COLUMBIAN MUTUAL LIFE INSURANCE COMPANY • HOME OFFICE: BINGHAMTON, NY
COLUMBIAN LIFE INSURANCE COMPANY • HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE:
PO BOX 1381 • BINGHAMTON, NY 13902-1381
www.cfglife.com

FAX TO: (866) 253-9459

APPLICATION FAX COVER SHEET CHECKLIST For ALL PRODUCTS ADMINISTERED IN THE BINGHAMTON OFFICE:
Total Number of Pages: _____

NAME OF PROPOSED INSURED:_____

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

Before faxing the application, complete the following checklist to ensure prompt processing and service:

☐ **Properly signed and completed application**

☐ **Properly signed and completed supplemental forms, i.e.:**
- **HIPAA Form No. 4636CFG**
- **For face amounts of $100,000 or more:** state-specific HIV Consent Form
- **As needed:** Applicable state required disclosure if applying for the Accelerated Death Benefit Option (Caring Solutions and ParMaster) and any other state required disclosure forms, i.e.: **NEW YORK** - **Definition of Replacement form 2207NY, PENNSYLVANIA - Disclosure Form 713CFG**

☐ **Properly completed forms as defined by the state in which the application is signed for existing insurance and/or replacement (please remember that all 1035 exchanges are replacements).**

☐ **ILLUSTRATIONS: For TERMLINE you must submit a signed Illustration or an unsigned Illustration with a completed 4259CFG NAIC Alternate Illustration form.**

☐ **Completed AUTHORIZATION FOR ONE TIME ELECTRONIC FUND TRANSFER.**

OR

☐ **Signed Authorization to Fax Check and Check for initial premium (no money orders). Personal and agency checks must be made payable to Columbian and signed by the account holder.**

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

Faxed by: _____

Your E-Mail Address: _____

Your Phone No.: _____

Authorization for Release of Health-Related Information to

COLUMBIAN MUTUAL LIFE INSURANCE COMPANY • HOME OFFICE: BINGHAMTON, NY
COLUMBIAN LIFE INSURANCE COMPANY • HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICES:
VESTAL PARKWAY EAST • PO BOX 1381 • BINGHAMTON, NY 13902-1381
507 PLUM STREET • PO BOX 1056 • SYRACUSE, NY 13201-1056
25 TECHNOLOGY PARKWAY S, SUITE 200 • PO BOX 4850 • NORCROSS, GA 30091-4850

This authorization complies with the HIPAA Privacy Rule

Name of proposed insured/patient (please print) _____ Date of birth / / Social Security No _____ / /

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed, and any other protected health information concerning me to Columbian Life Insurance Company/ Columbian Mutual Life Insurance Company (Columbian) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Columbian may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Columbian.

This authorization shall remain in force for two (2) years following the date of my signature below, and **a copy of this authorization is as valid as the original.** I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Columbian at Administrative Service Office: Vestal Parkway East, P.O. Box 1381, Binghamton, NY 13902-1381 Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Columbian has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Columbian may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

X _____

Signature of Proposed Insured (Parent/Guardian if 15 or under) Date

X _____

Agent Name Writing Number

Form No. 4636CFG (Rev. 2/12)

COLUMBIAN MUTUAL LIFE INSURANCE COMPANY • HOME OFFICE: BINGHAMTON, NY
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ADMINISTRATIVE SERVICE OFFICES:
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25 TECHNOLOGY PARKWAY S, SUITE 200 • PO BOX 4850 • NORCROSS, GA 30091-4850

ACCOUNT VERIFICATION
Electronic Draft Information
To be used with EFT authorization
if no voided check/deposit slip is available

FINANCIAL INSTITUTION: _____

ADDRESS: _____

_____

_____

PHONE #: _____

ACCOUNT TYPE : ( ) CHECKING or ( ) SAVINGS

ROUTING NUMBER: ☐☐☐☐☐☐☐☐☐
must have 9 digits in routing #

ACCOUNT NUMBER: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Can have up to 17 digits in account #

PAYOR'S NAME: (Please Print):_____, has a current account with the above financial institution and they will permit account drafts.

I do hereby attest that I personally verified this information.

AGENT NAME (Print): _____

AGENT SIGNATURE: _____ DATE: _____

COMMENTS: _____

FORM NO 4740CFG (Rev 1/12)

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

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

COLUMBIAN MUTUAL LIFE INSURANCE COMPANY • HOME OFFICE: BINGHAMTON, NY
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ADMINISTRATIVE SERVICE OFFICES:
VESTAL PARKWAY EAST • PO BOX 1381 • BINGHAMTON, NY 13902-1381
WIDEWATERS PARKWAY • PO BOX 1056 • SYRACUSE, NY 13201-1056
TECHNOLOGY PARKWAY S • PO BOX 4850 • NORCROSS, GA 30091-4850

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

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

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

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

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

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

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

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

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

The existing policy or contract is being replaced because _____

_____.

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

_____ _____
Applicant's Signature and Printed Name Date

_____ _____
Producer's Signature and Printed Name Date

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

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:
- Are they affordable?
- Could they change?
- You're older -- are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:
- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:
- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:
- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
- What are the tax consequences of buying the new policy?
- Is this a tax free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

If a replacement is involved in the purchase of the new policy or contract, you may return it within thirty (30) days of receipt for a full refund of all premiums or considerations paid on it, including any policy fees or charges. For a variable or market value adjustment policy or contract, the amount paid will be the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations or imposed under the policy or contract. If the policy or contract is returned, the coverage will be considered void from the beginning.

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

APPLICATION FOR INDIVIDUAL WHOLE LIFE INSURANCE

FGN: _____

1. PROPOSED INSURED First Name	Middle Initial	Last Name	Citizen of What Country

Social Security No. / Green Card No.	Sex	Birth State	Date of Birth	Age	Occupation

Residence Address (Street, City, State, Zip Code)	Contact Information Home: Cell: Email:
Mailing Address; If Different From Street Address	

2. OWNER Name & Address	Relationship	Social Security No. / Green Card No.	Email

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

4. POLICY INFORMATION

Send Premium Notices to: ☐ Insured ☐ Owner ☐ Other
If Other, Name & Address:

Payment Mode
☐ Annual $_____ ☐ Semi-Annual $_____ ☐ Quarterly $_____ ☐ Monthly EFT $_____
☐ Monthly (Debit Collection) $_____

Premium Class ☐ Tobacco ☐ Non-Tobacco	Face Amount $_____	Premium Paid $_____

5. OPTIONAL BENEFITS / RIDERS (If Available)

Accidental Death Benefit Waiver of Premium Benefit
ADB and WP are automatically included unless specified otherwise in "Remarks."

☐ Level Convertible Term Rider
Amount: _____

☐ Children's Term Insurance Rider
Amount: _____

Beneficiary: Applies to all Children, including Children added after Issue Date.
(Include Name, Address, Telephone, SSN, and Relationship)

Name	Date of Birth	Sex	Age	Social Security #

☐ Other Insured Term Rider Amount: ☐ Tobacco ☐ Non-Tobacco Relationship:

Name

Birth State	Birth Date	Sex	Age	Social Security #	Occupation

Beneficiary: (Include Name, Address, Telephone, SSN, and Relationship)

6. AGENT INFORMATION

Agent Name	Writing #	GA Name	GA #

7. HEALTH HISTORY

If any question is answered "YES" for the Base Proposed Insured, do not submit the application.
If any question is answered "YES" for the Other Insured, he or she is not eligible for the Other Insured Term Rider coverage.
Please complete the GUARANTEED ISSUE application if appropriate.

If any question is answered "YES" for a proposed insured child, please include the child's name in the Special Requests / Remarks section.
For any child for which a "YES" answer is given, that child will be excluded from coverage.

		YES	NO
1.	Is any Proposed Insured currently hospitalized, institutionalized, confined to a nursing home, hospice, receiving home health care, or permanently confined to a bed, ever been diagnosed by a member of the medical profession with Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or 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?……	☐	☐
2.	Have any persons proposed for insurance ever had, or been recommended by a member of the medical profession for, an organ or bone marrow transplant?.....	☐	☐
3.	Have any persons proposed for insurance ever been diagnosed by, or received treatment from a member of the medical profession for: congestive heart failure, sickle cell anemia, mental retardation, Down's Syndrome, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, Lou Gehrig's disease, Alzheimer's disease or dementia?.....	☐	☐
4.	Have any persons proposed for insurance ever been diagnosed by, or received treatment from a member of the medical profession for congenital heart disease, had an amputation due to disease, or is confined to a wheelchair due to a disease or chronic illness?.....	☐	☐
5.	During the last five (5) years, have any persons proposed for insurance, been diagnosed by or received treatment from a member of the medical profession (including taking medication), for any form of cancer (other than basal cell skin cancer), kidney disease, liver disease, chronic hepatitis, drug or alcohol abuse, or Systemic Lupus?.....	☐	☐
6.	Is any male proposed insured over 350 pounds, or is any female proposed insured over 300 pounds?.....	☐	☐
7.	During the last five (5) years, have any persons proposed for insurance been diagnosed by a member of the medical profession as having: A stroke (including TIA), aneurysm, a heart attack, enlarged heart, atrial fibrillation, angina, pacemaker or defibrillator implant, stent insertion or any procedure to improve circulation to the heart or brain?.....	☐	☐
8.	During the last three (3) years, have any persons proposed for insurance, been diagnosed by or received treatment from a member of the medical profession (including taking medication), for:		
	A. Emphysema, chronic obstructive pulmonary disease (COPD), black lung disease, any chronic respiratory disorder (excluding sleep apnea), used oxygen equipment to assist in breathing or been treated for asthma that has required one or more acute emergency care visits or inpatient hospitalization?.....	☐	☐
	B. Multiple Sclerosis, Parkinson's Disease, schizophrenia, brain tumor, bipolar disorder or major depression or has the Proposed Insured been hospitalized or institutionalized for a mental or nervous disorder within the last two (2) years?.....	☐	☐
9.	During the last two (2) years, have any persons proposed for insurance experienced complications of diabetes, including insulin shock, diabetic coma, Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve, circulatory), or diabetes not under control with current treatment, or has the Proposed Insured used insulin for the treatment of diabetes prior to age 50?.....	☐	☐
10.	In the past three (3) years have any persons proposed for insurance been on probation, parole, convicted of, or pled guilty to a felony, or have such charge pending against them, or been convicted of driving under the influence of alcohol or drugs or had a driver's license suspended or revoked?.....	☐	☐

8. TOBACCO USE

	YES	NO
Within the past twelve (12) months, has any person proposed for insurance used any form of tobacco or nicotine products including cigarettes, cigars, pipes, chewing tobacco or snuff?.....	☐	☐

9. SPECIAL REQUESTS / REMARKS

10. REPLACEMENT

	YES	NO
Does anyone proposed for insurance 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.)*	☐	☐

11. TELEPHONE INTERVIEW:

A telephone interview may be necessary to verify or supplement information given to us on our application. This interview may be made from our Administrative Service Office or from a consumer-reporting agency by a trained interviewer acting on our behalf. Please enter the information requested below so we can call you at a time and place convenient to you.

Telephone Number: Home: _____ Business: _____

Preferred Time to Call: _____ AM/PM (Local Time) Preferred Place to Call: ☐ Home ☐ Business

12. 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.

13. 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, to give any such information to Columbian Life Insurance Company ("the Company") or its reinsurers for underwriting or claims purposes. This authorization also includes information about drugs, alcoholism, prescription drug records, or any other medical history information. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand my information may be subject to redisclosure to a third party and may no longer be protected by federal privacy laws. I authorize Columbian Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. I understand a telephone interview may be necessary to verify or supplement information given to the Company on this application. This interview may be made from the Administrative Service Office or from a consumer-reporting agency by a trained interviewer acting on the Company's behalf. A photocopy of this form will be as valid as the original; this authorization will be valid for two (2) years from the date shown below, 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.

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

_____	X _____	X _____
Date of Application	Proposed Insured	Applicant/Owner (If other than Proposed Insured)
_____	X _____	X _____
Dated At (City & State)	Proposed Other Insured (Required for Authorization & Acknowledgement)	Parent/Guardian (If Proposed Insured is Under Age 18, or age of majority in the state where the application is signed)

14. REPORT OF LICENSED AGENT

Does the applicant 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.)

Did you see the proposed insured(s) at the time of application?..... ☐ YES ☐ NO

(If "NO" give details in Special Requests / Remarks.)

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 agree to accept any Important Notices on behalf of the named Proposed Insured.

X _____

Signature of Secondary Addressee/Third Party (If Required)

INITIAL PREMIUM OPTIONS

☐ AGENT COLLECTION

☐ 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 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

I authorize the payment of debits drawn on my account payable to Columbian Life Insurance Company, provided there are sufficient funds in the account. I agree that if any such debit be dishonored, you shall be under no liability in the event the dishonored debit results in forfeiture of insurance.

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

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

Financial Institution _____ ☐ 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)_____

_____ _____ 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 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. 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 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 MIB on those individuals about whom we have information about underwriting significance. We will not report what action we have taken on your application. 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 (Name) _____ the sum of _____ dollars. Columbian Life Insurance Company ("we") accepts this payment in connection with an application for insurance having the same date and number, to provide coverage under the following conditions:

EFFECTIVE DATE - The "effective date" is the date of the application or a specific effective date as requested in the application, whichever is later.

CONDITIONS - Insurance coverage will begin on the effective date only if on that date (1) you had paid the full first premium on the policy applied for; and (2) you are insurable and an acceptable risk for the amount and plan requested, and for the premium paid. Otherwise, we shall have no liability except to return your payment.

TERMINATION OF COVERAGE - Any insurance that results from this receipt will terminate immediately: (1) if we offer to refund your payment; or (2) if you have not received the policy within ninety (90) days after the date of this receipt. In this event, we will refund your payment.

_____ 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