

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

FAX COVER SHEET
Dignified Choice[®] Final Expense
Columbian Life New Business Only

FAX TO: (877) 261-3266

NAME OF PROPOSED INSURED: _____

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

TOTAL NUMBER OF PAGES: _____

PRODUCT NAME: _____

AGENT NAME: _____

AGENCY NAME: _____

AGENT EMAIL: _____

AGENT PHONE NUMBER: _____

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

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

APPLICATION FOR INDIVIDUAL WHOLE LIFE INSURANCE POLICY

COLUMBIAN LIFE INSURANCE COMPANY

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

| 1. PROPOSED INSURED | | | | |
|--|---|---|--|--|
| First Name | Middle Initial | Last Name | Social Security No./Green Card No. | Sex <input type="checkbox"/> M <input type="checkbox"/> F |
| Date of Birth (MM/DD/YYYY) | Age (Last Birthday) | State (USA) / Country of Birth | Phone Number <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell () | |
| Home Address/Apt. #, Street | | City | State | Zip Code |
| Answer only for ages 18-35: Do you have a Driver's License? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, please provide your Driver's License No. and State. If NO, please provide details in Section 7 Special Requests / Remarks on Page 3. | | | Driver's License No. | State |
| | | | WEIGHT _____ lbs. | HEIGHT _____ Ft. _____ In. |
| 2. BENEFICIARY For multiple Primary or Contingent Beneficiaries, provide additional beneficiary information including % share in Section 7 Special Requests/ Remarks on Page 3. | | | | |
| PRIMARY BENEFICIARY First Name | Middle Initial | Last Name | Relationship to Proposed Insured | |
| Date of Birth (MM/DD/YYYY) | Social Security No./Green Card No. | Phone Number <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell () | | |
| Street Address | | City | State | Zip Code |
| CONTINGENT BENEFICIARY First Name | Middle Initial | Last Name | Relationship to Proposed Insured | |
| Date of Birth (MM/DD/YYYY) | Social Security No./Green Card No. | Phone Number: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell () | | |
| Street Address | | City | State | Zip Code |
| 3. POLICY DELIVERY OPTIONS | | | | |
| DELIVER TO: <input type="checkbox"/> Agent <input type="checkbox"/> Owner | | | | |
| OWNER (Complete only if Owner is other than Proposed Insured.) | | | | |
| First Name, Middle Initial, Last Name | Social Security No./Green Card No./Taxpayer Id. No. | Relationship to Proposed Insured | | |
| Mailing Address (If different from Insured)/Apt. #, Street | | City | State | Zip Code |
| To designate a Contingent Owner, provide information in Section 7 Special Requests / Remarks on Page 3. | | | | |
| SECONDARY ADDRESSEE (Complete ONLY if Applicant/Owner is designating a Secondary Addressee/Third Party to receive a copy of notifications of a past due premium and possible lapse in coverage) | | | | |
| First Name | Middle Initial | Last Name | | |
| Street Address | | City | State | Zip Code |
| 4. POLICY INFORMATION | | | | |
| <input type="checkbox"/> Check here if you are willing to accept any plan shown below, for which you qualify based on this application. The insurance for which you qualify may have a return of premium death benefit for the first two (2) years, a face amount less than indicated on this application and riders may not be available. Adjust the face amount to match premium? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Base Plan of Insurance | Amount of Insurance (Face Amount) | Amount Paid with Application (Indicate \$0 if initial premium is to be drafted.) | Amount of Base Modal Premium (Minus Riders) | Automatic Premium Loan (MUST select Yes or No) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Full Benefit Whole Life - Dignified Choice Classic Elite <input type="checkbox"/> Full Benefit Whole Life - Dignified Choice Classic Select <input type="checkbox"/> Graded Benefit Whole Life - Dignified Choice Classic Advantage | \$ _____ | \$ _____ | \$ _____ | |

| RIDERS (if available) | | | |
|--|---|--|--------------------------|
| <input type="checkbox"/> | Accidental Death Benefit Rider | Premium \$ _____ | |
| <input type="checkbox"/> | Accelerated Death Benefit Rider | Premium \$ (No Charge) | |
| <input type="checkbox"/> | Children's Term Insurance Rider | Premium \$ _____ Complete Supplemental Application for Children's Term Insurance Rider | |
| 5. HEALTH HISTORY | | | |
| TOBACCO USE | | | |
| 1. | Have you used any form of tobacco or nicotine products including cigarettes, cigars, pipes, e-cigarettes, chewing tobacco, snuff, nicotine patches, or nicotine gum in the past twelve (12) months? <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 2. | Have you smoked marijuana in the past twelve (12) months? <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| PART 1 (If any question in this section is answered "YES," DO NOT SUBMIT THE APPLICATION) | | YES | NO |
| 1. | Are you currently hospitalized, confined to a nursing home, hospice, bed, assisted living facility, convalescent home, institutionalized, receiving home health care, or confined to a wheelchair due to illness or disease?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Have you ever been diagnosed by a member of the medical profession as having or tested positive for Human Immunodeficiency Virus (HIV), or having an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or have you been diagnosed by a member of the medical profession as having a terminal medical condition that is expected to result in death within the next twelve (12) months?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Have you ever been recommended by a member of the medical profession for an organ or bone marrow transplant, or ever had a heart, lung, liver or bone marrow transplant, or ever had an amputation due to disease or, within the last twelve (12) months, received kidney dialysis?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | Are you awaiting a diagnosis or test result, or been advised by a member of the medical profession to have a surgical operation, a diagnostic test (except for HIV) other than for routine screening, that has not been completed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Have you ever been diagnosed by a member of the medical profession with, or received treatment for: mental retardation, Down's Syndrome, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, sickle cell anemia, or Huntington's Disease?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | Have you ever been diagnosed or treated (including taking medication) by a member of the medical profession with congestive heart failure, Alzheimer's disease, dementia or Lou Gehrig's disease (ALS), or received a cardiac defibrillator implant (except pacemaker implant)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | During the last twenty-four (24) months, have you been diagnosed or treated (including taking medication) by a member of the medical profession for any form of cancer, including, leukemia, melanoma or any other internal cancer (other than basal cell skin cancer)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | During the last six (6) months have you been diagnosed by a member of the medical profession as having a heart attack?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| PART 2 (If any question in this section is answered "YES," the Proposed Insured will be considered for the Classic Advantage Graded Benefit plan. If two or more questions are answered "YES," DO NOT SUBMIT THE APPLICATION.) | | YES | NO |
| 1. | Have you ever been diagnosed, treated (including taking medication), tested positive for, or been advised by a member of the medical profession to seek treatment for chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, black lung disease, chronic respiratory disorder (excluding asthma or sleep apnea), or used oxygen to assist with breathing (except for sleep apnea)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | During the last thirty-six (36) months, have you been diagnosed or received treatment (including taking medication) by a member of the medical profession for: | | |
| | a. Kidney disease, kidney failure, liver disease, chronic hepatitis, drug or alcohol abuse or dependency, sarcoidosis or Systemic Lupus? | <input type="checkbox"/> | <input type="checkbox"/> |
| | b. Multiple Sclerosis, Parkinson's Disease, schizophrenia, or brain tumor?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | In the past twenty-four (24) months, have you been hospitalized or institutionalized for a mental or nervous disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | In the past thirty-six (36) months, have you: | | |
| | a. Been on probation, parole, been convicted of, or pled guilty to, any crime or to possession or distribution of drugs or any other illegal substance?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | b. Been convicted of three (3) or more moving violations, or been convicted of driving under the influence of alcohol or drugs?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | During the last twenty-four (24) months, have you been diagnosed by a member of the medical profession as having: A stroke (including TIA), aneurysm, enlarged heart, angina, peripheral vascular disease, pacemaker implant, stent, angioplasty, bypass surgery, or any procedure to improve the circulation to the brain?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | During the last thirty-six (36) months, have you: | | |
| | a. been diagnosed by a member of the medical profession as having complications of diabetes, including insulin shock, or diabetic coma, or diabetes not under control with current treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | b. been diagnosed by a member of the medical profession as having complications of diabetes, including Retinopathy (eye), Nephropathy (kidney), or Neuropathy (nerve, circulatory), or have you used insulin for the treatment of diabetes prior to age 50?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | During the last seven to twenty-four (7-24) months have you been diagnosed by a member of the medical profession as having a heart attack?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| PART 3 (If any question in this section is answered "YES," the Proposed Insured will be considered for the Classic Select Full Benefit Plan. If two or more questions are answered "YES," the Proposed Insured will be considered for the Classic Advantage Graded Benefit plan.) If all questions in all sections are answered "NO," the Proposed Insured will be considered for the Classic Elite Full Benefit plan. | | YES | NO |
| 1. | In the past five (5) years, have you been diagnosed, treated (including taking medication), tested positive for, or been advised by a member of the medical profession to seek treatment for cancer, leukemia, melanoma, or any other internal cancer (except basal cell carcinoma)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Have you ever been diagnosed, treated (including taking medication), tested positive for, or been advised by a member of the medical profession to seek treatment for atrial fibrillation?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Are you currently requiring the assistance of another person in performing any ADL's (Activities of Daily Living) including eating, bathing, dressing, toileting, continence, transferring in and out of a bed or chair, or taking medications?..... | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

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

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

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

Home Phone: _____ Cell Phone: _____ Email: _____

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

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

INITIAL PREMIUM:

Amount of Initial Premium: \$ _____

- Draft initial premium from the account below at a future date. **The first draft must be within 35 days of the application date. If you select an initial premium draft date in the future, you will not have potential coverage until that date under the Conditional Receipt. Insurance age will be calculated as of the date the premium is drafted.**
- Immediate Draft - Draft initial premium **upon receipt** of the application at Columbian's office, from the account below. **Please note that your bank account may be debited the same day your agent submits this authorization.**
- Check, cashier's check or money order. By signing below, you authorize the Company to initiate an electronic funds transfer from your bank account if payment is made by check. **Please note that your bank account may be debited the same day your agent submits this authorization.**

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

SUBSEQUENT PREMIUM PAYMENTS MADE BY:

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

Choose a specific day (1st -28th)

OR

Choose a specific week and day of the month

_____ Ongoing Premium Draft Day

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

Select Day: Monday Tuesday Wednesday Thursday Friday

beginning in the month of _____

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

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

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

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

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

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

Transit / Routing Number (must have 9 digits)

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

Account Number (may have up to 17 digits)

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

Name of Bank Account Holder

Date

Authorized Signature as it appears on Bank Records

INFORMATION PRACTICES RELATING TO UNDERWRITING YOUR APPLICATION

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

INVESTIGATIVE CONSUMER REPORT

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

IDENTIFICATION

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

ACCESS TO INFORMATION

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

WHERE TO WRITE US

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

MIB, INC. PRE-NOTICE

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

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

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

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

CONDITIONAL RECEIPT

Complete Only When Payment Received

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO COLUMBIAN LIFE INSURANCE COMPANY.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Received from (Print) _____, the sum of _____ on the life of (Proposed Insured) _____. Columbian Life Insurance Company ("the Company") accepts this payment in connection with your application for insurance and, subject to the terms and conditions of this Conditional Receipt and subject to all the terms and conditions of the policy applied for, agrees to provide coverage under the following conditions:

EFFECTIVE DATE OF COVERAGE: Provided that each of the conditions below is satisfied, coverage under this Conditional Receipt will begin on the later of the Underwriting Date (as defined below) or the specific policy date requested on the application. The Underwriting Date is the later of (1) the date of the application; or (2) the date all underwriting requirements, as required by the Company's underwriting rules, are completed.

CONDITIONS: Insurance coverage under this Conditional Receipt will begin on the Effective Date (as defined above) only if, on that date, all of the following criteria are met:

- (1) You had paid the full first modal premium on the policy applied for; and
- (2) All Proposed Insureds were insurable at standard rates on the date of the application; and
- (3) The Company is able to issue the policy as applied for; and
- (4) The amount of insurance applied for, with respect to any Proposed Insured, is not in excess of \$50,000.

TERMINATION OF COVERAGE: Any insurance provided under this Conditional Receipt will terminate: (1) Immediately, if the Company refunds your payment or your check was not honored by your Bank; or (2) The date coverage under the policy applied for becomes effective; or (3) Ninety (90) days after the date of the application.

Date X _____
Signature of Licensed Agent

**IMPORTANT NOTICE TO THE AGENT: DO NOT SIGN THE CONDITIONAL RECEIPT
UNLESS PREMIUM IS TAKEN WITH THE APPLICATION.**

**NOTICE REGARDING
REPLACEMENT OF LIFE
INSURANCE AND ANNUITIES**

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

REPLACING YOUR LIFE INSURANCE OR ANNUITY?

It is in your best interest to get all the facts before making a decision. Make sure you fully understand both the proposed new policy and your existing insurance. New policies may contain provisions which limit benefits during the initial period of the contract, in particular, the suicide and incontestable clauses.

To assist you in evaluating the proposed and the existing insurance, Delaware Insurance Regulation 30 requires that the insurer advising or recommending replacement:

- Provide the consumer with a concise summary of the policy it proposes to issue;
- Allow a twenty day period for the issue of the proposed policy during which time the consumer may surrender the new policy for a full refund;
- Advise the present insurance company(s) of the pending replacement.

This same regulation requires your present insurer to provide, on your request, a similar summary describing your present insurance. This information will be provided if you request it using the form below:

INFORMATION ON PRESENT POLICIES

| <u>Company Name</u> | <u>Policy Number</u> | <u>Name of Insured</u> | <u>Summary Requested</u> (Mark Yes or No) |
|---------------------|----------------------|------------------------|--|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

IT IS SELDOM WISE TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT TO BE ACCEPTABLE.

I have read this notice and received a copy of it.

Applicant's Signature

Date

Agent's Signature

Date

Agent's Name and Address (Printed)

COLUMBIAN MUTUAL LIFE INSURANCE COMPANY • HOME OFFICE: BINGHAMTON, NY
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ADMINISTRATIVE SERVICE OFFICES:
4704 VESTAL PARKWAY EAST • PO BOX 1381 • BINGHAMTON, NY 13902-1381
507 PLUM STREET • PO BOX 1056 • SYRACUSE, NY 13201-1056

AUTHORIZATION TO RELEASE INFORMATION TO MY INSURANCE AGENT OR AGENCY

I authorize Columbian Mutual Life Insurance Company or Columbian Life Insurance Company (“the Company”) to disclose personal and medical information about me to my insurance agent and/or agency.

Information that the Company may disclose includes medical information and other personal information as it relates to actions the Company may have taken based on this information. These include changing benefits or riders to something other than I applied for, ordering requirements, or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that I may refuse to sign this authorization. If I refuse to sign, it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time by writing to the Company at: Columbian Financial Group, Attn: Underwriting, PO Box 1381, Binghamton, NY 13902.

I realize that my right to revoke this authorization is limited to the extent that the Company has taken action in reliance on the authorization.

I understand that I can request a copy of this authorization.

Signature of Applicant: _____ Date: _____

Signature of Agent: _____ Date: _____

**SUPPLEMENTAL
APPLICATION FOR
INDIVIDUAL CHILDREN'S
TERM INSURANCE RIDER**

COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: PO Box 1381, Binghamton, NY 13902-1381

This application supplements Application Form No. _____, dated _____.

CHILDREN'S TERM INSURANCE RIDER NUMBER OF UNITS APPLIED FOR: _____

You can apply for coverage on a maximum of 20 children as defined below.

Please attach a 2nd Supplemental Application for Children's Term Insurance to list more than 10 Proposed Insured children.

1. CHILDREN PROPOSED FOR INSURANCE

Name natural born children, stepchildren, legally adopted children, grandchildren, step grandchildren, legally adopted grandchildren, great grandchildren, step great grandchildren and legally adopted great grandchildren proposed for insurance. Insurance will not be provided on newborn children less than 15 days of age or children that are not US citizens.

| Full Name of Proposed Insured Child | Address and Telephone Number | Date of Birth MM/DD/YYYY | Age Last Birthday | Social Security No. |
|-------------------------------------|------------------------------|--------------------------|-------------------|---------------------|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

2. BENEFICIARY If a trust, give Trustee Name, Trust Name & Trust Date. Each child rider may have a different Beneficiary. If no Beneficiary is named for any child, the Beneficiary will be the Insured of the base policy. Attach a separate sheet for additional beneficiaries.

| | | |
|---|-------------------------|---------------------|
| Primary Beneficiary Designation (Full name and address) For Child Rider #__ (Write All if this beneficiary shall apply to all Child Riders.) | Relationship to Insured | Social Security No. |
| | Telephone Number | Date of Birth |
| Contingent Beneficiary Designation (Full name and address) For Child Rider #__ (Write All if this beneficiary shall apply to all Child Riders.) | Relationship to Insured | Social Security No. |
| | Telephone Number | Date of Birth |

3. HEALTH HISTORY

| | YES | NO |
|--|--------------------------|--------------------------|
| 1. Has any child proposed for insurance ever been diagnosed or treated by a member of the medical profession for an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or has any Proposed Insured Child tested positive for Human Immunodeficiency Virus (HIV)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has any child proposed for insurance ever used or received treatment, advice or counseling from a physician or other practitioner relating to the usage of alcohol, heroin, cocaine, narcotics, hallucinogens, tranquilizers, barbiturates, amphetamines, or other similar drugs except as prescribed by a physician?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has any child proposed for insurance ever been diagnosed or treated (including taking medication) for high blood pressure, heart or circulatory disorder, cancer, mental disorder, mental retardation, Down's Syndrome, muscular dystrophy, spina bifida, cystic fibrosis, kidney or liver disease, diabetes, sickle cell anemia, seizures, cerebral palsy, paralysis, had or been recommended for an organ transplant or been hospitalized for asthma or any respiratory disorder in the past twelve (12) months?..... | <input type="checkbox"/> | <input type="checkbox"/> |

If any of these questions are answered "YES" that child will be excluded from coverage. Please list the children for which "YES" answers were given:

4. ACKNOWLEDGEMENT & SIGNATURES

I declare and represent that the foregoing statements and answers have been correctly recorded and that they are full, complete and true to the best of my knowledge and belief and shall constitute a part of the application.

Date **X** _____
Signature of Primary Insured

Date **X** _____
Signature of Licensed Agent Agent Number

COLUMBIAN FINANCIAL GROUP

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

FOR USE WITH NEW BUSINESS APPLICATIONS ONLY

AUTHORIZATION TO FAX CHECK

Your agent will submit your application for insurance and your initial payment to Columbian Financial Group via facsimile.

By signing this form, you authorize Columbian Financial Group to initiate an electronic funds transfer from your bank account according to the terms of the check. This means that your check will be converted to an electronic transaction. Your agent will retain your original check in his/her files.

Please note that your checking account may be debited the same day your agent faxes your check to us.

The below hereby authorizes Columbian Financial Group to draw an electronic fund transfer from my checking account for payment of new life insurance.

Authorized Signature as it Appears on Bank Records

Date

Authorized Signature as it Appears on Bank Records

Date