base Plan of Insurance | Amount of Insurance (Face Amount) | Amount Paid with Application (Indicate $0 if initial premium is to be drafted.) | Amount of Base Modal Premium (Minus Riders) | Automatic Premium Loan (**MUST select Yes or No**) |
|---|---|---|---|---|
| ☐ Full Benefit Whole Life - Dignified Choice Classic Elite<br>☐ Full Benefit Whole Life - Dignified Choice Classic Select<br>☐ Graded Benefit Whole Life – Dignified Choice Classic Advantage | $_____ | $_____ | $_____ | ☐ Yes ☐ No |



DIGNIFIED CHOICE

| RIDERS (if available) | | |
|---|---|---|
| ☐ Accidental Death Benefit Rider | Premium $ _____ | |
| ☐ Accelerated Death Benefit Rider | Premium $ (No Charge) | |
| ☐ Children's Term Insurance Rider | Premium $_____ | *Complete Supplemental Application for Children's Term Insurance Rider* |

**5. HEALTH HISTORY**

**Any person who knowingly presents a false statement in an application for life insurance may be guilty of a criminal offense and subject to penalties under state law.**

**TOBACCO USE**

1. Have you used any form of tobacco or nicotine products including cigarettes, cigars, pipes, e-cigarettes, chewing tobacco, snuff, nicotine patches, or nicotine gum in the past twelve (12) months? ☐ YES ☐ NO
2. Have you smoked marijuana in the past twelve (12) months? ☐ YES ☐ NO

| **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? | ☐ | ☐ |
| 5. 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? | ☐ | ☐ |
| 6. 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)? | ☐ | ☐ |
| 7. 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)? | ☐ | ☐ |
| 8. During the last six (6) months have you been diagnosed by a member of the medical profession as having a heart attack? | ☐ | ☐ |

| **PART 2 (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," DO NOT SUBMIT THE APPLICATION.)** | **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 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, or brain tumor? | ☐ | ☐ |
| 3. In the past twenty-four (24) months, have you been hospitalized or institutionalized for a mental or nervous disorder? | ☐ | ☐ |
| 4. 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? | ☐ | ☐ |
| 5. 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? | ☐ | ☐ |
| 6. During the last thirty-six (36) months, have you: | | |
| a. been diagnosed by a member of the medical profession as having complications of diabetes, including insulin shock, or diabetic coma, or diabetes not under control with current treatment? | ☐ | ☐ |
| b. been diagnosed by a member of the medical profession as having complications of diabetes, including Retinopathy (eye), Nephropathy (kidney), or Neuropathy (nerve, circulatory), or have you used insulin for the treatment of diabetes prior to age 50? | ☐ | ☐ |
| 7. 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 3 (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 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 4 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. REPLACEMENT:**

| | YES | NO |
|---|---|---|
| Does any Proposed Insured have any existing life insurance or annuities? | ☐ | ☐ |
| Is this application for insurance intended to replace or change any life insurance or annuities now in force? | ☐ | ☐ |

*(If "YES," submit any special forms required by the state in which the application is signed.)*

**7. SPECIAL REQUESTS / REMARKS / CONTINGENT OWNER DESIGNATION / ADDITIONAL BENEFICIARY INFORMATION**

**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. 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.

**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 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, 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 — (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.)*

Is the agent related to the Proposed Insured or Owner? If "YES," please provide relationship _____ ☐ YES ☐ NO

**I hereby affirm that I personally solicited and completed this application and all answers given above are true and correct to the best of my knowledge. The application was signed in my presence.**

_____ **X** _____

Name of Licensed Agent (Print) — 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 1st and 2nd Agent must equal 100%)

**PAYMENT INFORMATION & AUTHORIZATION (The premium quoted may change following underwriting review.)**

**PAYOR IS:** ☐ PROPOSED INSURED ☐ OWNER (if other than Proposed Insured) ☐ OTHER

**OTHER PAYOR (Complete only if the Payor is NOT the Proposed Insured or Owner)**

| First Name | Middle Initial | Last Name or Company Name if the Payor is a Corporation | Relationship to Proposed Insured |
|---|---|---|---|
| | | | |

| Mailing Address (Apt. #, Street) | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Home Phone: | Cell Phone: | Email: |
|---|---|---|
| | | |

**REQUESTED EFFECTIVE DATE:**
**(Use only for backdating. Initial premium amount must include back premiums to requested effective date.)**

**PAYMENT FREQUENCY:** ☐ Monthly (not available for direct bill) ☐ Quarterly ☐ Semi-Annual ☐ Annual

**INITIAL PREMIUM:**

Amount of Initial Premium: $ _____

☐ Draft initial premium from the account below at a future date. **The first draft must be within 35 days of the application 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. Insurance age will be calculated as of the date the premium is drafted.**

☐ Immediate Draft - 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 authorization.**

☐ Check, cashier's check or money order. By signing below, you authorize the Company to initiate an electronic funds transfer from your bank account if payment is made by check. **Please note that your bank account may be debited the same day your agent submits this authorization.**

*Agent, complete the Conditional Receipt only if premium is paid by immediate draft or by check, cashier's check, or money order*

**SUBSEQUENT PREMIUM PAYMENTS MADE BY:**

☐ Direct Bill (Not available for monthly payment mode) ☐ Electronic Funds Transfer (Select option below)

☐ **Choose a specific day (1st -28th)** ***OR*** ☐ **Choose a specific week and day of the month**

_____
Ongoing Premium Draft Day

Select Week: ☐1st Week ☐2nd Week ☐3rd Week ☐4th Week

Select Day: ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday

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 the Company shall be under no liability in the event the dishonored debit results in forfeiture of insurance.

☐ **SOCIAL SECURITY BENEFIT AUTHORIZATION:** If checked, I authorize the Company to adjust the date of withdrawal from my bank account to match my Social Security Benefit deposit.

Any requirement for giving notice of premiums due shall be waived as long as this Electronic Funds Transfer plan is in effect. No premium shall be deemed to have been paid until the Company receives actual payment. The use of this plan shall in no way change the previsions of the policy with respect to the termination of such policy upon nonpayment of the premium due.

This plan shall continue in effect until terminated by the Company or by me by thirty days written notice to the other party. The Company may terminate the EFT plan if any check or electronic fund transfer is not paid on presentation. Upon termination of the Electronic Funds Transfer plan, premiums due under the policy after such termination shall be payable directly to the Company at the minimum modal premium available at the time.

Financial Institution _____ ☐ Checking (*Attach Voided check if available*) ☐ Savings

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

Transit / Routing Number (must have 9 digits)

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | |

Account Number (may have up to 17 digits)

**I have read and understand the above statements in bold regarding the timing for the initial premium to be drawn from my account. I hereby acknowledge that the Company is not responsible to reimburse me if my account has insufficient funds and overdraft fees are charged by the bank.**

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

## INFORMATION PRACTICES RELATING TO UNDERWRITING YOUR APPLICATION

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

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

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

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

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

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

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

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

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

## CONDITIONAL RECEIPT

Complete Only When Payment Received

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 $50,000.

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**

**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

# Important Disclosures
# Accelerated Benefit Rider

This briefly describes the provisions of the Accelerated Benefit Rider. Consult your rider for specific information. Please read your policy and rider carefully.

The Accelerated Benefit Rider allows you to elect to receive an advance on the death benefit of the policy when the Insured is diagnosed as having a non-correctable terminal illness 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. Diagnosis must be made during the time the rider and the policy are in force.

The Accelerated Benefit is equal to fifty percent (50%) of the insured's base policy death benefit. We will pay this amount less any loan (and unpaid loan interest) on the policy, any due and unpaid premium, and an Administrative Service Fee of $250.00. The policy loan and unpaid loan interest will be repaid. There will be no change in premiums. Regular premium payments as specified in the policy will be required in order to keep the policy in force. We will establish a lien against the death benefit of the policy equal to the amount of the Accelerated Benefit, plus accrued interest at the Accelerated Benefit interest rates. At the death of the insured, we will deduct the lien from the death benefit of the policy. If the Policy has a Surrender Value, the total amount of the lien and any policy loans and loan or lien interest will be deducted from the Surrender Value of the policy. If the total of all liens, loans and loan interest equals or exceeds the death benefit of the Policy, the Policy will terminate.

IF AN ACCELERATED BENEFIT IS PAID THE POLICY DEATH BENEFIT AND SURRENDER VALUE WILL BE REDUCED. RECEIPT OF ACCELERATED BENEFITS MAY BE TAXABLE. YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR TO DETERMINE THE CURRENT TAX CONSEQUENCES PRIOR TO MAKING ANY ELECTION.

The rider may affect your ability to receive certain government benefits or entitlements. The Accelerated Benefit may be considered an asset in determining eligibility. You should contact your local Medicaid Unit and the Social Security Administration for more information.

The Accelerated Benefit Rider is not long-term care insurance and does not provide long-term care benefits.

There is no premium charge for the rider; however, there is a $250 Administrative Service Fee for processing an Accelerated Benefit payment.

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I hereby acknowledge that I have received a copy of this statement. I understand that there is no premium charge for the rider, but there will be a $250 Administrative Service Fee for processing an Accelerated Benefit payment. I understand that the rider may affect my ability to receive certain government benefits or entitlements and that receipt of an Accelerated Benefit may be taxable.

| | |
|---|---|
| Signature of Applicant/Owner | Date |
| Printed Name of Applicant/Owner | Social Security Number |
| Signature of Licensed Agent License No. | Date |

**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

# Important Disclosures
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This briefly describes the provisions of the Accelerated Benefit Rider. Consult your rider for specific information. Please read your policy and rider carefully.

The Accelerated Benefit Rider allows you to elect to receive an advance on the death benefit of the policy when the Insured is diagnosed as having a non-correctable terminal illness 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. Diagnosis must be made during the time the rider and the policy are in force.

The Accelerated Benefit is equal to fifty percent (50%) of the insured's base policy death benefit. We will pay this amount less any loan (and unpaid loan interest) on the policy, any due and unpaid premium, and an Administrative Service Fee of $250.00. The policy loan and unpaid loan interest will be repaid. There will be no change in premiums. Regular premium payments as specified in the policy will be required in order to keep the policy in force. We will establish a lien against the death benefit of the policy equal to the amount of the Accelerated Benefit, plus accrued interest at the Accelerated Benefit interest rates. At the death of the insured, we will deduct the lien from the death benefit of the policy. If the Policy has a Surrender Value, the total amount of the lien and any policy loans and loan or lien interest will be deducted from the Surrender Value of the policy. If the total of all liens, loans and loan interest equals or exceeds the death benefit of the Policy, the Policy will terminate.

IF AN ACCELERATED BENEFIT IS PAID THE POLICY DEATH BENEFIT AND SURRENDER VALUE WILL BE REDUCED. RECEIPT OF ACCELERATED BENEFITS MAY BE TAXABLE. YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR TO DETERMINE THE CURRENT TAX CONSEQUENCES PRIOR TO MAKING ANY ELECTION.

The rider may affect your ability to receive certain government benefits or entitlements. The Accelerated Benefit may be considered an asset in determining eligibility. You should contact your local Medicaid Unit and the Social Security Administration for more information.

The Accelerated Benefit Rider is not long-term care insurance and does not provide long-term care benefits.

There is no premium charge for the rider; however, there is a $250 Administrative Service Fee for processing an Accelerated Benefit payment.

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I hereby acknowledge that I have received a copy of this statement. I understand that there is no premium charge for the rider, but there will be a $250 Administrative Service Fee for processing an Accelerated Benefit payment. I understand that the rider may affect my ability to receive certain government benefits or entitlements and that receipt of an Accelerated Benefit may be taxable.

| | |
|---|---|
| Signature of Applicant/Owner | Date |
| Printed Name of Applicant/Owner | Social Security Number |
| Signature of Licensed Agent License No. | Date |

# SUPPLEMENTAL APPLICATION FOR INDIVIDUAL 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 NUMBER OF UNITS 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. Each child rider may have a different Beneficiary. If no Beneficiary is named for any child, the Beneficiary will be the Insured of the base policy. Attach a separate sheet for additional beneficiaries.

| | | |
|---|---|---|
| Primary Beneficiary Designation (Full name and address) For Child Rider #__ (Write All if this beneficiary shall apply to all Child Riders.) | Relationship to Insured | Social Security No. |
| | Telephone Number | Date of Birth |
| Contingent Beneficiary Designation (Full name and address) For Child Rider #__ (Write All if this beneficiary shall apply to all Child Riders.) | 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 or 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) by a member of the medical profession 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. ICC18 A640-CL**

**COLUMBIAN LIFE INSURANCE COMPANY • HOME OFFICE: CHICAGO, IL**
ADMINISTRATIVE SERVICE OFFICE
P.O. BOX 1381 • BINGHAMTON, NY 13902-1381
Phone (800) 305-1335
**www.cfglife.com**

# FAX COVER SHEET
# Dignified Choice® Final Expense

## *Columbian Life New Business Only*

## FAX TO: (877) 261-3266

NAME OF PROPOSED INSURED: _____

*****Please submit a separate fax cover for each application*****

TOTAL NUMBER OF PAGES: _____

PRODUCT NAME: _____

AGENT NAME: _____

AGENCY NAME: _____

AGENT EMAIL: _____

AGENT PHONE NUMBER: _____

**Do not reduce when copying applications. Form number on each form must be legible.**

***Fax cover sheet for Columbian Life Final Expense NEW BUSINESS applications only***