Final Expense Dignified Choice® – Classic Series

You can help speed the processing of your applications by reviewing each application before you submit.

Our Final Expense Service Team has noted a number of common errors that slow down the processing of applications. By taking just a few moments to review each application before submitting, you can help to ensure that your applications are not delayed. Please be sure to use the correct application for your state. See the attached application sample as a reference to the items below.

Important items that will speed processing of your applications:

1. Indicate whether the policy is to be mailed to the Agent or the Owner.
2. If the Owner is other than the Insured, include the Owner's address.
3. Indicate the relationship of the Primary and Contingent Beneficiary to the Insured.
4. Be sure to calculate premiums using the age last birthday *as of the requested effective date of the policy.*
5. If the initial premium is to be drafted from an account **immediately upon receipt of the application** (cash with app), complete the One Time Electronic Fund Transfer section of the application. Enter all of the account information, even if you are sending a voided check. Do not complete this section if you are mailing a check or for Draft First Premium.
6. If the initial premium will be drafted **on a specified date**, check the Draft First Premium box on page 1 and complete the First Draft and Ongoing Electronic Fund Transfer section of the application. Enter all of the account information, even if you are sending a voided check.
7. Enter a requested effective date only if backdating or if requesting a specific future date. Backdating is allowed up to six months with submission of all premiums. For Draft First Premium, the effective date must match the first draft date. For "day of the month" draft, the first draft must be within 30 days of the application date. For "week/day of the month" draft, the first draft must be within 35 days of the application date.
8. Please mark either "yes" or "no" for the Automatic Premium Loan question in section 4.
9. Be sure that all health questions are answered, *even when applying for a graded benefit policy*. A telephone interview is required on full benefit policies. When the interview is conducted from the Applicant's home, it allows you to close the sale and greatly speeds policy issue. Please refer to your Telephone Interview Brochure, Form No. 4780CFG for details on how to arrange the interview.
10. Answer ***both*** questions regarding replacements in Section 6. In states that have adopted the NAIC Model Replacement Regulation, a signed Replacement Form must be submitted if the applicant has existing life insurance or annuities, even if a replacement is not occurring.
11. In Section 9, be sure to indicate the City and State where the application was signed.
12. For Monthly EFT mode, include a voided check and complete the First Draft and Ongoing Electronic Fund Transfer section on page 3. Be sure to indicate a draw date for the ongoing withdrawals.

COLUMBIAN MUTUAL LIFE INSURANCE COMPANY
HOME OFFICE: BINGHAMTON, NY
ADMINISTRATIVE SERVICE OFFICE: P.O. BOX 4850
NORCROSS, GA 30091-4850

www.cfglife.com

COLUMBIAN LIFE INSURANCE COMPANY
HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: P.O. BOX 4850
NORCROSS, GA 30091-4850

Columbian Life Insurance Company is not licensed in every state.

Not for consumer use.
Refers to Policy Form No. 1F154, 1F155, 1F154-CL. 1F155-CL or state variation.

Form No. 5309CFG (Rev. 11/14)

APPLICATION FOR WHOLE LIFE INSURANCE POLICY

COLUMBIAN LIFE INSURANCE COMPANY

MAIL POLICY TO: ☐ **Agent** ☐ **Owner** — O Box 4850, Norcross, GA 30091 - 4850

1 *If neither box is checked, the policy will be mailed to the Policyowner.*

1. PROPOSED INSURED:

Proposed Insured (First, Middle Initial, Last)	Social Security Number	Sex	Age Last Birthday	Date of Birth	State of Birth

Home Address/Apt. #, City, State, Zip Code	Phone Number ( )

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)

2 *If Owner is other than the Insured, be sure to include the address.*

3. BENEFICIARY:

Primary Beneficiary Designation: (Full Name & Relationship to Insured) — Contingent Bene… to Insured)

3 *Beneficiary's relationship to Insured MUST be included.*

4. POLICY INFORMATION:

Email Address

Base Plan of Insurance:	Amount of Base Premium (Minus Riders):	Amount of Insurance (…e Amount):	Riders:	Rider Premium:	Amount Paid with Application:
☐ Full Benefit Plan ☐ Non-Tobacco ☐ Tobacco ☐ Graded Benefit	$_____		☐ Accidental Death Benefit ☐ Accelerated Death Benefit ☐ W…r of P…m… – Nursing Home ☐ – Disability ☐ …urance Rider ☐ r * *Circle benefit per month (250 / 350 / 500)	$_____ (No Charge) $_____ $_____ $_____ $_____	$

4 *Calculate premiums using the Insured's age as of last birthday.*

Payment Mode: ☐ **Annual** ☐ **Semi-A…nual** ☐ **Quarterly** ☐ **Monthly EFT** ☐ **Draft 1…** (Draft date must be wi…

6 *For Draft First Premium, check here and enter 0 in Amount Paid with Application (above).*

Requested Effective Date: **…tomatic Premium Loan:**

7 *Enter a requested effective date only if requesting a specific date.*

5. HEALTH HISTORY:

PART 1 (If any question in this section is answered …ES," DO NOT SUBMIT THE APPLICATION)	**YES**	**NO**
1. Is the Proposed Insured currently hospitalized, confined to a nursing home, hospice, bed, or confined to a wheelchair (due to a disease or chronic illness), institutionalized, receiving home health care, ever been recommended for an organ or bone marrow transplant, or ever had a heart, lung, liver or bone marrow transplant, or ever had an amputation due to disease or, within the last twelve (12) months, received kidney dialysis?.....	☐	☐
2. Has the Proposed Insured ever been diagnosed or treated by a member of the medical profession for an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or has the Proposed Insured been diagnosed as having a terminal medical condition that is expected to result in death within the next twelve (12) months?.....	☐	☐
3. Has the Proposed Insured ever been diagnosed with, or received treatment for: mental retardation, Down's Syndrome, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, sickle cell anemia or un-operated heart defects?.....	☐	☐
4. Has the Proposed Insured ever been diagnosed or received treatment (including taking medication) with congestive heart failure, Alzheimer's disease, dementia or Lou Gehrig's disease (ALS)?.....	☐	☐
5. During the last twenty-four (24) months, has the Proposed Insured had, been diagnosed or received treatment (including taking medication) for any form of cancer (other than basal cell skin cancer)?.....	☐	☐
6. During the last twelve (12) months has the Proposed Insured been diagnosed as having a heart attack?	☐	☐
7. Are you male and over 350 pounds, or are you female and over 300 pounds?	☐	☐
PART 2 (If the answer to any question in Part 2 is "YES," the Proposed Insured is eligible for the GRADE…		
1. During the last thirteen to twenty-four (13 - 24) months has the Proposed Insured been diagnosed as having a …		
2. During the last twenty-four (24) months, has the Proposed Insured been diagnosed as having: A stroke (inclu… …A), aneurysm, enlarged heart, angina, pacemaker implant or any procedure to improve circulation to the heart or brain?.....	☐	☐
3. During the last thirty-six (36) months, has the Proposed Insured had, been diagnosed or received treatment (including taking medication) for:		
A. Emphysema, chronic obstructive pulmonary disease (COPD), black lung disease, any chronic respiratory disorder (excluding asthma or sleep apnea), or used oxygen equipment to assist in breathing?.....	☐	☐
B. Kidney disease, kidney failure, liver disease, chronic hepatitis, drug or alcohol abuse, or Systemic Lupus?.....	☐	☐
C. Multiple Sclerosis, Parkinson's Disease, schizophrenia, brain tumor or has the Proposed Insured been hospitalized or institutionalized for a mental or nervous disorder within the last twenty-four (24) months?.....	☐	☐
4. During the last twenty-four (24) months, has the Proposed Insured experienced complications of diabetes, including insulin shock, diabetic coma, Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve, circulatory) disorder, or diabetes not under control with current treatment , or has the Proposed Insured used insulin for the treatment of diabetes prior to age 50?.....	☐	☐

9 *Answer ALL health questions, regardless of the plan applied for*

APPLICATION FORM MAY VARY BY STATE

PART 3 TOBACCO USE | **YES** | **NO**

1. Within the past twelve (12) months, has the Proposed Insured used any form of tobacco or nicotine products including cigarettes, cigars, pipes, chewing tobacco or snuff?..... ☐ ☐

PART 4 ANSWER ONLY IF APPLYING FOR THE NURSING HOME WAIVER OF PREMIUM RIDER | **YES** | **NO**

(If any question in Part 2 is answered "YES," the Proposed Insured is not eligible for this rider):

Does the Proposed Insured currently use mechanical devices such as a wheelchair, crutches, hospital bed or oxygen; or currently need or require assistance from another person in bathing, eating, dressing, toileting, transferring from bed to chair or maintaining continence; or has the Proposed Insured received medical advice or treatment or consulted with a member of the medical profession for osteoporosis or memory loss? ..... ☐ ☐

6. REPLACEMENT: **NO**

Do you 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.)

10 *BOTH questions must be answered.*

7. SPECIAL REQUESTS / REMARKS:

8. CONDITIONS RELATING TO THE APPLICATION:

I have read the questions and answers in all parts of this application and agree that they are complete and true to the best of my knowledge and belief. I agree that this application shall form a part of any policy issued. I understand and agree that no agent has the authority to waive a complete answer to any question in the application, pass on insurability, make or alter any contract, or waive any of the Company's other rights or requirements; that any policy applied for shall not take effect (except as provided in the Conditional Receipt bearing the same number as this application) unless and until the policy has been issued and delivered and the full first premium, according to the mode of payment selected by the applicant (as permitted by the Company) and stipulated in the policy, has been paid and accepted by the Company during the lifetime and condition of health of the Proposed Insured as stated in the application.

9. AUTHORIZATION & ACKNOWLEDGMENT:

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance company, MIB, Inc., consumer reporting agency, or other organization, institution or person that has any records or knowledge of me, 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.
I have read and acknowledge the applicable fraud notice required by state law.

11 *City and state where Application is signed MUST be included.*

Date of Application _____ ure of Proposed Insured (Parent/Guardian if 15 or under) (Date)

Dated At (City, State) _____ ure of Owner (If other than Insured) (Date)

10. 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 insura..... ☐ YES ☐ NO

(If "YES," submit any special forms required by the state in which th

HAS THE TELEPHONE INTERVIEW BEEN COMPLETED? ..... ☐ YES ☐ NO

9 *Completing the interview for Classic I will speed processing.*

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

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

Agent Number _____ % Second Agent Number _____ % (If Splitting) _____ Agent's State License ID No. (in jurisdictions where required)

APPLICATION FORM MAY VARY BY STATE

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

X _____

Signature of Secondary Addressee/Third Party (If Required)

REQUEST FOR ELECTRONIC FUNDS TRANSFER PLAN - (Mu… …mplete in full) DO NOT USE FOR DRAFT 1st PREMIUM

5 *Complete this section to have initial premium drafted **IMMEDIATELY UPON RECEIPT** of the application. Do not use this section for Draft First Premium.*

Amount Paid With Application: $_____

☐ **ONE TIME ELECTRONIC FUND TRANSFER**

For Electronic Funds Transfer, your agent will submit your… …e Insurance Company ("the Company"). By signing this form, you authorize t… …pany to initiate an electronic funds transfer from your bank account.

Please note that your bank account may be debited the same day … …ur 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

Routing Number: ☐☐☐☐☐☐☐☐☐ 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 ELECTRO… …NDS TRANSFER, PLEASE COMPLETE THE INFORMATION BELOW AND SIGN. PLEASE NOTE: YOU NEED ONLY INCLUDE THE AC…

6, 12 *Complete for Draft First Premium and/or Monthly EFT mode. For Draft First Premium, the policy effective date will be the date of the draft.*

☐ **FIRST DRAFT AND ONGOING ELECTRONIC FUND TRANSF…**

I authorize the payment of debits drawn on my account payable to Columbian … agree that if any such debit be dishonored, you shall be under no liability in the ev… …e 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.

Bank Name _____ ☐ **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… …

I… …als)

- For Cash with App, the initial premium will be drawn from the account **immediately upon receipt of the application**. The policy effective date will be the application date except:
  - If the application date is the 29th, 30th or 31st of the month, the effective date will be the 1st of the following month. If this would cause a change in age, the effective date will be the 28th of the month in which the application was signed. The start date for drafts will be adjusted accordingly.
  - A specific effective date may be requested on the application. The effective date cannot be more than 30 days from the application date.
- For Draft First Premium, the first premium will be drawn from the account **on the date specified**. The policy effective date will be the date of the first draft.

APPLICATION FORM MAY VARY BY STATE