COLUMBIAN LIFE INSURANCE COMPANY • HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICES:
VESTAL PARKWAY EAST • PO BOX 1381 • BINGHAMTON, NY 13902-1381

FAX TO: (877) 270-3266

APPLICATION FAX COVER SHEET CHECKLIST SIMPLIFIED ISSUE TERM
Total Number of Pages:

NAME OF PROPOSED INSURED: John D Doe

*****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 disclosure forms:**
  - **As needed:** Applicable state required disclosure if applying for the Accelerated Death Benefit Option form 6141-CL or state variation and any other state required disclosure forms
- ☐ **Properly completed replacement forms as defined by the state in which the application is signed.**

FOR INITIAL PREMIUM:

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

OR

- ☐ **For immediate draft of initial premium, complete AUTHORIZATION FOR ONE TIME IMMEDIATE ELECTRONIC FUND TRANSFER on page 5 of the application;**

OR

- ☐ **For the initial premium to be drafted on a specific date, complete FIRST DRAFT AND ONGOING ELECTRONIC FUND TRANSFER on page 5 of the application.**

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

Faxed by: Cody M. Beck

Your E-Mail Address: Cbeck@equisfinancial.com

Your Phone No.: (937) 307-2089

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

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 D John	222-22-2222	M	55	11-22-1960	OH

Home Address/Apt. No., City, State, Zip Code: 895 Herr St Englewood OH 45322

Phone Number: ☒ Home ☐ Work ☐ Cell (937) 832-1378

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

Name of Owner	Social Security Number	Relationship to Proposed Insured

Mailing Address/ (If different from Insured)

3. BENEFICIARY	Name & Address	Relationship	Telephone No.	Social Security No.
Primary	Mary A Doe	Wife	937 832-1378	333-33-3333
Contingent				

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: $ draft

Payment Mode: ☐ Annual $_____ ☐ Semi-Annual $_____
☒ EFT - Please specify Annual, Semi-Annual or Monthly monthly $ 106.05
☒ Draft 1st Premium? (Please see Initial Payment Options on Page 4.)

Requested Effective Date / Draft Date: 4-5-2016

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

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

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: Electrician		
Annual Income: 60,000 Total Household Income: 60,000		
3. Do you have a Driver's License? If "NO," please provide details: _____	☒	☐
If "YES," Driver's License No. and State: RW11111 - OH		
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?	☐	☒

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 catheter? ☐ ☒
   If "YES," please provide details: _____
4. a. What is your current height and weight? HEIGHT 5 Ft. 10 In. WEIGHT 220 lbs.
   b. Any unexplained history of weight loss of more than 10 lbs. in the last year? ☐ ☒
   If "YES," please provide details: _____
5. In the past three (3) years has any proposed insured:
   a. Engaged in: hang-gliding, cliff diving, scuba diving over 130 feet, parachuting, skydiving, rock or mountain climbing, speeds (in any vehicle) in excess of 100 mph (land or water) or plan such activity in the next 2 years? ☐ ☒
   b. Flown as a student pilot, or private pilot with over 250 flight hours per year, used an ultra-light aircraft or plan such activity in the next 12 months? ☐ ☒
   If "YES," to either question please provide details: _____

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 D Doe	lisinopril	3-17-2016	Dr Jones 12 W Wenger Rd	HBP	5yrs

6. ANSWER ONLY IF APPLYING FOR THE DISABILITY INCOME RIDER YES NO

1. Are you currently covered by Workers Compensation? ☐ ☐
   (If yes, you are only eligible to apply for an Off-the-Job Disability Income Rider. If so, skip to question #3.)
2. Occupation Information:
   a. Description of duties _____
   b. Have you been working full-time (at least 30 hours per week) for the last 12 months? ☐ ☐
   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 Compensation or State Disability benefits? ☐ ☐
   If yes, please provide details _____

7. ANSWER ONLY IF APPLYING FOR THE CHRONIC ILLNESS ACCELERATED BENEFIT RIDER YES NO

1. Do you require any assistance or supervision to perform any of the following activities of daily living: bathing, eating, dressing, toileting, 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, consulted with, been tested for, or advised to be tested or 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 which limits motion or mobility? ☐ ☐

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.**

3-17-2016
Date of Application

Englewood OH
Dated At (City, State)

X John D Doe 3-17-2016
Signature of Proposed Insured (Date)

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

12. REPORT OF LICENSED AGENT:

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

(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.

Cody M. Beck
Name of Licensed Agent (Print)

X Cody M. Beck 3-17-2016
Signature of Licensed Agent *(required)* (Date)

555555 100%
Agent Number %

Second Agent Number % (If Splitting)

888888-OH
Agent's State License ID No. (in jurisdictions where required)

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.)

First Name	Middle Initial	Last Name or Company Name if the Payor is a Corporation		
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) 5th (OR) Week (1st - 4th) _____ / Day (Mon - Fri) _____

beginning in the month of April.

BANK ACCOUNT AUTHORIZATION (Complete if initial premium or ongoing premiums will be drafted from an account)

I authorize the ds in the account. I
agree that if ar ce.

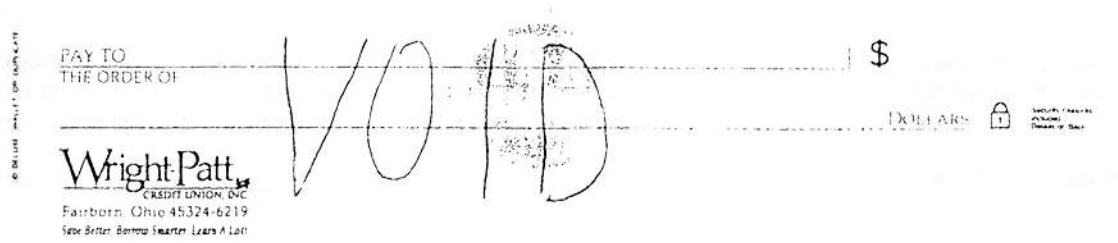
Any requireme m shall be deemed
to have been p ith respect to the
termination of

This plan shall ay terminate the EFT
plan if any che lue under the policy
after such term

Financial Instit) or ☐ Savings

Transit / Routi

Account Numb ccount number.



John O Doe
Name of Bank Account Holder

3-17-2016
Date

X John St Doe
Authorized Signature as it appears on Bank Records

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
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
655 ENGINEERING DRIVE • 3RD FLOOR • 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 _X_ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES _X_ 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 No Replacement.

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

John D Doe John O Doe — 3-17-2016
Applicant's Signature and Printed Name — Date

Cody M. Beck Cody M. Beck — 3-17-2016
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.