SafeShield®

Simplified Issue Term Life Insurance

Agent Guide

Form No. 6147-CL (Rev. 10/15)

COLUMBIAN LIFE INSURANCE COMPANY
HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: BINGHAMTON, NY

BASE PLANS

	SafeShield®	SafeShield® *Plus*
Initial Term Periods	15, 20, or 30 years	20 or 30 years
Benefits	- Level death benefit all years	- Level death benefit all years - Returns 50% or 100% of premiums paid on the base policy at the end of the initial term period
Issue Ages (age last birthday)	15-Year 18 - 65 20-Year 18 - 60 30-Year 18 - 55**	50% ROP* 100% ROP* 20-Year NT 18 - 60 18 - 50 20-Year Tob 18 - 60 18 - 45 30-Year 18 - 50** 18 - 50**
Issue Amounts	$25,000 - $250,000	$25,000 - $250,000
Renewability	Policy may be renewed at annual renewable term premiums to the first policy anniversary on or after the insured's 95th birthday.	Policy may be renewed at annual renewable term premiums to the first policy anniversary on or after the insured's 95th birthday.
Life Event Requirement	None	None
Simplified Underwriting	- MIB - Prescription Drug Database - Motor Vehicle Report - Telephone Interview if needed	- MIB - Prescription Drug Database - Motor Vehicle Report - Telephone Interview if needed
Underwriting Classes	- Standard Non-Tobacco - Standard Tobacco Issued through Table D	- Standard Non-Tobacco - Standard Tobacco Issued through Table D
Modal Factors	Annual 1.00 Semi-Annual .52 Monthly .087 (Monthly available via EFT only)	Annual 1.00 Semi-Annual .50 Monthly .0833 (Monthly available via EFT only)
Policy Fee	$60 Annual Fee (commissionable)	No Policy Fee
Unemployment Premium Waiver* **	Premiums waived for up to 6 months if insured becomes unemployed for 4 weeks or more after the 2nd policy anniversary.	Premiums waived for up to 6 months if insured becomes unemployed for 4 weeks or more after the 2nd policy anniversary.
Dividends	Non-participating	Non-participating
Convertibility	May be converted to permanent insurance after the first policy year and no later than age 65 - 15-Year: through year 10 - 20-Year: through year 15 - 30-Year: through year 25	May be converted to permanent insurance after the first policy year and no later than age 65 - 20-Year: through year 15 - 30-Year: through year 25

*In Pennsylvania, the Return of Premium benefit is called "Endowment Benefit."
**In WA, issue ages for 30-Year Term are 18-50 for non-tobacco and 18-45 for tobacco.
***Unemployment Premium Waiver not available in CT, FL, MA, MD, TN or WA.

OPTIONAL RIDERS

Living Benefit Riders - *available with SafeShield® (non ROP) only*

Accelerated Death Benefit - Terminal Illness

Allows for acceleration of up to 95% of the base policy death benefit if the Insured is diagnosed with a non-correctable medical condition which is expected to result in death within 12 months.

Availability	- Available with Non Return of Premium plans only - All issue ages - No additional health questions

Accelerated Death Benefit - Critical Illness*

Allows for acceleration of up to 95% of the base policy death benefit if the Insured has one or more of the following:

- Life Threatening Cancer
- Amyotrophic Lateral Sclerosis (ALS)
- End Stage Renal Failure (Kidney Failure)
- Myocardial Infarction (Heart Attack)
- Major Organ Failure
- Stroke

Availability	- Available with Non Return of Premium plans only - All issue ages - No additional health questions

Accelerated Death Benefit - Chronic Illness**

Allows for acceleration of up to 24% of the base policy death benefit per year, to a maximum of 95% in total, if the insured is:

- Unable to perform, without substantial assistance from another person, at least two of the activities of daily living (bathing, continence, dressing, eating, toileting and transferring) for a period of at least 90 days, due to a loss of functional capacity; or
- Requires substantial supervision for a period of at least 90 days by another person to protect the insured from threats to health and safety due severe cognitive impairment.

The chronic illness must be diagnosed by a physician as permanent.

Availability	- Available with Non Return of Premium policies with minimum face $42,000 - All issue ages - Two additional health questions - Chronic Illness Rider and Disability Income Rider cannot be attached to the same policy
Premiums	- No additional premium charge
Accelerated Benefit Claims	- Maximum acceleration percentage = 95% of base policy face amount - Minimum face amount accelerated = $10,000 - Minimum residual amount = $5,000 - Minimum acceleration benefit amount = $2,500 - Administrative Charge = $250 (may vary by state) - Accelerated Benefit payment will be reduced by a discount factor based on expected mortality, anticipated future premiums and interest. - Policy values and premiums (except policy fee) will be reduced by the acceleration percentage.
Coverage Period	Riders will terminate when the total accelerated amount under all accelerated death benefit riders attached to the policy equals the maximum accelerated death benefit amount. Terminal Illness Rider will terminate after any accelerated benefit has been paid under the rider.

*Critical Illness Rider not available in CT.

**In CT, benefit may also be used if the insured is permanently confined at home or in an institution.

OPTIONAL RIDERS

Accelerated Benefit Rider - Terminal Illness *available with SafeShield®* Plus (ROP) *only*		
Benefit	Allows for acceleration of 50% of the base policy death benefit if the Insured is diagnosed with a terminal condition and life expectancy of 12 months or less (24 months where required by state).	
Rider Eligibility	- Available with Return of Premium policies only - All issue ages - No additional health questions	
Coverage Period	To the first policy anniversary on or after the insured's 90th birthday	
Premiums	No additional premium charge	
Accelerated Benefit Claims	- $250 administrative fee is deducted from the payment (may vary by state). - Premium amount required to keep the coverage in force for the next 12 months is deducted from the payment (except where prohibited). Premiums resume if the Insured is living at the end of the 12-month period. - The accelerated benefit payment will be treated as a lien against the death benefit and there will be an interest charge assessed. - Receipt of the accelerated death benefit may affect eligibility for public assistance programs and may be taxable.	
Accidental Death Benefit Rider		
Benefit	Additional benefit payable for accidental death of the insured	
Qualifying Event	Death due to bodily injuries which are the direct and independent cause of death occurring within 90 days after the date of an accident	
Benefit Amount	Equal to base policy death benefit. Maximum ADB payable for all Columbian policies combined is $250,000.	
Issue Ages	Same as base plans	
Coverage Period	To the first policy anniversary on or after the insured's 70th birthday	
Children's Insurance Rider		
Benefit	Each Unit provides $1,000 level term insurance on all eligible children	
Issue Ages	Parent: 18 – 55 Child: 15 days – less than 19 years	
Issue Amounts	5 Units – 15 Units	
Coverage Period	Coverage for each insured child ends on the earlier of: - The first policy anniversary on or after the primary insured's 70th birthday; - The insured child's 25th birthday; or - Upon conversion of coverage to a permanent policy If the primary insured dies while the rider is in force, coverage under the rider will remain in force with no further premiums. This benefit is not provided if the insured commits suicide within 2 years of policy issue.	
Eligibility	Natural born children, stepchildren and legally adopted children of the primary insured may become insured under this rider.	
Availability	- Issued through Table D to children eligible at the time of application - Children becoming eligible after rider issue are automatically covered if less than 19 years old	
Convertibility	Up to the amount of the rider: - Until age 21 - Upon rider expiry before age 21 - Upon conversion of base policy	Up to 5 times the amount of the rider or to $50,000, whichever is less: - Between ages 21 and 25

OPTIONAL RIDERS

Waiver of Premium - Disability Rider	
Benefit	Waives all premiums after 6 months of total and continuous disability
Issue Ages	18 – 55
Coverage Period	To the first policy anniversary on or after the insured's 65th birthday. If total and continuous disability begins prior to age 60, premiums will continue to be waived until such disability ceases. If total and continuous disability begins at age 60 or later, premiums payments will resume at age 65.
Availability	Issued through Table D
Disability Income Rider*	
Benefit	Monthly benefit if the insured becomes totally disabled due to injury or sickness. - **Occupational Rider** available for those who are not covered by Worker's Compensation Insurance. Certain occupations are excluded.** - **Off-the-job Rider** available for those who are covered by Worker's Compensation Insurance. This rider does not provide benefits for occupational disabilities.
Issue Ages	20 – 55
Benefit Amounts	Minimum Monthly Benefit: $250 Maximum Monthly Benefit is the lesser of: - 1.5% of the base policy face amount; or - $2,000; or - 50% of the insured's monthly gross income
Maximum Benefit Payable	Lifetime maximum benefit of 24 months for all periods of disability
Coverage Period	To the policy anniversary following the insured's 60th birthday
Availability	- Issued through Table D - Disability Income Rider and Chronic Illness Rider may not be attached to the same policy
Premiums	First-year premiums are guaranteed. Subsequent premiums may change on a class basis only and will not exceed two times the initial premium.

*Disability Income Rider not available in FL, IL, KS, MA or WA. Off-the-job Rider not available in SD.
The following occupations are uninsurable under The **Occupational Rider:

- Asbestos Workers
- Automobile Workers – assembly, factory
- Beauticians – hair stylists and nail salon workers
- Bridge Construction – painter, structural, steel worker
- Building Construction – painter, structural steel worker, tunnel worker, blaster, explosive handler, steeple jack, tower erectors
- Car detailer – to include car wash operators & workers
- Chemical Industry – material handlers, machine operators, maintenance workers
- Daycare/Childcare worker
- Delivery – to include appliance installers
- Dockworkers
- Driver – armored truck, delivery, garbage, hazardous material, trash, emergency vehicle
- Drivers - taxicab
- Fire Fighter
- Fishing Industry – diver, deep sea fisher, dock worker

- Farmers
- Guard – prison or correctional facility
- Home Health Care
- Hospital – attendant, housekeeping, porter
- House cleaning – to include housekeepers & housewives
- Law Enforcement – jailer, matron, parole, probation, police officer – narcotics, vice or undercover, prison guard, bomb squad, riot squad, SWAT
- Lineman – to include all industries
- Longshore Worker
- Lumber Industry/Logging – raft or river crew, crew supervisor
- Lumber Industry/Road Building – workers and crew supervisor
- Lumber Industry/Sawmills – laborer
- Lumber Industry/Woods Crew – fallers (shear operator), chopper, bucker, busheler, choke setter, chainsaw operator, hooker, rigger, etc.
- Lumber Industry/Yard, Lumber – all but non-clerical
- Marine Industry/Seagoing Vessels – sailor, cargo-crew
- Meat Cutter
- Mining Industry – underground mining, blaster or explosive handler
- Oil, Natural Gas Industry – on shore field operations – others, off shore operations – all workers
- Painter – bridge, flagpole, stack, steeple, billboard, high-rise, artist, construction
- Prison – all workers including doctor & nurses
- Public Utilities/Electric – cable splicer, lineman, power line installer/repairer, troubleshooter, tower erectors, tree trimmers, tunnel workers (shaft or subway)
- Quarries - blaster
- Radium Workers
- Restaurant – bartender, cocktail lounge, nightclub
- Rug – carpet layer
- Sanitation, Waste Disposal – incinerator plant, others
- Unskilled workers
- US Deputy Marshall
- US Postal Workers
- Waitress
- Waste Disposal – septic tank, sewage workers
- Wrecking/Demolition – on site or in yard

The above list is a guideline only and may not include all excluded occupations. Please note that occupation is only one factor in the underwriting assessment and that occupation approval does not guarantee acceptance of the rider.

Instructions for Completing the Application

Check the appropriate box at the top of the application to indicate whether the policy will be mailed to you or to the Policyowner. If neither box is checked, the policy will be mailed to the Policyowner. Policies with outstanding delivery requirements will be mailed to the agent regardless of which box is checked.

If a delivery receipt is included with the policy, it must be signed by the Policyowner and returned to the Company.

1. PROPOSED INSURED

Fill this out completely, being sure to include the Social Security number and phone number of the Proposed Insured. When calculating the Proposed Insured's age, if a specific effective date is requested or if the first premium is to be paid by bank draft, calculate the age as of the effective date or draft date, not the application date.

2. OWNER

Complete this section if the Proposed Insured will not be the owner of the policy. Be sure to include the owner's Social Security number. The Policyowner must have an insurable interest in the life of the Proposed Insured. The insurable interest requirement is satisfied if the individual is an immediate family member or would suffer an economic loss by the death of the Proposed Insured. The relationship must be stated on the application.

3. BENEFICIARY

If the Proposed Insured is the Owner, he or she may name the beneficiary of their choice.
If the Owner is other than the Proposed Insured, the beneficiary must have an insurable interest.
The relationship must be stated on the application.

4. POLICY INFORMATION

- Select the plan of insurance and any desired riders.
  - If applying for a Return of Premium policy and the Accelerated Death Benefit Terminal Illness Rider is selected, provide the appropriate Disclosure Statement if required in your state. The Critical Illness and Chronic Illness Riders are not available with Return of Premium policies.
  - If applying for a Non-Return of Premium policy and any of the Accelerated Death Benefit Riders are selected, provide the appropriate Disclosure Statement for your state.
- Indicate the amount of insurance (base plan only) and the amount of premium paid with the application. This should be the total of the amount of base premium plus any rider premiums.
- Payment Mode: Check the payment mode selected. *Monthly payments are available only with Electronic Funds Transfer (bank draft).* If the initial premium will be paid by Draft First Premium, check the Draft 1st Premium box in addition to the payment mode selection.
- Requested Effective Date: The Effective Date of the policy is the Underwriting Date 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. A specific effective date can be requested within the following parameters:
  - Backdating up to 6 months is allowed. All premiums must be submitted with the application.
  - A future effective date up to 30 days from the application date is allowed.

5. HEALTH HISTORY

- If the applicant has a driver's license, be sure to include the Driver's License Number and state of issue in the space provided in Section A, Question 3.

6. DISABILITY INCOME RIDER

Complete this section only if applying for the Disability Income Rider. If the proposed insured is covered by Worker's Compensation, he or she is eligible to apply only for the Off-the-job Rider. The Disability Income Rider and Accelerated Benefit Chronic Illness Rider may not be attached to the same policy.

7. CHRONIC ILLNESS ACCELERATED BENEFIT RIDER

Complete this section only if applying for the Chronic Illness Rider.

8. REPLACEMENT

Answer both replacement questions on the application.

- If the application is signed in a state that has adopted the Model Replacement Regulation:
  - If the Applicant *does not have* any existing life insurance or annuities, your duties with respect to replacement are complete.
  - If the Applicant *does have* existing life insurance or annuities, you must complete the appropriate replacement notice for your state, even if the existing insurance or annuities are not being replaced. The notice must be read aloud to the Applicant, unless he or she initials the bottom of the form indicating that they have declined to have it read aloud.
- If the application is signed in a state that has not adopted the Model Regulation, complete the appropriate replacement notice if the Applicant answers "yes" to the second replacement question: *"Is this application for insurance intended to replace any life insurance or annuities now in force?"*

A replacement should be recommended only when it is in the best interest of the Applicant. Columbian does not condone unwarranted or unsuitable replacements. Any time that you complete a replacement notice, you must submit a copy with the application and leave a copy with the Applicant, as well as copies of all sales materials used in the presentation.

9. SPECIAL REQUESTS/REMARKS

Use this space to add any details regarding the application.

11. AUTHORIZATION & ACKNOWLEDGEMENT

The Proposed Insured must sign the application. A Power of Attorney signature will not be accepted. If the Owner will be other than the Insured, the Owner must sign as well. Signatures are to be witnessed by the Agent. If the signature was not witnessed by the Agent, the reason must be noted under "Special Requests/Remarks."

Note: The application must be received by the Company within 30 days of signature.

12. REPORT OF LICENSED AGENT

Answer both replacement questions.

INITIAL PREMIUM PAYMENT

Check the appropriate box to indicate whether the initial premium will be paid by draft at a future date, by immediate draft or by check, cashier's check or money order.

ONGOING PREMIUM PAYMENTS

Indicate whether ongoing premium payments will be billed or paid by electronic funds transfer.

CONDITIONAL RECEIPT

Complete this section *only if premium is submitted with the application*. If requesting Draft First Premium, do not complete the receipt.

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.cflife.com

APPLICATION FOR INDIVIDUAL TERM LIFE INSURANCE POLICY

MAIL POLICY TO: ☐ Agent ☒ Owner

1. PROPOSED INSURED

Name (Last, Middle Initial, First)	Social Security Number	Sex	Age	Date of Birth	State of Birth
Doe, John	999-99-9999	M	30	8/14/85	GA

Home Address/Apt. No., City, State, Zip Code: 123 Peachtree Blvd. Anywhere, GA 12345

Phone Number: ☒ Home ☐ Work ☐ Cell: (123) 456-7890

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

Name of Owner | Social Sec... Number | Relationship to Proposed Insured

Mailing Address/ (If different from Insured)

Complete this section if the owner will be other than the insured. Specify relationship to insured.

3. BENEFICIARY

	Name & Address	Relationship	Telephone No.	Social Security No.
Primary	Jane Doe	Spouse	123-45-6790	222-22-2222
Contingent				

Be sure to specify the relationship of the beneficiary to the insured.

4. POLICY INFORMATION

Email Address

PLAN OF INSURANCE:
☐ 15 Year Term ☐ 20 Year Term ☐ 30 Year Term

50% Return of Premium Benefit
☐ 20 Year Term ☒ 30 Year Term

100% Return of Premium Benefit
☐ 20 Year Term ☐ 30 Year

RIDERS:
☒ Accidental Death Benefit
☐ Waiver of Premium – Disability
☒ Children's Term Insurance Rider
☐ Accelerated Death Benefit – Chronic Illness
☐ Accelerated Death Benefit – Critical Illness
☒ Accelerated Death Benefit – Terminal Illness
☐ Disability Income Rider
Monthly Benefit _____

AMOUNT OF INSURANCE (Face Amount): $ 100,000

AMOUNT PAID WITH APPLICATION: $ 48.00

Payment Mode: ☐ **Annual** $_____ ☐ **Semi-Annual** $_____
☒ **EFT - Please specify Annual, Semi-Annual or Monthly** Monthly $ 48.00
☐ **Draft 1st Premium?** (Please see Initial Payment Options on Page 4.)

Requested Effective Date / Draft Date:

Children's Rider Amount: 10 **Units (Children are natural, step, and legally adopted children.)**

Name	Sex	Date of Birth	Height / Weight	Beneficiary
David Doe	M	5/8/14	31" / 24 lbs.	Applies to all Children, including Children added after Issue Date.
			/	
			/	NAME: John Doe
			/	
			/	RELATIONSHIP: Father

5. HEALTH HISTORY

SECTION A.	YES	NO
1. Are all proposed insureds US citizens, permanent US residents or holding a permanent Visa?	☒	☐
2. Are you currently employed? If "NO," please explain _____	☒	☐
Occupation: Engineer		
Annual Income: $50,000 Total Household Income: $97,000		
3. Do you have a Driver's License? If "NO," please provide details: _____	☒	☐
If "YES," Driver's License No. and State: Georgia License #123456789		
4. In the past three (3) years, has any proposed insured:		
▪ 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?	☐	☒
▪ Been convicted of three or more moving violations, been convicted of driving under the influence of alcohol or drugs, or had a driver's license suspended or revoked?	☐	☒
If "YES" to above, please provide details: _____		
5. Have you used any form of tobacco or nicotine products including cigarettes, cigars, pipes, e-cigarettes, chewing tobacco, snuff, nicotine patches or nicotine gum, within the last twelve (12) months?	☐	☒

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MIB

Application form may vary by state.

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

1. Has any proposed insured been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infections (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a member of the medical profession? ☐ ☒
2. In the past five (5) years has any proposed insured ever received or been recommended by a physician for an organ or bone marrow transplant? ☐ ☒
3. Is any proposed insured currently:
   a. Bedridden or confined to any hospital, nursing home, or other medical facility? ☐ ☒
   b. Using any of the following: walker, wheelchair, electric scooter, oxygen or cath[illegible]? ☐ ☒
   If "YES," please provide detai[illegible]
4. a. What is your current heigh[illegible] HEIGHT 5 Ft. 8 In. WEIGHT 164 lbs.
   b. Any unexplained history o[illegible] ☐ ☒
   If "YES," please provide details: _____
5. In the past three (3) years has any proposed insured:
   a. Engaged in: hang-gliding, cliff diving, scuba diving over 130 feet, parachuting, skydiving, rock or mountain climbing, speeds (in any vehicle) in excess of 100 mph (land or water) or plan such activity in the next 2 years? ☐ ☒
   b. Flown as a student pilot, or private pilot with over 250 flight hours per year, used an ultra-light aircraft or plan such activity in the next 12 months? ☐ ☒
   If "YES," to either question please provide details: _____

Be sure to include height and weight.

SECTION C YES NO

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

TABLE FOR "YES" ANSWERS IN SECTIONS B OR C

Person Proposed for Insurance	Medication Name (Copy from Pharmacy Label)	Date last taken	Name & Address of Physician or Medical Facility	Treatment / Diagnosis	Dates & Durations
John Doe	Amoxicillin	9/20/14	Dr Brown 12[illegible]ain St Anywhere GA	Sinus infection	9/20/14

6. ANSWER ONLY IF APPLYING FOR THE DISABILITY INCOME RIDER [illegible]O

1. Are you currently covered by Workers Compensation? ☐
   (If yes, you are only eligible to apply for an Off-the-Job Disability Income Ri[illegible]
2. Occupation Information:
   a. Description of duties _____
   b. Have you been working full-time (at least 30 hours per week) for the last 12 mo[illegible]s? ☐ ☐
   c. If self-employed, % of time working at home? _____
3. What is the monthly amount of any individual disability insurance you have in force? _____
4. In the past ten (10) years, have you received care or treatment for, or been diagnosed by a member of the medical profession as having:
   a. Fibromyalgia, Chronic Fatigue Syndrome, Chronic Epstein-Barr, Rheumatoid Arthritis or other inflammatory arthritis? ☐ ☐
   b. Inflammatory Bowel Disease including Crohn's Disease or Ulcerative Colitis, Diabetes, Skin or Connective Tissue Disorder? ☐ ☐
   c. Disease or impairment of the spinal column, neck or back, including acute and Chronic neck or back strain; herniated disc syndrome, surgery of the spine or back, acute and chronic sciatica, or congenital disorders of the spinal column and back? ☐ ☐
   d. Recurring disease or impairment of other bones or joints, e.g. wrist, knee, or shoulder? ☐ ☐
   e. Any emotional or psychological disorder, including stress, anxiety, depression or nervous system disorder (including Grand mal Epilepsy)? ☐ ☐
5. In the past five (5) years, have you filed for or received Disability, Worker's Comp[illegible]ion or State Disability benefits? ☐ ☐
   If yes, please provide details _____

Answer only if applying for Disability Income Rider. Disability Income Rider and Chronic Illness Rider cannot be attached to the same policy.

7. ANSWER ONLY IF APPLYING FOR THE CHRONIC ILLNESS ACCELERAT[illegible]

1. Do you require any assistance or supervision to perform any of the follow[illegible] walking, transferring to or from bed or chair, or maintaining continence?
2. Have you ever been diagnosed by a member of the medical profession for, treated by a member of the medical profession for any of the following:
   a. Memory loss, cognitive impairment, organic brain syndrome? ☐ ☐
   b. Fractures due to osteoporosis, numbness, tremors, imbalance or any conditions [illegible]ich limits motion or mobility? ☐ ☐

Answer only if applying for Chronic Illness Rider. This rider is available with non-return of premium plans only. Chronic Illness Rider and Disability Income Rider cannot be attached to the same policy.

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8. REPLACEMENT:

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

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

9. SPECIAL REQUESTS / REMARKS:

10. 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.

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

7/15/15
Date of Application

X John Doe 7/15/15
Signature of Proposed Insured (Date)

Anywhere, GA
Dated At (City, State)

X _____
Signature of Owner (If other than Insured) (Date)

12. REPORT OF LICENSED AGENT:

Does any Proposed Insured have any existing life insurance or annuities?.....	☒ YES	☐ NO
Is this insurance intended to replace, in whole or part, any life insurance or annuities?.....	☐ YES	☒ NO

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

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

Frank Agent
Name of Licensed Agent (Print)

X _____
Signature of Licensed Agent *(required)* (Date)

12345 100%
Agent Number %

_____
Second Agent Number % (If Splitting)

123456789
Agent's State License ID No. (in jurisdictions where required)

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SECONDARY ADDRESSEE / THIRD PARTY DESIGNEE

(The Applicant/Owner may designate a Secondary Addressee/Third Party to receive a copy of notifications of a past due premium and possible lapse in coverage.)

☒ Not Designating A Secondary Addressee/Third Party At this Time; or

☐ Designating a Secondary Addressee / Third Party (include full name and address of the designee):

PAYOR (Complete only if the Payor is not the Owner.)

Complete this section if premiums will be paid by someone other than the Policyowner.

First Name	Middle Initial	Last Name		
Mailing Address (Apt. #, Street)		City	State	Zip Code
Home Phone:	Cell Phone:	Email:		

INITIAL PREMIUM PAYMENT

☐ Draft initial premium from the account below at a future date. **If you select an initial premium draft date in the future, you will not have potential coverage until that date under the Conditional Receipt.**
- When specifying a day of the month (the 1st through the 28th), the first draft must be within 30 days of the application date.
- When specifying a day of the week and week of the month (i.e., the third Wednesday of the month), the first draft must be within 35 days of the application date.

☒ Draft initial premium **upon receipt** of the application at Columbian's office, from the account below. **Please note that your bank account may be debited the same day your agent submits this application.**

☐ Check, cashier's check or money order

ONGOING PREMIUM PAYMENTS

☐ Direct Bill (not available for monthly payment mode)

☒ Electronic Funds Transfer

I request withdrawal of payments on: (CHOOSE ONE) Date (1st through 28th) 15th (OR) Week (1st - 4th) _____ / Day (Mon - Fri) _____

beginning in the month of August .

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, 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 First Bank of Anywhere Account Type: ☒ Checking **(attach voided check if available)** or ☐ Savings

Transit / Routing Number 1 2 3 4 5 6 7 8 9 Must have 9 digits in routing number.

Account Number 1 2 3 4 5 6 7 8 9 0 9 8 7 6 5 4 3 May have up to 17 positions in account number.

John Doe
Name of Bank Account Holder

7/15/15
Date

X John Doe
Authorized Signature as it appears on Bank Records

Unacceptable Risks

- **AIDS/ARC/HIV:** Has been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infections (Symptomatic or Asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or healthcare provider.
- **ALCOHOL:**
  - If in the past 5 years the proposed insured has been advised to stop alcohol use or received treatment and the proposed insured is still drinking alcohol; or
  - Ages 18 – 65 with less than 4 years since treatment; or
  - Ages 18 – 30 with 4 – 5 years since treatment; or
  - Ages 18 – 65 with relapse since treatment.
- **ALZHEIMER'S DISEASE/DEMENTIA:** In the past 10 years, received diagnosis of or required follow-up.
- **ASTHMA:** If moderate/severe, if a smoker or with complications.
- **BEDRIDDEN:** Currently bedridden or confined to any hospital, nursing home, or other medical facility.
- **CANCER:**
  - If cancer has spread to the regional lymph nodes or adjacent structure or if there is any metastasis
  - Hodgkin's Disease, Leukemia, lymphoma, liver, lung or pancreatic cancer
  - If it has been less than 5 years since cancer treatment
  - Carcinoma in situ and cancer that is confined to the tissue or organ of origin may be considered five years after diagnosis or treatment, but medical records may be required to help in the determination of acceptable risk.
- **CORONARY ARTERY/HEART DISEASE/HEART ATTACK/HEART SURGERY:** In the past 10 years, received diagnosis of or required follow-up for Aneurysm, Angina, Heart Arrhythmia, Cardiomyopathy, Congenital Heart Disease, Congestive Heart Failure, Coronary Angioplasty (PTCA), Coronary Bypass Surgery (CABG), Heart Attack, Heart Valve Replacement, Valve Disorder, Pacemaker, or Defibrillator. Heart disease diagnosed or treated more than 10 years ago may be considered, but medical records may be required to help in the determination of acceptable risk.
- **CRIMINAL HISTORY:** In the past 3 years, been on probation, parole, arrested, convicted, pled guilty to any crime or possession or distribution of drugs or other illegal substances.
- **CVA (Stroke) & TIA (Transient Ischemic Attack) (Mini Stroke):**
  - All cases less than 1 year from date of event;
  - If less than 40 at age of event;
  - All ages with moderate to severe residuals.
- **DEGENERATIVE MUSCLE or NERVE DISEASE/DISORDER**
- **DIABETES – TYPE I (Insulin):**
  - Ages 18 – 49 and Ages 50 – 59 with duration 6+ years;
  - Ages 60 – 69 with duration 25 years;
  - Any complications such as Neuropathy (Circulation), Retinopathy (Eye), Nephropathy (Kidneys), Insulin Shock, Coma, Leg Ulcers, Amputation, or poorly controlled Diabetes;
  - Any combination of Diabetes with tobacco use (use of any tobacco or nicotine product), Coronary Artery Disease or ratable build.

DIABETES – TYPE II:

- Ages 18 – 29 and Ages 30 – 39 with duration 6+ years;
- Ages 40 – 49 with duration 16+ years;
- Any complications such as Neuropathy (Circulation), Retinopathy (Eye), Nephropathy (Kidneys), Insulin Shock, Coma, Leg Ulcers, Amputation, or poorly controlled Diabetes;
- Any combination of Diabetes with Coronary Artery Disease or ratable build;
- Smokers (use of any tobacco or nicotine product) in combination with Diabetes for ages 50 and under.

- **DISEASE OF BRAIN / PERIPHERAL ARTERIES / LIVER / PANCREAS / KIDNEY**
- **DRUGS:** In the past 5 years, used or been treated for amphetamines, cocaine, narcotics, hallucinogens, or barbiturates.
- **EMPHYSEMA/COPD**: If moderate to severe, if a smoker or with complications.
- **EPILEPSY/SEIZURES:** With seizures in the past year.
- **IMMUNE SYSTEM or CONNECTIVE TISSUE DISEASE/DISORDER**
- **MULTIPLE SCLEROSIS:** In the past 10 years, received diagnosis of or required follow-up; progressive or relapsing.
- **PARALYSIS:** Any paraplegia or quadriplegia.
- **PARKINSON'S DISEASE:** Moderate, Severe, or Progressive.
- **PSYCHIATRIC DISORDERS:** In the past 10 years, received diagnosis of or required follow-up for: Bipolar Disorder, Down's syndrome, Mental Retardation, or Schizophrenia. Moderate to severe depression diagnosed within 3 years.
- **RHEUMATOID ARTHRITIS:** Required follow-up if severe.
- **SARCOIDOSIS:** In the past 10 years, received diagnosis of or required follow-up for Pulmonary Sarcoidosis.
- **SICKLE CELL ANEMIA**
- **SYSTEMIC LUPUS:** Diagnosed less than 5 Years with Medication.
- **TRANSPLANT:** Has received or been recommended for an organ or bone marrow transplant.
- **TRANSPORTATION ASSISTANCE:** Permanent usage of the following: walker, wheelchair, electric scooter, oxygen, or catheter.
- **ULCERATIVE COLITIS/CROHN'S DISEASE:** If less than 3 years since last flare-up of Crohn's Disease. Moderate to severe ulcerative colitis.

The above list is intended as a guide.

Height/Weight Guidelines					
Height	**Maximum Weight**	**Height**	**Maximum Weight**	**Height**	**Maximum Weight**
4' 8"	189 lbs.	5' 5"	255 lbs.	6' 2"	331 lbs.
4' 9"	196 lbs.	5' 6"	263 lbs.	6' 3"	340 lbs.
4' 10"	203 lbs.	5' 7"	271 lbs.	6' 4"	349 lbs.
4' 11"	210 lbs.	5' 8"	279 lbs.	6' 5"	358 lbs.
5' 0"	217 lbs.	5' 9"	287 lbs.	6' 6"	367 lbs.
5' 1"	224 lbs.	5' 10"	296 lbs.	6' 7"	377 lbs.
5' 2"	232 lbs.	5' 11"	304 lbs.	6' 8"	386 lbs.
5' 3"	239 lbs.	6' 0"	313 lbs.	6' 9"	396 lbs.
5' 4"	247 lbs.	6' 1"	322 lbs.		

Weight is only one factor in the underwriting assessment. A build that is within the parameters does not guarantee acceptance. Weight exceeding the maximum will be declined.

800-423-9765
www.cfglife.com

This guide is not intended for consumer use, nor is it intended to represent a legal contract. The information contained herein is designed to serve as a general reference source only. The Company procedures and practices outlined in this guide are subject to change due to legal compliance requirements or the needs of the business. Sample forms are provided for reference only. Actual forms may vary by state and are subject to change or revision.

For complete policy and rider terms, please refer to Policy/Rider Form 1F580-CL, 1F581-CL, 1F582-CL, 1F583-CL, 1F584-CL, 1F585-CL, 1F586-CL, 1F587-CL, 1F588-CL, 1F589-CL, 1F590-CL, 1H840-CL, 1H841-CL, 1H843-CL, 1H844-CL, 1H845-CL, 1H846-CL, 1H906-CL, 1H907-CL and 1H908-CL or appropriate state variation. Product/Rider specifications and availability may vary by state.

Form No. 6147-CL (Rev. 10/15)