



# Columbus Life Insurance Company

A member of Western & Southern Financial Group

400 EAST FOURTH STREET • CINCINNATI, OHIO 45202-3302 • 1-800-677-9696 • WWW.COLUMBUSLIFE.COM

The following checklist can assist you in fulfilling all form requirements.  
Forms can be found in iPipeline through the Columbus Life extranet at [www.columbuslife.com](http://www.columbuslife.com).

New Business       Reinstatement (Complete sections A, B, I, J, K, L and N)

## Essential Forms

<input type="checkbox"/> Life Insurance Application	ICC19 CL 45.300	<p><b>New Business:</b> Must Complete: Sections A, C, G, H, I, J, K, L, N. (Completion of Section N is optional if a Paramedic or MD exam is required.) Complete if Applicable: B – Survivorship or Other Insured only. D – For any optional benefits/riders. E – Proposed Insured under 18. F – Owner other than Proposed Insured. M - Additional remarks. Attach a separate page if more space is needed.</p> <p><b>Reinstatements:</b> Must complete sections A, B (if applicable), I, J, K, L, N Section K, Tobacco Use. Complete if Proposed Insured is age 18 or older.</p> <p><b>Important: If answer is NO to tobacco use, be sure to answer the second part of the question indicating when quit or never used. Failure to answer may result in a policy with tobacco user rates.</b></p> <p>Account Bill: Three policies must be listed for one account to set up Account Bill.</p>
<input type="checkbox"/> Replacement Forms	State Specific	Always required when replacement is planned. May also be required in some states if Proposed Insured has other insurance or annuities whether or not replacement is planned.
<input type="checkbox"/> Authorization for Release of Health Information	CL 45.406	Always required for insureds 18 years or older.
<input type="checkbox"/> 1035 Exchange	CL 45.172	If existing policy has a loan, indicate if the loan is to be carried over to the new policy.
<input type="checkbox"/> Confidential Financial Statement	CL 70.255	Must complete if coverage applied for is greater than \$1,000,000. (In Washington state, always for Key Person/Business Owner)
<input type="checkbox"/> Pre-Authorized Transfer (PAT)	CL 35.47-NB	Must be completed if PAT is selected. Provide details in Agent's Report, form CL 45.459.
<input type="checkbox"/> Conditional Receipt for Life Insurance Application	CL 45.14	Money will be accepted on an eligible Proposed Insured only if the face amount applied for, plus the amount already in force with Columbus Life, does not exceed \$1,000,000.
<input type="checkbox"/> Information Practices Disclosure	CL 45.456	Must always be given to the Applicant.
<input type="checkbox"/> Agent's Report	CL 45.459	Complete sections that apply. Always complete Writing Agent Report section and sign.
<input type="checkbox"/> UL Accelerated Death Benefit Disclosure	CL 45.944	Provide copy to Applicant, Signed copy to Home Office with application. For Explorer Plus ages 80 – 85 provide CL 5.720 to the Applicant.
<input type="checkbox"/> Term Accelerated Death Benefit Disclosure	CL 45.925	Provide copy to Applicant, Signed copy to Home Office with application.
<input type="checkbox"/> Privacy Policy Disclosure	CL 5.850-NB	Always give to the Applicant.

## Supplemental Forms

<input type="checkbox"/> Indexed UL Supplement	CL 45.452	Complete to designate premium allocation.
<input type="checkbox"/> Indexed Explorer Plus UL Disclosure	CL 45.450	Provide a copy to Applicant, and a signed copy to the Home Office with application.
<input type="checkbox"/> Children's Term	CL 45.458	Complete only when Children's Term rider is applied for.
<input type="checkbox"/> Secondary Addressee	CL 45.457	An Applicant who is a resident of California, Florida, Maine or Vermont has the option to designate a secondary addressee who will be notified of a possible lapse of the policy.
<input type="checkbox"/> Citizenship Supplement	CL 45.918	Complete for any Proposed Insured who is not a U.S. citizen (not used in Florida).



## Application for Individual Life Insurance

New Business     Reinstatement of Policy #      Qualified Plan (IUL Plans Only)

For reinstatement, complete the following sections: Proposed Insured Information, Coverage Applied For, Proposed Insured Questions, Replacement Questions, Lifestyle, Personal Physician Information, Additional Remarks, and Medication Information.

### PROPOSED INSURED INFORMATION

#### Proposed Insured 1

**NAME (First, Middle, Last, Suffix)**

**SOCIAL SECURITY NUMBER**

**DATE OF BIRTH (MM/DD/YYYY)**

**BIRTHPLACE (State/Country)**

**AGE**

**SEX**

Male

Female

**DRIVER'S LICENSE NUMBER**

**DRIVER'S LICENSE STATE OF ISSUE**

**MARITAL STATUS**

**EMPLOYER**

**OCCUPATION**

**DUTIES**

**YEARS EMPLOYED**

**EARNED INCOME**

\$

**NET WORTH**

\$

**U.S. CITIZEN?**

Yes

No

*If No, complete the Citizenship Supplement*

**ADDRESS Line 1**

**Line 2**

**CITY**

**STATE**

**ZIP**

**YEARS AT ADDRESS**

**EMAIL ADDRESS**

**PRIMARY PHONE NUMBER (include area code)**

**ALTERNATE PHONE NUMBER (include area code)**



**PROPOSED INSURED INFORMATION**

**Proposed Insured 2 (for Survivorship or Other Insured Rider)**

**NAME (First, Middle, Last, Suffix)**

**SOCIAL SECURITY NUMBER**

**DATE OF BIRTH (MM/DD/YYYY)**

**BIRTHPLACE (State/Country)**

**AGE**

**SEX**

Male

Female

**DRIVER'S LICENSE NUMBER**

**DRIVER'S LICENSE STATE OF ISSUE**

**MARITAL STATUS**

**EMPLOYER**

**OCCUPATION**

**DUTIES**

**YEARS EMPLOYED**

**EARNED INCOME**

\$

**NET WORTH**

\$

**U.S. CITIZEN?**

Yes

No

*If No, complete the Citizenship Supplement*

**ADDRESS Line 1**

**Line 2**

**CITY**

**STATE**

**ZIP**

**YEARS AT ADDRESS**

**EMAIL ADDRESS**

**PRIMARY PHONE NUMBER (include area code)**

**ALTERNATE PHONE NUMBER (include area code)**

**COVERAGE APPLIED FOR (If Indexed UL, complete Premium Allocation Election.)**

**PLAN OF INSURANCE**

**BASE AMOUNT**

\$

**SUPPLEMENTAL COVERAGE RIDER (SCR) AMOUNT**

\$

**TOTAL AMOUNT**

\$

**Universal Life Only**

**DEATH BENEFIT OPTION**

1. Level Death Benefit

2. Specified Amount plus Cash Value

**LIFE INSURANCE QUALIFICATION TEST**

Guideline Premium (default for all plans besides Voyager, if none selected)

Cash Value Accumulation (default for Voyager, not available for all plans)

**Term Plans Only**

**TERM PERIOD**

Ten Year

Fifteen Year

Twenty Year

Thirty Year



**OPTIONAL BENEFITS AND RIDERS**

**Universal Life Only**

No Lapse Guarantee:  Intermediate  Lifetime

**MONTHLY CREDIT AMOUNT**

Disability Credit: \$

Premium Deposit Account Rider (Available in approved states)  Enhanced Cash Value

Change of Insured  Estate Protection Rider

**Term Plans Only**

Waiver of Premium  Accidental Death/Specific Loss

For **Voyager** only, you may select a shorter No Lapse Guarantee than the Lifetime No-Lapse:

To age 90  To age 95  Lifetime

**Universal Life and Term**

Accidental Death **AMOUNT** \$

Insured Insurability **AMOUNT** \$

Other Insured **AMOUNT** \$

Children's Term (complete Child Term Rider Supplement)

**CHILD AS PRIMARY PROPOSED INSURED**

Answer if Proposed Insured is at least 15 days old and under 18 years.

- 1. Is Applicant a Parent or Legal Guardian (attach proof of guardianship) of proposed Insured?  Yes  No
- 2. Is Applicant employed and providing Proposed Insured's main support?  Yes  No
- 3. Is all life insurance in force on Applicant at least equal to 2 times that on Proposed Insured?  Yes  No
- 4. Are all other children in family insured or to be insured for an amount at least equal to that on Proposed Insured?  Yes  No

**OWNER INFORMATION - Complete only if Owner is other than Proposed Insured 1**

If Trust Owner, complete Name, Date of Trust, TIN, Email Address, and Mailing Address and attach declarations and signature pages of Trust Agreement. If Multiple Owners, provide all details below for other Owners in Additional Owner section.

**OWNERSHIP TYPE**

- Joint with right of survivorship (fill out both Owner sections below)  Trust (fill out form ICC19 CL 45.959)
- Tenants in common (fill out both Owner sections below)  Qualified Plan (fill out form ICC19 CL 45.959)
- Other Legal Entity (fill out form ICC19 CL 45.959)

**Owner Information**

**NAME (First, Middle, Last, Suffix)**

**ADDRESS Line 1**

**Line 2**

**CITY**

**STATE**

**ZIP**



**OWNER INFORMATION - Complete only if Owner is other than Proposed Insured 1 - Continued**

**Owner Information - Continued**

**DATE OF BIRTH/TRUST** (MM/DD/YYYY)

**BIRTHPLACE** (State/Country)

**SOCIAL SECURITY NUMBER/TIN**

**EMAIL ADDRESS**

**RELATIONSHIP TO PROPOSED INSURED**

**PRIMARY PHONE NUMBER** (include area code)

**ALTERNATE PHONE NUMBER** (include area code)

**Additional Owner Information**

**NAME** (First, Middle, Last, Suffix)

**ADDITIONAL OWNER TYPE**

Contingent  Joint

**ADDRESS** Line 1

Line 2

**CITY**

**STATE**

**ZIP**

**DATE OF BIRTH/TRUST** (MM/DD/YYYY)

**BIRTHPLACE** (State/Country)

**SOCIAL SECURITY NUMBER/TIN**

**EMAIL ADDRESS**

**RELATIONSHIP TO PROPOSED INSURED**

**PRIMARY PHONE NUMBER** (include area code)

**ALTERNATE PHONE NUMBER** (include area code)

**BENEFICIARIES**

Policy proceeds are first payable to the primary beneficiaries who survive the insured. If no primary beneficiary survives the insured, policy proceeds are then payable to the contingent beneficiaries who survive the insured. Unless otherwise stated, policy proceeds shall be paid in equal shares to the beneficiaries of the highest class who survive the insured. If unequal percentages are designated, then upon the death of any beneficiary, his or her share shall be apportioned among the surviving beneficiaries of the same class in accordance with the ratio that each surviving beneficiary's percentage of the net proceeds bears to the total of all surviving beneficiaries' percentages of the net proceeds of the same class.

**NAME** (First, Middle, Last, Suffix)

**TELEPHONE NUMBER** (include area code)

**ADDRESS**

**CITY**

**STATE**

**ZIP**

**EMAIL ADDRESS**

**RELATIONSHIP**



**BENEFICIARIES - Continued**

**SOCIAL SECURITY NUMBER / TIN**

Check if TIN

**DATE OF BIRTH / TRUST (MM/DD/YYYY)**

**BENEFICIARY TYPE**

Primary  Contingent

**PERCENTAGE**

 %

**NAME (First, Middle, Last, Suffix)**

**TELEPHONE NUMBER (include area code)**

**ADDRESS**

**CITY**

**STATE**

**ZIP**

**EMAIL ADDRESS**

**RELATIONSHIP**

**SOCIAL SECURITY NUMBER / TIN**

Check if TIN

**DATE OF BIRTH / TRUST (MM/DD/YYYY)**

**BENEFICIARY TYPE**

Primary  Contingent

**PERCENTAGE**

 %

**NAME (First, Middle, Last, Suffix)**

**TELEPHONE NUMBER (include area code)**

**ADDRESS**

**CITY**

**STATE**

**ZIP**

**EMAIL ADDRESS**

**RELATIONSHIP**

**SOCIAL SECURITY NUMBER / TIN**

Check if TIN

**DATE OF BIRTH / TRUST (MM/DD/YYYY)**

**BENEFICIARY TYPE**

Primary  Contingent

**PERCENTAGE**

 %

**PREMIUM INFORMATION**

**MODAL PREMIUM AMOUNT**

\$

**MODE\***

**TOTAL AMOUNT PAID**

(If none, indicate zero or leave blank)

\$



**PAYER INFORMATION (if other than Owner)**

**NAME (First, Middle, Last, Suffix)**

**RELATIONSHIP TO PROPOSED INSURED**

**ADDRESS**

**CITY**

**STATE**

**ZIP**

**SOCIAL SECURITY NUMBER / TIN**

Check if TIN

**DATE OF BIRTH (MM/DD/YYYY)**

**SEX**

 Male Female

**PRIMARY PHONE NUMBER (include area code)**

**ALTERNATE PHONE NUMBER (include area code)**

**CONTRACT QUESTIONS**

**Complete each question for the Proposed Owner and Proposed Insured(s) (if other than Owner)**

	<b>Proposed Owner</b>	<b>Proposed Insured 1</b>	<b>Proposed Insured 2</b>
1. Have you entered into or do you have plans to enter into any agreement or contract to sell or assign the ownership of or any beneficial interest in the applied for policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever sold a policy to a life, settlement, viatical or other secondary market provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Will any portion of the premiums for this policy be financed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Will any insured or policy owner receive any payment in connection with insurance issued on the basis of this application?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

For "Yes" answers to questions 1, 2, 3, or 4, please give details.

**DETAILS**



**LIFE INSURANCE IN FORCE, PENDING OR REPLACEMENT**

- |   | <b>Proposed Insured 1</b>                                   | <b>Proposed Insured 2</b>                                   |
|---|---|---|
| 1. Has anyone proposed for insurance ever applied for life, health or disability insurance; or a reinstatement for life, health or disability insurance and been declined, postponed or charged an increased premium? | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| 2. Does any Proposed Insured/Other Insured have any applications or preliminary or informal quote requests currently pending with any other life, settlement, viatical or secondary market provider or company?       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |

If answered "Yes," give details below for each Proposed Insured, including owner, beneficiary, carrier name and purpose of each policy.

**DETAILS**

3. Excluding this policy, does the applicant (proposed owner) or any Proposed Insured have any existing annuities or life insurance policies in force or pending with any insurer? (This includes insurance sold or assigned, or that is in the process of being sold or assigned, informal inquiries and preliminaries.)  Yes  No
4. Will the existing annuity contract(s) or life insurance policy(ies) be replaced\* as a result of this application?  Yes  No

\* "Replaced" includes a lapse, surrender, partial surrender, 1035 Exchange, loan, withdrawal, modification, amendment, or other change to any existing life insurance or annuity.

If "Yes" to question 3, please list all insurance in force for any Proposed or Other Insured.

**PROPOSED INSURED NAME**

**NAME OF COMPANY**

**POLICY NUMBER**

**TYPE (check one if applicable)**

- Replacement  1035 Exchange

**ACCOUNT TYPE**

- Business  Personal

**AMOUNT**

\$

**ISSUE YEAR**

**PURPOSE**

**PROPOSED INSURED NAME**

**NAME OF COMPANY**

**POLICY NUMBER**

**TYPE (check one if applicable)**

- Replacement  1035 Exchange

**ACCOUNT TYPE**

- Business  Personal

**AMOUNT**

\$

**ISSUE YEAR**

**PURPOSE**



**LIFE INSURANCE IN FORCE, PENDING OR REPLACEMENT - Continued**

**PROPOSED INSURED NAME**

**NAME OF COMPANY**

**POLICY NUMBER**

**TYPE (check one if applicable)**

Replacement     1035 Exchange

**ACCOUNT TYPE**

Business     Personal

**AMOUNT**

\$

**ISSUE YEAR**

**PURPOSE**

**LIFESTYLE INFORMATION**

For "Yes" answers, complete Details section below.

		<b>Proposed Insured 1</b>	<b>Proposed Insured 2</b>
1. Have you used any form of nicotine in the past 12 months? Nicotine includes: cigarettes, cigars, pipe, smokeless tobacco, e-cigarettes, vaporizers, nicotine gum, patch, nasal spray, etc. If "No," select the answer that best describes tobacco/nicotine product history:		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/> No
<b>Proposed Insured 1</b>	<input type="checkbox"/> Never Used <input type="checkbox"/> Quit over 5 years ago <input type="checkbox"/> Quit over 2 years ago		<input type="checkbox"/> Quit over 1 year ago
<b>Proposed Insured 2</b>	<input type="checkbox"/> Never Used <input type="checkbox"/> Quit over 5 years ago <input type="checkbox"/> Quit over 2 years ago		<input type="checkbox"/> Quit over 1 year ago
2. Have you ever used illegal or other habit forming drugs, except as prescribed by a physician, ever received medical treatment or counseling for, or been advised by a physician to reduce or discontinue the use of alcohol or prescribed and/or non-prescribed drugs?		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/> No
3. Do you consume alcoholic beverages? If "Yes," provide the type, frequency and amount:		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/> No
	<b>TYPE OF BEVERAGE(S)</b> <b>FREQUENCY</b> <b>AMOUNT</b>		
	<input type="text"/> <input type="text"/> <input type="text"/>		
4. Received or been advised to seek treatment for, attended a program for or been counseled for alcohol or drug abuse, or been advised by a physician to reduce the use of alcohol?		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/> No
5. Have you ever had a driver's license suspended or revoked or, within the last 5 years, been convicted of or pled no contest to reckless or negligent driving or driving under the influence of alcohol or drugs?		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/> No
6. Are you currently receiving, or within the past 5 years have you received or applied for, any disability benefits, including Worker's Compensation, Social Security Disability Insurance, or any other form of Disability insurance?		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/> No
7. In the past 2 years have you been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home?		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/> No



**LIFESTYLE INFORMATION - Continued**

For “Yes” answers, complete Details section below.

- |   | <b>Proposed Insured 1</b>                                   | <b>Proposed Insured 2</b>                                   |
|---|---|---|
| 8. Within the next year, do you intend to travel or live outside of the U.S. or Canada? If “Yes,” list where, when, purpose and duration in the Details section. <b>If “Yes,” complete a Foreign Travel Supplement.</b>                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| 9. Within the past 2 years, did you fly as a pilot, crew member, or with any duties aboard an aircraft, or is there any intention of doing so within the next 2 years? <b>If “Yes,” complete an Aviation Supplement.</b>                      | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| 10. Within the past 2 years, did you engage in racing, parachuting, or scuba diving, or is there any intention of doing so within the next 2 years? <b>If “Yes,” complete a Scuba Diving Questionnaire.</b>                                   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| 11. Have you ever been convicted of, pled no contest to, or are you currently awaiting trial for, a felony or misdemeanor? If “Yes,” indicate in Details section type, date and city/state of felony and if currently on probation or parole. | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| 12. Are you a member of, or applied to be a member of, or received a notice of required service in, the military, reserves or National Guard? If “Yes,” please list branch of service, rank, duties, and current duty station.                | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| 13. Have you used, in either synthetic or natural form, marijuana (cannabis) or marijuana products in the past 12 months? If “No,” select the answer that best describes your marijuana or marijuana product history.                         | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| <b>Proposed Insured 1</b> <input type="checkbox"/> Never Used <input type="checkbox"/> Quit over 5 years ago <input type="checkbox"/> Quit over 2 years ago <input type="checkbox"/> Quit over 1 year ago                                     |   |   |
| <b>Proposed Insured 2</b> <input type="checkbox"/> Never Used <input type="checkbox"/> Quit over 5 years ago <input type="checkbox"/> Quit over 2 years ago <input type="checkbox"/> Quit over 1 year ago                                     |   |   |
| 14. Within the past 5 years, have you been declined, withdrawn, or postponed for insurance or had a policy issued other than as applied for?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| 15. What is your height and weight? If weight changed in the past 12 months, indicate pounds lost or gained.  |   |   |

<b>Proposed Insured 1</b>	<b>HEIGHT</b> (feet, inches) <input style="width: 100%;" type="text"/>	<b>WEIGHT</b> (pounds) <input style="width: 100%;" type="text"/>	<b>CHANGES IN WEIGHT</b> <input type="checkbox"/> Gain <input type="checkbox"/> Loss	<b>AMOUNT OF CHANGE</b> <input style="width: 100%;" type="text"/>
<b>Proposed Insured 2</b>	<b>HEIGHT</b> (feet, inches) <input style="width: 100%;" type="text"/>	<b>WEIGHT</b> (pounds) <input style="width: 100%;" type="text"/>	<b>CHANGES IN WEIGHT</b> <input type="checkbox"/> Gain <input type="checkbox"/> Loss	<b>AMOUNT OF CHANGE</b> <input style="width: 100%;" type="text"/>

**DETAILS**



**PHYSICIAN INFORMATION**

**PHYSICIAN NAME (for Proposed Insured 1)**

**TELEPHONE NUMBER (include area code)**

**ADDRESS**

**CITY**

**STATE**

**ZIP**

**DATE LAST SEEN (MM/DD/YYYY)**

**REASON FOR VISIT**

**TREATMENT / MEDICATION**

**PHYSICIAN NAME (for Proposed Insured 2)**

**TELEPHONE NUMBER (include area code)**

**ADDRESS**

**CITY**

**STATE**

**ZIP**

**DATE LAST SEEN (MM/DD/YYYY)**

**REASON FOR VISIT**

**TREATMENT / MEDICATION**

**ADDITIONAL REMARKS**

**MEDICAL INFORMATION**

**Complete this section unless a full paramedic exam or medical exam is required on the Proposed Insured(s). DO NOT remove these pages from the application. For "Yes" answers, complete Details section below.**

- |   | <b>Proposed Insured 1</b>    | <b>Proposed Insured 2</b>    |
|---|------------------------------|------------------------------|
| 1. Have you ever been diagnosed with, treated for, hospitalized for or been advised to seek treatment by a member of the medical profession for any of the following: |                              |                              |
| a. High blood pressure, high cholesterol or high triglycerides?   | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
|   | <input type="checkbox"/> No  | <input type="checkbox"/> No  |
| b. Heart disease or disorder, heart attack, heart failure, heart murmur, angina or chest pain, palpitations, irregular heart beat or coronary artery disease?         | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
|   | <input type="checkbox"/> No  | <input type="checkbox"/> No  |



**MEDICAL INFORMATION - Continued**

	<b>Proposed Insured 1</b>	<b>Proposed Insured 2</b>
c. Circulatory system disorder, thrombophlebitis, aneurysm, embolism, peripheral vascular disease or edema?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Chronic headaches, seizures, fainting, dizziness, epilepsy, paralysis, dementia, Alzheimer's Disease, cognitive impairment, or other nervous system or brain disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Any tumor, masses, cysts, cancer, melanoma, pre-cancerous lesion, lymphoma, or disorder of the lymph nodes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Anemia, leukemia, clotting disorder, or any other blood disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Diabetes or any complications of diabetes, elevated blood sugar, a disorder of the urinary tract or findings of sugar, protein or blood in the urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Asthma, emphysema, chronic obstructive pulmonary disease (COPD), shortness of breath, sleep apnea, tuberculosis, sarcoidosis, persistent bronchitis, spitting up blood or any other disorder of the lungs or respiratory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Arthritis, gout, fibromyalgia, any disorder of the back, spine, muscles, nerves, bones, joints or skin or a neuromuscular disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Ulcers, colitis (including Ulcerative Colitis), Crohn's disease, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder or pancreas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. Disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney, urinary bladder, kidney failure, reproductive organs, or any complication of pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. Thyroid, pituitary or other endocrine or glandular disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. Any nervous, mental, emotional, mood, anxiety, depression, PTSD, BiPolar, Schizophrenia, or a psychiatric disorder, or eating disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
n. Lupus, Scleroderma, Multiple Sclerosis (MS), Rheumatoid Arthritis, autoimmune disease, or connective tissue disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
o. Carotid artery disease, stroke, mini-stroke, or Transient Ischemic Attack (TIA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



**MEDICAL INFORMATION - Continued**

For “Yes” answers, complete Details section below.

- |   | <b>Proposed Insured 1</b>                                   | <b>Proposed Insured 2</b>                                   |
|---|---|---|
| 2. Ever tested positive for exposure to HIV (Human Immunodeficiency Virus) or been diagnosed as having or been treated for AIDS (Acquired Immune Deficiency Syndrome), or any other immune deficiency disorder?   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| 3. In the past 12 months have you been prescribed any medications other than contraceptives?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| 4. Within the past five years, have you been treated or examined by a member of the medical profession or been advised by a member of the medical profession to get specified medical care which was not completed, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)? | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| 5. Has any immediate family member (parents, sisters or brothers) died as a result of, or been diagnosed with, heart disease or cancer prior to age 60?   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |

**ADDITIONAL DETAILS AND EXPLANATIONS**

If any of the questions in the Medical Questions section are answered “Yes,” please give complete details below.

Question Number	Proposed Insured Name	Physicians, hospitals, illness, treatment, medical information, reason for checkup.	Date and Duration of Illness	Name, address, phone number of medical professionals, hospitals.



## AUTHORIZATION AND SIGNATURES

If you reside or have resided in a community property state (AZ, CA, ID, LA, NV, NM, TX, WA, or WI), and have not named your spouse sole beneficiary of this policy, your spouse may need to consent to a non-spouse being designated as beneficiary for any portion of its benefits. You may obtain such consent by having your spouse sign below. **The Company is not liable for any consequences resulting from your failure to obtain proper consent.**

**Spousal Consent (if applicable):** I have reviewed this beneficiary designation and, as spouse of the policy owner, I consent to it and waive any rights I may have to the policy proceeds to the extent of this designation. This consent supersedes any prior spousal consent regarding the policy.

Print Name \_\_\_\_\_  
OWNER'S SPOUSE (if applicable)

Sign Here \_\_\_\_\_ Date \_\_\_\_\_  
SIGNATURE OF OWNER'S SPOUSE (if applicable)

**MIB Authorization:** The undersigned, individually and on behalf of any children named in the application, authorize MIB, Inc. to give to Columbus Life Insurance Company, or its reinsurers, any information it has on me or named children.

I (we) also authorize the Company or its reinsurers to release any information collected about me or named child(ren) to MIB, Inc. and to other insurance companies with whom I (we) may apply for insurance. This authorization shall remain in effect for 24 months following the date of signature(s) below and can be revoked at any time by notifying the Company in writing at 400 East Fourth Street, P.O. Box 5737, Cincinnati, Ohio, 45201-5737. This time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery.

### AGREEMENT AND ACKNOWLEDGEMENT

**I (we) agree that:** A. These statements and answers and those in all overflow pages, supplements, amendments and medical examiners' reports will form the basis of any policy you issue. B. No one except your Chairman, President, or Secretary has the power to make or modify any contract of insurance or bind you in any way. C. No statement made by me (us) or by your agent or anyone else will bind you unless stated in this application. D. Unless a Temporary Insurance Agreement is duly executed and in effect, no insurance will take effect: (1) before this application is approved; and (2) before a policy is delivered and the first premium paid during the lifetime of each and every person proposed for insurance under the policy and then only if the health and other conditions affecting insurability remain as described in the application. The Company is liable under a Temporary Insurance Agreement only to the extent provided in such agreement. E. To the extent it may be lawful, I (we) waive all laws prohibiting a physician or other person from disclosing information obtained in the examination or treatment of a person to be insured. F. I (we) acknowledge receipt of notice about an investigative consumer report and the MIB, Inc. and insurance information practices.

I have read and acknowledge the Accelerated Death Benefit Disclosure Statement. I have received 1) a Privacy Policy Disclosure which details the method I must use to exercise my right to access, correct and amend any information gathered about me or my children which relates to this application; and 2) Disclosures Regarding Insurance Information Practices, including the MIB, Inc. Pre-Notice.

**OWNER: Taxpayer Identification Certifications (Substitute W-9) - Note: The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required below.** Under penalties of perjury, I certify that: (1) The SSN/TIN shown on this form is my correct Taxpayer Identification Number, and (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as the result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, or (d) if I am subject to backup withholding I will complete for you a separate original IRS form W-9 and (3) I am a U.S. citizen or other U.S. person. An IRS form W-9 and instructions can be found at <http://www.irs.gov/pub/irs-pdf/fw9.pdf>. I (we) have carefully reviewed each and every statement and answer in this application and represent that they are true and complete to the best of my (our) knowledge and belief.

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

A faxed or electronically transmitted signed document to Columbus Life Insurance Company has the same legal force and effect as the original signed document, and once received, is the controlling record.



**AUTHORIZATION AND SIGNATURES - Continued**

Signed in the State of: \_\_\_\_\_

Print Name \_\_\_\_\_  
PROPOSED INSURED 1 (if age 15 or older)

Sign Here \_\_\_\_\_  
SIGNATURE OF PROPOSED INSURED (if age 15 or older)

Date \_\_\_\_\_

Print Name \_\_\_\_\_  
APPLICANT / OWNER (if other than Proposed Insured)

Sign Here \_\_\_\_\_  
SIGNATURE OF APPLICANT / OWNER (if other than Proposed Insured)

Date \_\_\_\_\_

Print Name \_\_\_\_\_  
PROPOSED INSURED 2 (if age 15 or older)

Sign Here \_\_\_\_\_  
SIGNATURE OF PROPOSED INSURED 2 (if age 15 or older)

Date \_\_\_\_\_

Print Name \_\_\_\_\_  
PARENT (if Proposed Insured is under 18 years of age)

Sign Here \_\_\_\_\_  
SIGNATURE OF PARENT (if Proposed Insured is under 18 years of age)

Date \_\_\_\_\_

**AGENT INFORMATION AND SIGNATURE**

Excluding this policy, does the applicant (proposed owner) or any Proposed Insured have any existing annuities or life insurance policies in force or pending with any insurer? (This includes insurance sold or assigned, or that is in the process of being sold or assigned, informal inquiries and preliminaries).  Yes  No

Will the existing annuity contract(s) or life insurance policy(ies) be replaced as a result of this application?  Yes  No

By the signature below, I certify that I have asked and recorded completely and accurately the answers to all questions on this application. I know nothing affecting the risk that has not been recorded herein. I also certify that prior to signing the application; only Company approved sales material was used and I delivered to the applicant copies of all sales material, any proposal, outline of coverage, buyer's guide, comparison, and/or disclosure statement required by federal or state law to be delivered at the time of application.

**Primary Representative**

**NAME (First, Middle, Last)**  
\_\_\_\_\_

**AGENT STATE LICENSE NUMBER**  
\_\_\_\_\_

Sign Here \_\_\_\_\_  
SIGNATURE OF SALES REPRESENTATIVE/LICENSED AGENT

Date \_\_\_\_\_





# Columbus Life Insurance Company

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**Instruction to Agent:** The Illustration Certification Form is required to be completed and submitted with the application if:

1. No illustration is used in the sale of the policy; or
2. The life insurance policy is applied for other than as illustrated

## AGENT CERTIFICATION

**NO ILLUSTRATION USED**

I certify that no illustration conforming to the policy applied for was provided to the Applicant/Owner. I understand that an illustration conforming to the policy as issued will be provided to the Applicant/Owner no later than at the time the policy is delivered.

\_\_\_\_\_  
Agent's Printed Name

\_\_\_\_\_  
Agent's Signature

\_\_\_\_\_  
Date

**POLICY APPLIED FOR OTHER THAN AS ILLUSTRATED**

I certify that an illustration was presented to the Applicant/Owner, but the policy applied for is different than what was illustrated. I understand that an illustration conforming to the policy as issued will be provided to the Applicant/Owner no later than at the time the policy is delivered.

\_\_\_\_\_  
Agent's Printed Name

\_\_\_\_\_  
Agent's Signature

\_\_\_\_\_  
Date

## APPLICANT/OWNER ACKNOWLEDGEMENT

I acknowledge that no illustration conforming to the policy applied for was provided to me. I understand that an illustration conforming to the policy as issued will be provided to me no later than at the time the policy is delivered.

\_\_\_\_\_  
Applicant/Owner's Printed Name

\_\_\_\_\_  
Applicant/Owner's Signature

\_\_\_\_\_  
Date

**Complete two copies - provide one copy to the Applicant/Owner, return one copy to the Home Office.**





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## STATE OF TEXAS

### NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the Insurer, Columbus Life Insurance Company has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

#### Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV-related test a person should seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

#### Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

#### Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

## Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result:

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Address:

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In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

## Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the collection of sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

---

Name of Proposed Insured

---

Signature of Proposed Insured  
or Parent/Guardian

---

Address

Date signed: \_\_\_\_\_

Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result:

\_\_\_\_\_

Address:

\_\_\_\_\_

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the collection of sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

\_\_\_\_\_  
Name of Proposed Insured

\_\_\_\_\_  
Signature of Proposed Insured  
or Parent/Guardian

\_\_\_\_\_  
Address

Date signed: \_\_\_\_\_



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## **INDEXED EXPLORER PLUS AND SURVIVORSHIP INDEXED UNIVERSAL LIFE DISCLOSURE— INTEREST CREDITING**

(For use with Indexed Accounts with **0%** Indexed Account Minimum Guaranteed Interest Rate)

It is important you understand your Columbus Life Indexed Explorer Plus Universal Life Insurance policy and how we credit interest. Please review this document and the Life Insurance Illustration before signing at the bottom. For an explanation of anything you do not understand, please contact Columbus Life or your Producer. This disclosure is not intended to be a full description of your insurance policy. Refer to your policy for a full explanation of policy terms.

### **Insurance Product**

Your indexed universal life insurance policy is an insurance product. It is not a security or a substitute for a stock, bond, or mutual fund. It does not directly participate in the market or any market index.

A life insurance policy is designed for long-term needs such as a death benefit and retirement income. It is **not** designed to meet short-term financial goals. Monthly deductions will be taken from your policy's Account Value to pay various charges for insurance coverage. These charges, and any loans, withdrawals, or surrender (subject to charges) will offset to some extent interest credited to your policy. Regardless of performance from credited interest, your policy could lapse if your Net Cash Surrender Value is insufficient to pay policy charges or if loan indebtedness equals or exceeds Cash Surrender Value.

Your policy currently offers one Fixed Account, one Dollar Cost Averaging Account and three Indexed Accounts for allocation of premium and account value. You can allocate your money to one or more of these accounts. Interest that may be credited to your policy's Account Value is calculated the same for the Fixed Account and a Dollar Cost Averaging Account. Each indexed account is calculated differently. We may add, remove, or change the accounts available in the future.

### **Interest Crediting—Fixed Account / Dollar Cost Averaging Account (DCA Account)**

The Fixed Account and DCA Account credit interest daily at a fixed interest rate. We declare the fixed rate from time to time, but it will not be lower than 2%. Fixed interest applies only to the funds allocated to Fixed Account and DCA account.

### **Interest Crediting—Indexed Accounts**

Indexed Accounts calculate interest based on the performance of an external S&P 500® market index (without dividends) and on the indexed crediting methods described below.

Every allocation of premium to an Index Account begins an Index Account Segment. Indexed interest for each segment is calculated based on performance of the Indexed Account over a 12-month Index Period. No interest is credited, if any, until the end of the Index Period. Indexed Accounts for this policy have a minimum guaranteed interest rate of 0% for each 12-month Index Period. If at the end of the Index Period, the Index Rate is calculated as 0%, no interest will be credited. Or, if the value of an Indexed Account Segment equals zero prior to the end of the Index Period due to withdrawals, loans or deduction of charges, the Index Period will end and no indexed interest will be credited. Your Indexed Interest Credit will not be lower than zero, because of the 0% guarantee, even if the external index declined in value over the past year.

When a 12-month Index Period ends and indexed interest, if any, has been credited to a segment, the Indexed Account Segment ends and its value is reallocated to policy accounts according to your instructions for reallocation of segment Account Value.

Current participation rates, interest rate caps, spread rates and threshold rates, if applicable, used to determine indexed interest crediting, are declared in advance for each crediting period. Guaranteed rates vary by account and are shown below. Current rates may be changed, subject to policy guarantees. Any change will affect interest credited.

Separate Indexed Account Segments will be created for each allocation if you allocate net premiums to an Indexed Account more frequently than once per year. If multiple premium payments are received during the same 31-day period, they may be allocated to the same Indexed Account Segment. A new participation, threshold, spread, and/or cap rate may be applicable to each Indexed Account Segment, subject to policy guarantees.



## Indexed Interest Crediting Methods

- **S&P® 500 Capped Annual Point-to-Point Indexed Account:** Interest is determined for this account, in part, using a Capped Annual Point-to-Point Method that measures the S&P Index at the beginning and the end of the one-year crediting period. If the value of the Index is greater at the end of the crediting period, we will multiply the increase by a number called the participation rate and then apply an interest rate cap (a maximum) which we declare at the beginning of the Index Period and guarantee for the Index Period. We deduct the Indexed Account Minimum Guaranteed Interest Rate (MGIR) already credited to obtain the Index Rate. The Index Rate will never be less than zero. This account has a guaranteed Minimum Index Cap Rate of 3% and a guaranteed Index Participation Rate of 100%.
- **S&P® 500 Uncapped Indexed Annual Point-to-Point Indexed Account with Spread:** Interest is determined for this account, in part, by using an Uncapped Annual Point-to-Point with Spread method that measures the S&P Index at the beginning and end of the one-year crediting period. The Index Rate is subject to an Index Threshold Rate and an Index Spread Rate that we declare at the beginning of the Index Period and guarantee for the Index Period. If the Index Rate is less than or equal to the currently declared index threshold rate, the higher of the Index Rate and the Indexed Account MGIR is used. If the Indexed Rate is greater than the threshold rate, the higher of the Index Threshold Rate and the Index Rate minus the Index Spread Rate is used. We deduct the Indexed Account Minimum Guaranteed Interest Rate (MGIR) already credited to obtain the Index Rate. The Index Rate will never be less than zero. This account has a guaranteed Minimum Index Threshold Rate of 2%, a guaranteed Maximum Index Spread Rate of 15%, and a guaranteed Index Participation Rate of 100%.
- **S&P® 500 Uncapped Monthly Average Indexed Account:** Interest is determined for this account, in part, by using an Uncapped Annual Point to Monthly Average method that measures the S&P Index each month over the crediting period and comparing the average of those values to the value of the Index at the beginning of the one-year crediting period. The Index Rate is adjusted by a participation rate (the percentage of the increase used in the index interest calculation) which we declare at the beginning of the Index Period and guarantee for the Index Period. We deduct the Indexed Account Minimum Guaranteed Interest Rate (MGIR) already credited to obtain the Index Rate. The Index Rate will never be less than zero. The participation rate may be more or less than 100%. The guaranteed Minimum Index Participation rate is 30%.

## Comparing the Crediting Methods

The Capped Annual Point-to-Point method may perform well in a steadily increasing Index environment because it will capture the full increase in the Index over the period, but the cap will limit returns. The Uncapped Annual Point-to-Point with Spread method may perform well in a significantly increasing Index environment because any large returns of the market will not be capped, but will be reduced by a spread. The Uncapped Annual Point to Monthly Average method may perform well in a fluctuating Index environment because it uses the average monthly increase. If the Index fluctuates during an Index period, but decreases toward the end, the net increase could be zero under the Capped Annual Point to Point and the Uncapped Annual Point-to-Point with Spread methods, but could have an average monthly increase greater than zero under the Uncapped Annual Point to Monthly Average method. In years where the Index decreases steadily, the Index increase will be zero under any method and you will receive no Indexed Interest Credit.

## Index Account Interest Crediting Examples

Assume you allocate part of your premium to each of the three indexed accounts, there are no withdrawals, loans, or charges taken from these accounts, and the beginning S&P 500® Index value is 1000.

- In Example 1, the index values on the next 12 Index Dates are 1020, 1040, 1060, 1080, 1100, 1100, 1080, 1060, 1040, 1020, 1000 and 1000. The average of the monthly values is 1050.
- In Example 2, the index values on the next 12 Index Dates are 1010, 1020, 1030, 1040, 1050, 1060, 1070, 1080, 1090, 1100, 1110, and 1120. The average of the monthly values is 1065.

For both examples, where applicable, the current assumed Index Cap Rate is 10% for the Capped Annual Point-to-Point, the Index Participation Rate is 110% for the Uncapped Annual Point to Monthly Average, and the Threshold and Spread rates are 9% and 5%, respectively for the Uncapped Annual Point-to-Point with Spread accounts.



Index values and percentages are for illustrative purposes only, do not project performance of the Index or of any Indexed Account, and are not guaranteed.

	<b>Step 1 (Compare Index Values)</b>	<b>Step 2 (Apply Cap, Threshold, Spread or Participation Rate; adjust to be no less than MGIR)</b>	<b>Step 3 (Deduct Minimum Guaranteed Interest)</b>
<b>Example 1 - Fluctuating Index</b>			
Capped Annual Point-to-Point	$(1000 - 1000)/1000 = 0\%$	0% is less than 10% cap; adjust to equal 0%	$0\% - 0\% = 0\%$
Uncapped Annual Point-to-Point with Spread	$(1000 - 1000)/1000 = 0\%$	0% is less than 9% threshold; adjust to equal 0%	$0\% - 0\% = 0\%$
Uncapped Annual Point to Monthly Average	$(1050 - 1000)/1000 = 5\%$	$5\% \times 110\%$ participation rate = 5.5%	$5.50\% - 0\% = 5.50\%$
<b>Example 2 - Steadily Increasing Index</b>			
Capped Annual Point-to-Point	$(1120 - 1000)/1000 = 12\%$	12% is adjusted to equal 10% cap	$10\% - 0\% = 10\%$
Uncapped Annual Point-to-Point with Spread	$(1120 - 1000)/1000 = 12\%$	12% is adjusted to equal 9%: the maximum of $12\% - 5\% = 7\%$ and 9% due to the index return greater than the threshold	$9\% - 0\% = 9\%$
Uncapped Annual Point to Monthly Average	$(1065 - 1000)/1000 = 6.5\%$	$6.5\% \times 110\%$ participation rate = 7.15%	$7.15\% - 0\% = 7.15\%$

I have read, understand, and have been given a copy of this Indexed Explorer Plus Universal Life Insurance Disclosure. The Insurance Producer has answered any concerns or questions and has not made any statements that differ from the Disclosure Statement nor any promises or assurances about future values of the policy.

\_\_\_\_\_  
Owner/Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Owner/Applicant's Printed Name

\_\_\_\_\_  
Joint Owner/Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Joint Owner/Applicant's Printed Name

\_\_\_\_\_  
Insurance Producer's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Insurance Producer's Printed Name



### **Index Provider Disclosures**

The S&P 500® is a product of S&P Dow Jones Indices LLC or its affiliates (“SPDJI”) and has been licensed for use by Columbus Life Insurance Company (“Columbus Life”), including the insurance company issuing this endorsement. S&P® is a registered trademark of Standard & Poor’s Financial Services LLC (“S&P”). This policy is not sponsored, endorsed, sold or promoted by SPDJI, S&P, or any of their respective affiliates (collectively, “S&P Dow Jones Indices”). S&P Dow Jones Indices makes no representation or warranty, express or implied, to the owners of this policy or any member of the public regarding the advisability of investing in securities generally or in this policy particularly or the ability of the Index to track general market performance. S&P Dow Jones Indices’ only relationship to the insurance company with respect to the S&P 500® is the licensing of the Index and certain trademarks, service marks and/or trade names of S&P Dow Jones Indices. The Index is determined, composed and calculated by S&P Dow Jones Indices without regard to Columbus Life or this policy. S&P Dow Jones Indices has no obligation to take the needs of Columbus Life or the owners of this policy into consideration in determining, composing or calculating the S&P 500®. S&P Dow Jones Indices is not responsible for and have not participated in the determination of the prices, and amount of this policy or the timing of the issuance or sale of this policy or in the determination or calculation of the equation by which this policy is to be converted into cash, surrendered or redeemed, as the case may be. S&P Dow Jones Indices has no obligation or liability in connection with the administration, marketing or trading of this policy. There is no assurance that investment products based on the S&P 500® will accurately track index performance or provide positive investment returns. S&P Dow Jones Indices LLC is not an investment advisor. Inclusion of a security within an index is not a recommendation by S&P Dow Jones Indices to buy, sell, or hold such security, nor is it considered to be investment advice.

S&P DOW JONES INDICES DOES NOT GUARANTEE THE ADEQUACY, ACCURACY, TIMELINESS AND/OR THE COMPLETENESS OF THE S&P 500® OR ANY DATA RELATED THERETO OR ANY COMMUNICATION, INCLUDING BUT NOT LIMITED TO, ORAL OR WRITTEN COMMUNICATION (INCLUDING ELECTRONIC COMMUNICATIONS) WITH RESPECT THERETO. S&P DOW JONES INDICES SHALL NOT BE SUBJECT TO ANY DAMAGES OR LIABILITY FOR ANY ERRORS, OMISSIONS, OR DELAYS THEREIN. S&P DOW JONES INDICES MAKES NO EXPRESS OR IMPLIED WARRANTIES, AND EXPRESSLY DISCLAIMS ALL WARRANTIES, OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OR USE OR AS TO RESULTS TO BE OBTAINED BY COLUMBUS LIFE, OWNERS OF THE POLICY, OR ANY OTHER PERSON OR ENTITY FROM THE USE OF THE S&P 500® OR WITH RESPECT TO ANY DATA RELATED THERETO. WITHOUT LIMITING ANY OF THE FOREGOING, IN NO EVENT WHATSOEVER SHALL S&P DOW JONES INDICES BE LIABLE FOR ANY INDIRECT, SPECIAL, INCIDENTAL, PUNITIVE, OR CONSEQUENTIAL DAMAGES INCLUDING BUT NOT LIMITED TO, LOSS OF PROFITS, TRADING LOSSES, LOST TIME OR GOODWILL, EVEN IF THEY HAVE BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES, WHETHER IN CONTRACT, TORT, STRICT LIABILITY, OR OTHERWISE. THERE ARE NO THIRD PARTY BENEFICIARIES OF ANY AGREEMENTS OR ARRANGEMENTS BETWEEN S&P DOW JONES INDICES AND COLUMBUS LIFE, OTHER THAN THE LICENSORS OF S&P DOW JONES INDICES.





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## **INDEXED EXPLORER PLUS AND SURVIVORSHIP INDEXED UNIVERSAL LIFE DISCLOSURE— INTEREST CREDITING**

(For use with Indexed Accounts with 1% Indexed Account Minimum Guaranteed Interest Rate)

It is important you understand your Columbus Life Indexed Explorer Plus Universal Life Insurance policy and how we credit interest. Please review this document and the Life Insurance Illustration before signing at the bottom. For an explanation of anything you do not understand, please contact Columbus Life or your Producer. This disclosure is not intended to be a full description of your insurance policy. Refer to your policy for a full explanation of policy terms.

### **Insurance Product**

Your indexed universal life insurance policy is an insurance product. It is not a security or a substitute for a stock, bond, or mutual fund. It does not directly participate in the market or any market index.

A life insurance policy is designed for long-term needs such as a death benefit and retirement income. It is **not** designed to meet short-term financial goals. Monthly deductions will be taken from your policy's Account Value to pay various charges for insurance coverage. These charges, and any loans, withdrawals, or surrender (subject to charges) will offset to some extent interest credited to your policy. Regardless of performance from credited interest, your policy could lapse if your Net Cash Surrender Value is insufficient to pay policy charges or if loan indebtedness equals or exceeds Cash Surrender Value.

Your policy currently offers one Fixed Account, one Dollar Cost Averaging Account and three Indexed Accounts for allocation of premium and Account Value. You can allocate your money to one or more of these accounts. Interest that may be credited to your policy's Account Value is calculated the same for the Fixed Account and a Dollar Cost Averaging Account. Each indexed account is calculated differently. We may add, remove, or change the accounts available in the future.

### **Interest Crediting—Fixed Account / Dollar Cost Averaging Account (DCA Account)**

The Fixed Account and DCA Account credit interest daily at a fixed interest rate. We declare the fixed rate from time to time, but it will not be lower than 2%. Fixed interest applies only to funds allocated to the Fixed Account and DCA Account.

### **Interest Crediting –Indexed Accounts**

Indexed Accounts calculate interest based on the performance of an external S&P 500<sup>®</sup> market index (without dividends) and on the indexed crediting methods described below.

Every allocation of premium to an Index Account begins an Index Account Segment. Indexed interest for each segment is calculated based on performance of the Indexed Account over a 12-month index period. Indexed Accounts for this policy have an Indexed Account Minimum Guaranteed Interest Rate (MGIR) of 1% for each 12-month Index Period. After the Index Period begins, we will credit 1% interest to your Indexed Account Segments on each day during the Index Period. At the end of the Index Period, if the Index Rate is calculated as 0%, no additional interest (indexed interest) will be credited. If the value of an Indexed Account Segment equals zero prior to the end of the Index Period due to withdrawals, loans or deduction of charges, the Index Period will end and no indexed interest will be credited. Your Indexed Interest Credit will not be lower than zero, because of the 1% guarantee, even if the external index declined in value over the past year.

When a 12-month Index Period ends and indexed interest, if any, has been credited to a segment, the Indexed Account Segment ends and its value is reallocated to policy accounts according to your instructions for reallocation of segment Account Value.

Current participation rates, interest rate caps, spread rates and threshold rates, if applicable, used to determine indexed interest crediting, are declared in advance for each crediting period. Guaranteed rates vary by account and are shown below. Current rates may be changed, subject to policy guarantees. Any change will affect interest credited.

Separate Indexed Account Segments will be created for each allocation if you allocate net premiums to an Indexed Account more frequently than once per year. If multiple premium payments are received during the same 31-day period, they may be allocated to the same Indexed Account Segment. A new participation, threshold, spread, and/or cap rate may be applicable to each Indexed Account Segment, subject to policy guarantees.



## Indexed Interest Crediting Methods

- **S&P® 500 Capped Annual Point-to-Point Indexed Account:** Interest is determined for this account, in part, using a Capped Annual Point-to-Point Method that measures the S&P Index at the beginning and the end of the one-year crediting period. If the value of the Index is greater at the end of the crediting period, we will multiply the increase by a number called the participation rate and then apply an interest rate cap (a maximum) which we declare at the beginning of the Index Period and guarantee for the Index Period. We deduct the Indexed Account Minimum Guaranteed Interest Rate (MGIR) already credited to obtain the Index Rate. The Index Rate will never be less than zero. This account has a guaranteed Minimum Index Cap Rate of 3% and a guaranteed Index Participation Rate of 100%.
- **S&P® 500 Uncapped Indexed Annual Point-to-Point Indexed Account with Spread:** Interest is determined for this account, in part, by using an Uncapped Annual Point-to-Point with Spread method that measures the S&P Index at the beginning and end of the one-year crediting period. The Index Rate is subject to an Index Threshold Rate and an Index Spread Rate that we declare at the beginning of the Index Period and guarantee for the Index Period. If the Index Rate is less than or equal to the currently declared index threshold rate, the higher of the Index Rate and the Indexed Account MGIR is used. If the Indexed Rate is greater than the threshold rate, the higher of the Index Threshold Rate and the Index Rate minus the Index Spread Rate is used. We deduct the Indexed Account Minimum Guaranteed Interest Rate (MGIR) already credited to obtain the Index Rate. The Index Rate will never be less than zero. This account has a guaranteed Minimum Index Threshold Rate of 2%, a guaranteed Maximum Index Spread Rate of 15%, and a guaranteed Index Participation Rate of 100%.
- **S&P® 500 Uncapped Monthly Average Indexed Account:** Interest is determined for this account, in part, by using an Uncapped Annual Point to Monthly Average method that measures the S&P Index each month over the crediting period and comparing the average of those values to the value of the Index at the beginning of the one-year crediting period. The Index Rate is adjusted by a participation rate (the percentage of the increase used in the index interest calculation) which we declare at the beginning of the Index Period and guarantee for the Index Period. We deduct the Indexed Account Minimum Guaranteed Interest Rate (MGIR) already credited to obtain the Index Rate. The Index Rate will never be less than zero. The participation rate may be more or less than 100%. The guaranteed Minimum Index Participation rate is 30%.

## Comparing the Crediting Methods

The Capped Annual Point-to-Point method may perform well in a steadily increasing Index environment because it will capture the full increase in the Index over the period, but the cap will limit returns. The Uncapped Annual Point-to-Point with Spread method may perform well in a significantly increasing Index environment because any large returns of the market will not be capped, but will be reduced by a spread. The Uncapped Annual Point to Monthly Average method may perform well in a fluctuating Index environment because it uses the average monthly increase. If the Index fluctuates during an Index period, but decreases toward the end, the net increase could be zero under the Capped Annual Point-to-Point and the Uncapped Annual Point-to-Point with Spread methods, but could have an average monthly increase greater than zero under the Uncapped Annual Point to Monthly Average method. In years where the Index decreases steadily, the Index increase will be zero under any method and you will receive no Indexed Interest Credit.

## Index Account Interest Crediting Examples

Assume you allocate part of your premium to each of the three indexed accounts, that there are no withdrawals, loans, or charges taken from these accounts, and the beginning S&P 500® Index value is 1000.

- In Example 1, the index values on the next 12 Index Dates are 1020, 1040, 1060, 1080, 1100, 1100, 1080, 1060, 1040, 1020, 1000 and 1000. The average of the monthly values is 1050.
- In Example 2, the index values on the next 12 Index Dates are 1010, 1020, 1030, 1040, 1050, 1060, 1070, 1080, 1090, 1100, 1110, and 1120. The average of the monthly values is 1065.

For both examples, where applicable, the current assumed Index Cap Rate is 10% for the Capped Annual Point-to-Point, the Index Participation Rate is 110% for the Uncapped Annual Point to Monthly Average, and the Threshold and Spread rates are 9% and 5%, respectively for the Uncapped Annual Point-to-Point with Spread accounts.



Index values and percentages are for illustrative purposes only, do not project performance of the Index or of any Indexed Account, and are not guaranteed.

	Step 1 (Compare Index Values)	Step 2 (Apply Cap, Threshold, Spread or Participation Rate; adjust to be no less than MGIR)	Step 3 (Deduct Minimum Guaranteed Interest)
<b>Example 1 - Fluctuating Index</b>			
Capped Annual Point-to-Point	$(1000 - 1000)/1000 = 0\%$	0% is less than 10% cap; adjust to equal 1%	$1\% - 1\% = 0\%$
Uncapped Annual Point-to-Point with Spread	$(1000 - 1000)/1000 = 0\%$	0% is less than 9% threshold; adjust to equal 1%	$1\% - 1\% = 0\%$
Uncapped Annual Point to Monthly Average	$(1050 - 1000)/1000 = 5\%$	$5\% \times 110\%$ participation rate = 5.5%	$5.50\% - 1\% = 4.50\%$
<b>Example 2 - Steadily Increasing Index</b>			
Capped Annual Point-to-Point	$(1120 - 1000)/1000 = 12\%$	12% is adjusted to equal 10% cap	$10\% - 1\% = 9\%$
Uncapped Annual Point-to-Point with Spread	$(1120 - 1000)/1000 = 12\%$	12% is adjusted to equal 9%: the maximum of $12\% - 5\% = 7\%$ and 9% due to the index return greater than the threshold	$9\% - 1\% = 8\%$
Uncapped Annual Point to Monthly Average	$(1065 - 1000)/1000 = 6.5\%$	$6.5\% \times 110\%$ participation rate = 7.15%	$7.15\% - 1\% = 6.15\%$

I have read, understand, and have been given a copy of this Indexed Explorer Plus Universal Life Insurance Disclosure. The Insurance Producer has answered any concerns or questions and has not made any statements that differ from the Disclosure Statement nor any promises or assurances about future values of the policy.

\_\_\_\_\_  
Owner/Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Owner/Applicant's Printed Name

\_\_\_\_\_  
Joint Owner/Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Joint Owner/Applicant's Printed Name

\_\_\_\_\_  
Insurance Producer's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Insurance Producer's Printed Name



## Index Provider Disclosures

The S&P 500® is a product of S&P Dow Jones Indices LLC or its affiliates (“SPDJI”) and has been licensed for use by Columbus Life Insurance Company (“Columbus Life”), including the insurance company issuing this endorsement. S&P® is a registered trademark of Standard & Poor’s Financial Services LLC (“S&P”). This policy is not sponsored, endorsed, sold or promoted by SPDJI, S&P, or any of their respective affiliates (collectively, “S&P Dow Jones Indices”). S&P Dow Jones Indices makes no representation or warranty, express or implied, to the owners of this policy or any member of the public regarding the advisability of investing in securities generally or in this policy particularly or the ability of the Index to track general market performance. S&P Dow Jones Indices’ only relationship to the insurance company with respect to the S&P 500® is the licensing of the Index and certain trademarks, service marks and/or trade names of S&P Dow Jones Indices. The Index is determined, composed and calculated by S&P Dow Jones Indices without regard to Columbus Life or this policy. S&P Dow Jones Indices has no obligation to take the needs of Columbus Life or the owners of this policy into consideration in determining, composing or calculating the S&P 500®. S&P Dow Jones Indices is not responsible for and have not participated in the determination of the prices, and amount of this policy or the timing of the issuance or sale of this policy or in the determination or calculation of the equation by which this policy is to be converted into cash, surrendered or redeemed, as the case may be. S&P Dow Jones Indices has no obligation or liability in connection with the administration, marketing or trading of this policy. There is no assurance that investment products based on the S&P 500® will accurately track index performance or provide positive investment returns. S&P Dow Jones Indices LLC is not an investment advisor. Inclusion of a security within an index is not a recommendation by S&P Dow Jones Indices to buy, sell, or hold such security, nor is it considered to be investment advice.

S&P DOW JONES INDICES DOES NOT GUARANTEE THE ADEQUACY, ACCURACY, TIMELINESS AND/OR THE COMPLETENESS OF THE S&P 500® OR ANY DATA RELATED THERETO OR ANY COMMUNICATION, INCLUDING BUT NOT LIMITED TO, ORAL OR WRITTEN COMMUNICATION (INCLUDING ELECTRONIC COMMUNICATIONS) WITH RESPECT THERETO. S&P DOW JONES INDICES SHALL NOT BE SUBJECT TO ANY DAMAGES OR LIABILITY FOR ANY ERRORS, OMISSIONS, OR DELAYS THEREIN. S&P DOW JONES INDICES MAKES NO EXPRESS OR IMPLIED WARRANTIES, AND EXPRESSLY DISCLAIMS ALL WARRANTIES, OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OR USE OR AS TO RESULTS TO BE OBTAINED BY COLUMBUS LIFE, OWNERS OF THE POLICY, OR ANY OTHER PERSON OR ENTITY FROM THE USE OF THE S&P 500® OR WITH RESPECT TO ANY DATA RELATED THERETO. WITHOUT LIMITING ANY OF THE FOREGOING, IN NO EVENT WHATSOEVER SHALL S&P DOW JONES INDICES BE LIABLE FOR ANY INDIRECT, SPECIAL, INCIDENTAL, PUNITIVE, OR CONSEQUENTIAL DAMAGES INCLUDING BUT NOT LIMITED TO, LOSS OF PROFITS, TRADING LOSSES, LOST TIME OR GOODWILL, EVEN IF THEY HAVE BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES, WHETHER IN CONTRACT, TORT, STRICT LIABILITY, OR OTHERWISE. THERE ARE NO THIRD PARTY BENEFICIARIES OF ANY AGREEMENTS OR ARRANGEMENTS BETWEEN S&P DOW JONES INDICES AND COLUMBUS LIFE, OTHER THAN THE LICENSORS OF S&P DOW JONES INDICES.





# Columbus Life Insurance Company

A member of Western & Southern Financial Group

400 EAST FOURTH STREET • CINCINNATI, OHIO 45202-3302 • 1-800-677-9696 • WWW.COLUMBUSLIFE.COM

## Disclosures Regarding Insurance Information Practices

### MIB, Inc. Pre-Notice

Information regarding your insurability will be treated as confidential. We, or our reinsurers, may however, make a brief report to The MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

We, or our reinsurers, may also release information in our respective files to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

### Consumer Reports Notification

We may ask an independent agency to prepare a consumer report or an investigative consumer report about you. These reports may include information on your character, general reputation, personal characteristics, such as health, finances, or job, and mode of living. Any information obtained by the agency may be kept in its file and later given to others who have a business need for it.

If an investigative consumer report is ordered by us, the report will include information obtained through interviews with your neighbors, friends, or others with whom you are acquainted. You may also request a personal interview. The agency will then make a reasonable attempt to talk to you and include that information in its report. Also, the Federal Fair Credit Reporting Act gives you the right to make a written request, within a reasonable period of time, to receive additional information from us about the nature and scope of the investigation, if one is made. We will provide you with the name, address and phone number of any agency we ask to prepare such a report. Then you may contact the agency directly about the contents of the report.

### Notice Of Insurance Information Practices

Personal information may be collected from persons other than those proposed for insurance coverage. Such information as well as other personal or privileged information collected by us and our agent may in certain circumstances be disclosed to third parties without authorization. A right of access and correction exists with respect to all personal information collected. Further details of these practices are available upon request.

Applicant Copy



# Columbus Life Insurance Company

A member of Western & Southern Financial Group

400 East Fourth Street, Cincinnati, OH 45202

## UNIVERSAL LIFE PLANS Specified Disease , Chronic Illness & Terminal Illness Accelerated Death Benefit Rider Disclosure

The Accelerated Death Benefit Rider provides the owner the right to receive an accelerated payment of a portion of the death benefit in the form of an advance when the Insured has experienced any of the following qualifying events: (1) Specified Disease ; (2) Chronic Illness; or (3) Terminal Illness. In the case of a Chronic Illness, the owner may elect a periodic payment.

For joint life policies, no advance may be taken until the first Insured has died, and the surviving Insured has experienced one of the qualifying events.

### ACCELERATING CONDITIONS

“Specified Disease ” means Acquired Immune Deficiency Syndrome (AIDS), End-Stage Renal Failure, First Coronary Angioplasty, First Coronary Artery Bypass, First Myocardial Infarction, Life Threatening Cancer, Major Organ Transplant, Medical condition requiring permanent, continuous life support, or Stroke.

“Chronic Illness” means the Insured:

- (1) has been unable to perform (without substantial assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity and a Licensed Health Care Practitioner has determined the loss of ability to perform those Activities of Daily Living is expected to be permanent
- (2) be disabled at a similar level, as determined by rules promulgated by the US Secretary of Treasury, in consultation with the US Secretary of Health and Human Services, under section 7702B of the IRC of 1986, as amended by HIPAA of 1996;
- (3) requires Substantial Supervision to protect themselves from threats to health and safety due to Severe Cognitive Impairment.

An advance for Chronic Illness will not be paid until 24 months after the Policy Date unless the Chronic Illness results from an Accidental Bodily Injury that occurred after the Policy Date.

“Terminal Illness” means an illness that is expected to result in death within 24 months or less of the date the medical evidence is provided to us.

### RIDER CHARGES

There is no charge for this rider, but interest will be charged on the amount of the advance. Also, we reserve the right to assess an administrative fee of not more than \$150 to process claims under this rider.

### IMPACT ON POLICY VALUES

When an advance is paid, a lien is created against the policy. We will increase the lien, if necessary, to keep the policy in force. If a premium remains unpaid at the end of the grace period, we will increase the lien by the amount of the premium with lien interest to the next policy anniversary. If you do not pay lien interest when it is due, it will be added to the amount of the lien. For the portion of the outstanding lien that is less than or equal to the net cash surrender Value of the policy, the lien interest rate will be the lesser of (a) the fixed loan interest rate then in effect under the policy or (b) 8% per year. The lien interest rate on the amount of the outstanding lien in excess of the net cash surrender value will be 8%. The lien will continue to exist against the policy until it is repaid or the policy terminates. In addition, while a lien is outstanding, the lien will be increased each month to pay the monthly policy charges.

The loan amount available under the policy will be reduced by the amount of any outstanding lien. The net cash surrender value available upon surrender of the policy will be reduced by the amount of any outstanding lien.

A lien will not reduce the Specified Amount, Account Value, or Cash Surrender Value of the policy.

Unless the lien is repaid before the Insured's death, the death benefit payable will be reduced by any outstanding lien, including interest. Subject to meeting certain conditions, a Residual Death Benefit is available under the policy, which is offset by any policy loans existing at the time of the Insured's death.

### TAX CONSEQUENCES

**The acceleration-of-life-insurance benefits offered under this contract are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the acceleration-of-life-insurance benefits qualify for such favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to acceleration-of-life-insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive acceleration-of-life-insurance benefits excludable from income under federal law. Neither the Company nor its agents can provide tax advice on the form.**

Receipt of acceleration-of-life-insurance benefits may affect You, Your spouse or Your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect You, Your spouse, and Your family's eligibility for public assistance.

### ACKNOWLEDGEMENTS

**A. Complete this section at time of application.**

I acknowledge that I received, read and understand the Accelerated Death Benefit Rider Disclosure provided in connection with my application for a life insurance policy with the Columbus Life Insurance Company.

\_\_\_\_\_  
Printed Name of Applicant/Proposed Owner

\_\_\_\_\_  
Signature of Applicant/Proposed Owner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Agent

\_\_\_\_\_  
Signature of Agent

\_\_\_\_\_  
Date

**B. Complete this section when requesting a claim for accelerated benefits.**

I acknowledge that I received, read and understand the Accelerated Death Benefit Rider Disclosure provided and consent to payment of the benefit described in the Accelerated Death Benefit Rider form provided with my policy.

\_\_\_\_\_  
Name of Insured

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Printed Name of Owner

Complete two copies; one copy for the applicant/owner, return one copy to the Home Office

\_\_\_\_\_  
Signature of Owner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Irrevocable Beneficiary

\_\_\_\_\_  
Signature of Irrevocable Beneficiary

\_\_\_\_\_  
Date

Complete two copies; one copy for the applicant/owner, return one copy to the Home Office



<b>FACTS</b> WHAT DOES WESTERN & SOUTHERN FINANCIAL GROUP DO WITH YOUR PERSONAL INFORMATION?		
<b>Why?</b>	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.	
<b>What?</b>	<p>The types of personal information we collect and share depend on the product or service you have with us. This information can include:</p> <ul style="list-style-type: none"> <li>• Social Security number and address</li> <li>• Account balances and transaction history</li> <li>• Assets, income, and credit history</li> </ul>	
<b>How?</b>	All financial companies need to share customers' personal information to run their everyday business and provide applicable products and services. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Western & Southern Financial Group chooses to share; and whether you can limit this sharing.	
	<b>Reasons we can share your personal information</b>	<b>Does Western &amp; Southern Financial Group share?</b>
	<b>For our everyday business purposes—</b> such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes
	<b>For our marketing purposes—</b> to offer our products and services to you	Yes
	<b>For joint marketing with other financial companies</b>	Yes
	<b>For our affiliates' everyday business purposes—</b> information about your transactions and experiences	Yes
	<b>For our affiliates' everyday business purposes—</b> information about your creditworthiness	Yes
	<b>For our affiliates to market to you</b>	Yes
	<b>For nonaffiliates to market to you</b>	No
		<b>Can you limit this sharing?</b>
		No
		No
		No
		Yes
		Yes
		We don't share.
<b>To limit our sharing of the applicable items above</b>	<ul style="list-style-type: none"> <li>• Call (866) 590-1349 and follow the instructions provided</li> </ul> <p><b>Please note:</b> If you are a <i>new</i> customer, we can begin sharing your information 30 days from the date we sent this notice to you. When you are <i>no longer</i> our customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing of the applicable items above.</p>	
<b>Questions?</b>	Call (800) 926-1993.	

Who we are	
Who is providing this notice?	Companies owned by Western & Southern Financial Group, Inc. A list of companies is located at the end of this notice.
What we do	
How does Western & Southern Financial Group protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. Except as authorized by you in writing, we limit access to your information to those who need it to do their jobs or service your account.
How does Western & Southern Financial Group collect my personal information?	<p>We collect your personal information, for example, when you</p> <ul style="list-style-type: none"> <li>• Give us your contact information</li> <li>• Open an account</li> <li>• Provide account information</li> <li>• Purchase products or services from us</li> <li>• Seek advice about your investments</li> </ul> <p>We may also collect your personal information from others, such as credit bureaus, affiliates, or other companies.</p>
Why can't I limit all sharing?	<p>Federal law gives you the right to limit only</p> <ul style="list-style-type: none"> <li>• Sharing for affiliates' everyday business purposes—information about your credit worthiness</li> <li>• Affiliates from using your information to market to you</li> <li>• Sharing for nonaffiliates to market to you</li> </ul> <p>State laws and individual companies may provide you additional rights to limit sharing. See below for more on your rights under state law.</p>
What happens when I limit sharing for an account I hold jointly with someone else?	Your choices will apply to everyone on your account—unless you tell us otherwise.
Definitions	
<b>Affiliates</b>	<p>Companies related by common ownership or control. They can be financial and nonfinancial companies.</p> <ul style="list-style-type: none"> <li>• <i>Our affiliates include companies with the Western &amp; Southern name. Visit our website at <a href="https://www.westernsouthern.com/about/family-of-companies">https://www.westernsouthern.com/about/family-of-companies</a> for a list of affiliated companies.</i></li> </ul>
<b>Nonaffiliates</b>	<p>Companies not related by common ownership or control. They can be financial and nonfinancial companies.</p> <ul style="list-style-type: none"> <li>• <i>We do not share with nonaffiliates so they can market to you.</i></li> </ul>
<b>Joint marketing</b>	<p>A formal agreement between nonaffiliated financial companies that together market financial products or services to you.</p> <ul style="list-style-type: none"> <li>• Our joint marketing partners include other financial service companies, such as banks.</li> </ul>
Other important information	
You may have other privacy protections under applicable state laws. To the extent these state laws apply, we will comply with them when we share information about you.	
<p><b>For California residents:</b> In accordance with California law, we will not share information we collect about you except as permitted by California law. This may include: for our everyday business purposes, for marketing our products and services to you, and as permitted by law or otherwise authorized by you, including, for example, to service your account. We limit sharing among our affiliates to the extent required by California law. Types of information we collect, in addition to what is described in this notice, may include, but is not limited to: financial information, demographic information, medical information, and employment information. We do not sell your information, nor do we share information with nonaffiliate companies. Per the California Consumer Privacy Act, you have the right to: access your personal information that is collected, request that we delete your personal information pursuant to this Act, request information about how your information is shared and what it is used for, know with what third parties your information is shared, and opt-out of the sharing of your personal information. To exercise any of these rights, you may visit our website or call customer service to submit a request. For additional information regarding our privacy policies, visit our website or call (800) 926-1993.</p>	
<p><b>For Vermont residents:</b> We will not disclose information about your creditworthiness to our affiliates and will not disclose your personal information, financial information, credit report, or health information to nonaffiliated third parties to market to you, other than as permitted by Vermont law, unless you authorize us to make those disclosures. For additional information concerning our privacy policies, visit our website or call (800) 926-1993.</p>	

**For Nevada residents:** This notice is provided to you pursuant to state law. We may contact you by telephone to offer additional financial products that we believe may be of interest to you. You have the right to opt out of these calls by adding your name to our internal do-not-call list. To opt out of these calls, or for more information about your opt out rights, please contact our customer service department by telephoning (866) 590-1349. Nevada state law requires us to provide you with the following contact information: You may contact the Nevada Attorney General for more information about your opt out rights by calling 702-486-3132, emailing [aginfo@ag.nv.gov](mailto:aginfo@ag.nv.gov), or by writing to: Office of the Attorney General, Nevada Department of Justice, Bureau of Consumer Protection, 100 North Carson Street, Carson City, NV 89701-4717.

For insurance customers in AZ, CA, CT, GA, IL, ME, MA, MN, MT, NV, NJ, NM, NC, ND, OH, OR, and VA only: The term "Information" means information we collect during an insurance transaction. We will not use your medical information for marketing purposes without your consent. We may share your Information with others, including insurance-support organizations, insurance regulatory authorities, law enforcement, and consumer reporting agencies, without your prior authorization as permitted or required by law. Information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

**Who is providing this notice?**

The Western & Southern Financial Group, Inc. member companies are Columbus Life Insurance Company, The Western and Southern Life Insurance Company, Western-Southern Life Assurance Company, The Lafayette Life Insurance Company, Gerber Life Agency, LLC, Integrity Life Insurance Company, National Integrity Life Insurance Company, W&S Financial Group Distributors, Inc., IFS Financial Services, Inc., Touchstone Securities, Inc., Touchstone Advisors, Inc., Western & Southern Agency, Inc., W&S Brokerage Services, Inc., Eagle Realty Capital Partners, LLC, and Eagle Realty Group, LLC.



# Columbus Life Insurance Company

A member of Western & Southern Financial Group

400 EAST FOURTH STREET • CINCINNATI, OHIO 45202-3302 • 1-800-677-9696 • WWW.COLUMBUSLIFE.COM

## **AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION** (This Authorization is intended to comply with the HIPAA Privacy Rule)

Name of Proposed Insured (Please print) \_\_\_\_\_

I (We), individually (and/or on behalf of any named children listed on page 2, individually), hereby consent and authorize any health plan, physician, medical practitioner, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, other medical or medically related facility, treatment facility related to drug, alcohol or substance abuse or use (including treatment provided by a federally assisted alcohol, drug or substance abuse program), or other health care provider that has provided payment, treatment or services to me(us) or on my(our) behalf (hereafter, My(Our) Providers) to disclose my(our) entire medical record (including diagnosis, prognosis or treatment), prescription history, medications prescribed and any other health information concerning me(us) (protected health information) to Columbus Life Insurance Company (hereafter, 'the Company'), or its authorized representatives. I (We) also authorize any insurance company or agent from which I (we) have applied for or obtained insurance, MIB, Inc., consumer reporting agency, my(our) employer, or other company or institution that has provided payment, treatment, or services, or any other entity or person having information about me(us), to disclose it to the Company or its authorized representatives. Protected health information includes information on the diagnosis, prognosis, or treatment relative to any physical, or mental condition, or treatment related to drug or alcohol use, or Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex (ARC) and/or tests for antibodies to the AIDS Virus (HIV), but excludes psychotherapy notes.

The signature(s) on page 2 acknowledge that any agreements I (we) have made to restrict my(our) protected health information do not apply to this Authorization and I (we) instruct any of My(Our) Providers and other entities or persons referred to above to release and disclose my(our) health information without restriction.

This protected health information is to be used or disclosed under this Authorization so that the Company may: 1) underwrite applications for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine full responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities, including mortality or morbidity studies, that relate to any coverage I (we) have or have applied for with the Company.

I (We) also authorize the Company or its reinsurers to release any information collected about me(us) to MIB, Inc. and to other insurance companies with whom I (we) may apply for insurance.

Not valid without both pages.





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## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

(This Authorization is intended to comply with the HIPAA Privacy Rule)

This Authorization shall remain in effect for 24 months following the date of signature(s) below. A copy of the Authorization is as valid as the original. A signature on this Authorization transmitted electronically or via facsimile shall have the same force and effect as an original signature. I, each Proposed Insured, Named Child or Legal Representative, understand that I (we) have the right to obtain a copy of and revoke this Authorization at any time by notifying the Company in writing at 400 East Fourth Street, P.O. Box 5737, Cincinnati, Ohio, 45201-5737, Attention: Privacy Officer. I (We) understand that a revocation is not effective to the extent that any person or entity has already relied on this Authorization to disclose or use information about me(us) or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I (We) understand that if any of my(our) protected health information is re-disclosed, it may no longer be protected by federal rules governing privacy and confidentiality of health information. I (We) further understand that if I (we) refuse to sign this Authorization, the Company may not be able to process my(our) application, or if coverage has been issued, may not be able to make any benefit determinations or payments. I (We) understand that I (we) or any authorized representative will receive a copy of this Authorization.

\_\_\_\_\_  
Signature of Proposed Insured or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Proposed Insured or Legal Representative

\_\_\_\_\_  
Signature of Additional Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Additional Proposed Insured

\_\_\_\_\_  
Witness (Agent, if present)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Witness (Agent, if present)

### Full Names of Children Proposed for Insurance:

_____	_____
_____	_____
_____	_____
_____	_____

Not valid without both pages.





**Preauthorized Transfer (PAT)**

For your convenience, and with your written authorization, the Columbus Life Insurance Company of Cincinnati, Ohio ("CLIC") can electronically transfer funds from your bank account to pay premiums on your policy. To request this service, please complete this authorization form and provide a voided check **OR** complete the Bank Information section below.

We will need your bank's name and complete address. The bank account holder must sign the authorization. Joint checking accounts require both parties' signatures.

If your bank does not allow for an electronic funds transfer, the transfer will be done manually as a preauthorized check.

**Bank Information - Authorization for Preauthorized Transfer By  
Columbus Life Insurance Company, 400 East 4th St., Cincinnati, Ohio 45201-3302**

To Bank Name \_\_\_\_\_  
Bank Address (number and street) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_  
Bank Routing # \_\_\_\_\_ Bank Account # \_\_\_\_\_

Please indicate the type of Bank Account by selecting one of the following:  Checking Account  Savings Account

I hereby request and authorize you to electronically transfer funds to CLIC, or pay and charge to my account checks drawn on my account by and payable to the order of CLIC, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that CLIC's rights in respect to each such electronic transfer or check shall be the same as if it were a check drawn in favor of CLIC and signed personally by me.

This authorization is to remain in effect until revoked by me in writing, and until CLIC actually receives such notice I agree that CLIC shall be fully protected in honoring any such electronic transfer or check. I further agree that if any such transfer or check be dishonored, whether with or without cause and whether intentionally or inadvertently, CLIC shall be under no liability whatsoever even if such dishonor results in the termination of insurance.

**For policies issued with a policy date day of the 1<sup>st</sup> through the 15<sup>th</sup> of the month, the initial PAT withdrawal will be the 1<sup>st</sup> of the month following the month the policy is issued.** Subsequent withdrawals will occur on the 1<sup>st</sup> of each month thereafter (or according to the frequency if quarterly, semi-annual or annual PAT withdrawals are selected).

**For policies issued with a policy date day of the 16<sup>th</sup> through the 28<sup>th</sup> of the month, the initial PAT withdrawal will be the 15<sup>th</sup> of the month following the month the policy is issued.** Subsequent withdrawals will occur on the 15<sup>th</sup> of each month thereafter (or according to the frequency if quarterly, semi-annual or annual PAT withdrawals are selected).

**INITIAL PREMIUM DRAFT:** By checking this box, you understand and agree for a newly applied for policy that the initial premium draft will be requested on the date the policy is approved and issued by CLIC or, if later the date this form is received by CLIC. No insurance takes effect unless and until all the terms and conditions for coverage are met, including, but not limited to, payment of the initial premium.

Set up the PAT account based on the selection below:

Monthly\*  Quarterly  Semi-Annually  Annually

\*Frequency will be monthly if none selected.

Establish a **New** PAT account  Use **Existing** PAT account – Policy No. \_\_\_\_\_  
 Use existing PAT account – Change Bank Information Withdrawals to begin: \_\_\_/\_\_\_/\_\_\_ Amount: \$ \_\_\_\_\_  
 Use existing PAT account – Change Account Number Withdrawals to begin: \_\_\_/\_\_\_/\_\_\_ Amount: \$ \_\_\_\_\_  
 Please draft for back due premiums

CLIC Policy No.'s: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ Today's Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Premium Payer/Account Holder

\_\_\_\_\_  
Print Name of Premium Payer/Account Holder

\_\_\_\_\_  
Signature of Joint Account Holder

\_\_\_\_\_  
Print Name of Joint Account Holder





# Columbus Life Insurance Company

A member of Western & Southern Financial Group

400 EAST FOURTH STREET • CINCINNATI, OHIO 45202-3302 • 1-800-677-9696 • WWW.COLUMBUSLIFE.COM

## 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.**

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

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

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

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

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

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

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

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

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

The existing policy or contract is being replaced because \_\_\_\_\_  
\_\_\_\_\_.

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

\_\_\_\_\_  
Applicant's Signature and Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Producer's Signature and Printed Name

\_\_\_\_\_  
Date

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

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

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

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

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

**IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:**

How are premiums for both policies being paid?  
How will the premiums on your existing policy be affected?  
Will a loan be deducted from death benefits?  
What values from the old policy are being used to pay premiums?

**IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:**

Will you pay surrender charges on your old contract?  
What are the interest rate guarantees for the new contract?  
Have you compared the contract charges or other policy expenses?

**OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:**

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

**AGENT'S REPORT  
COLUMBUS LIFE INSURANCE COMPANY APPLICATION FOR INSURANCE**

Proposed Insured \_\_\_\_\_

Date of Birth \_\_\_\_\_

Complete if insurance applied for is \$1,000,000 or less.

**1. Purpose of Insurance Applied For:**

- |  |  |
|--|--|
| <input type="checkbox"/> Estate Planning           | <input type="checkbox"/> Buy/Sell                                  |
| <input type="checkbox"/> Family Income Replacement | <input type="checkbox"/> Deferred Comp.                            |
| <input type="checkbox"/> Final Expenses            | <input type="checkbox"/> Employee Bonus                            |
| <input type="checkbox"/> Mortgage Coverage         | <input type="checkbox"/> Key Person                                |
| <input type="checkbox"/> Split Dollar              | <input type="checkbox"/> Stock Redemption                          |
| <input type="checkbox"/> Retirement Plan           | <input type="checkbox"/> Required by Creditor<br>(debt protection) |
|  | <input type="checkbox"/> Other (specify) _____                     |

**2. Was Inspection Report Ordered?**  Yes  No

**3. Is the Proposed Insured a relative of the Producer?**  Yes  No

If Yes, explain \_\_\_\_\_

**4. Future Premiums – after first has been paid:**

- |  |  |
|--|--|
| <input type="checkbox"/> <b>None – Lump Sum</b> _____  | <input type="checkbox"/> <b>Account Bill</b>                                       |
| <input type="checkbox"/> <b>Direct Bill</b>  | <input type="checkbox"/> New Plan (Will be assigned by H.O.)                       |
| <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually                                  | <input type="checkbox"/> Existing Plan No. _____                                   |
|  | Policy Number or Account Number  |
| <input type="checkbox"/> <b>Pre-Authorized Transfer</b>  | Payable: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly       |
| <input type="checkbox"/> New Plan <input type="checkbox"/> Existing Plan   | <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually           |
| <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually | <input type="checkbox"/> <b>Government Allotment</b> (See Marketing Manual Rules.) |
|  | <input type="checkbox"/> New Plan  |
| Complete PAT form CL 35.47-NB. Please follow all instructions in that form.  | <input type="checkbox"/> Existing Plan No. _____                                   |
|  | Policy Number or Account Number  |

**5. Credit Application To:** (Please Print)

	% of App (whole numbers only)	CLIC Producer Number
<b>Writing Agent</b> _____	_____	CL000 _____
Agent #2 _____	_____	CL000 _____
Agent #3 _____	_____	CL000 _____
<b>Writing Agent Information:</b>		
Phone No. _____	Fax No. _____	E-Mail _____

**WRITING AGENT REPORT**

- |   | <b>Yes</b>               | <b>No</b>                |
|---|--------------------------|--------------------------|
| A. I declare that I asked the Proposed Insured(s) each question on the application. The answers have been recorded by me exactly as stated and I know of nothing affecting the insurability of the Proposed Insured(s) which is not fully recorded in this application. ....  | <input type="checkbox"/> | <input type="checkbox"/> |
| B. I declare that I have accurately answered any questions contained in the Agent's Report completed by me in connection with this application. ....  | <input type="checkbox"/> | <input type="checkbox"/> |
| C. I declare that I have provided each Proposed Insured and Owner with the Notices on the Medical Information Bureau and Fair Credit Reporting Act as well as a copy of the Privacy Practices Notice. ....  | <input type="checkbox"/> | <input type="checkbox"/> |
| D. I verified the Proposed Insured's/Proposed Insured's identity by viewing the individual's photograph on a driver's license, passport or other official document and have transcribed the number on Page 1 of the application. If applicant is a business or trust entity, I viewed documentation confirming the entity's legal status and state of formation, and I have provided the declarations and signature pages of the trust to Columbus Life. .... | <input type="checkbox"/> | <input type="checkbox"/> |

\_\_\_\_\_  
Name of Licensed Agent, Broker or Registered Representative (Print)

\_\_\_\_\_  
Signature of Licensed Agent, Broker or Registered Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of General Agent



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## OVERFLOW PAGE

The following information is made part of the Application question indicated.

This Overflow Page has been read and all answers are intended to be part of the Application attached to the life insurance policy.

\_\_\_\_\_  
Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Owner

\_\_\_\_\_  
Date



**Indexed Account Guarantee Selection & Initial Election of Premium Allocation**

(To be completed when applying for Indexed Explorer Plus or Survivorship Indexed Explorer Plus Universal Life Insurance)

**INDEXED ACCOUNT GUARANTEE SELECTION (REQUIRED)**

Select either the Indexed accounts with a minimum guaranteed interest rate of 0.00% or the Indexed Accounts with a minimum guaranteed interest rate of 1.00%. A selection is required. You cannot select both. You cannot change your selection after a policy has been issued.

- 0% Indexed Account Minimum Guaranteed Interest Rate (applicable to all available Indexed Accounts)
- 1% Indexed Account Minimum Guaranteed Interest Rate (applicable to all available Indexed Accounts)

**ALLOCATION SELECTION INSTRUCTIONS - PLEASE REVIEW**

Allocations must be in whole percentages and total 100%. This allocation will apply until changed by the policy owner.

**NOTE: DOLLAR COST AVERAGING SHOULD NOT BE SELECTED FOR MONTHLY PAT.**

If you do not want to Dollar cost average, please fill out **Section A**.

If you are going to choose to select the Dollar Cost Averaging feature for your first premium and all future premiums, please fill out **Section B**.

If you are going to choose to select the Dollar Cost Averaging feature for your first premium only, please fill out **Section C**.

**Section A - No Dollar Cost Averaging Selected**

Net Premium Allocation (REQUIRED)		Index Segment Reallocation (OPTIONAL)		
_____ %		_____ %	Indexed Account:	S&P 500 Capped Annual Point-to-Point
_____ %		_____ %	Indexed Account:	S&P 500 Uncapped Annual Point-to-Point with Spread
_____ %		_____ %	Indexed Account:	S&P 500 Uncapped Monthly Average
_____ %		_____ %	Fixed Account	
100%		100%		

**Section B - Dollar Cost Averaging First Premium and All Future Premiums**

**DOLLAR COST AVERAGING FREQUENCY (Select One Option Only)**

- 6 months
- 12 months

Net Premium Allocation (REQUIRED)	DCA Transfer Allocation (REQUIRED)	Index Segment Reallocation (REQUIRED)	
_____ %	_____ %	_____ %	Indexed Account: S&P 500 Capped Annual Point-to-Point
_____ %	_____ %	_____ %	Indexed Account: S&P 500 Uncapped Annual Point-to-Point with Spread
_____ %	_____ %	_____ %	Indexed Account: S&P 500 Uncapped Monthly Average
_____ %	_____ %	_____ %	Fixed Account
_____ %	N/A	N/A	Dollar Cost Averaging Account (REQUIRED)
100%	100%	100%	



**ALLOCATION SELECTION INSTRUCTIONS - Continued**

**Section C - Dollar Cost Averaging First Premium ONLY**

**NOTE:** NET PREMIUM ALLOCATION WILL BE USED FOR THE DCA TRANSFER ALLOCATION.

**DOLLAR COST AVERAGING FREQUENCY (Select One Option Only)**

6 months       12 months

Net Premium Allocation <b>(REQUIRED)</b>	Index Segment Reallocation <b>(OPTIONAL)</b>	
_____ %	_____ %	Indexed Account: S&P 500 Capped Annual Point-to-Point
_____ %	_____ %	Indexed Account: S&P 500 Uncapped Annual Point-to-Point with Spread
_____ %	_____ %	Indexed Account: S&P 500 Uncapped Monthly Average
_____ %	_____ %	Fixed Account
100%	100%	

**DISCLOSURES**

If no Reallocation is indicated and is optional, your segment value will reallocate according to your Net Premium Allocations.

I have read and acknowledge by my signature below, that I am applying for an Indexed product, and that while the values of the policy may be affected by an external index, the policy does not directly participate in any stock, bond, or equity investments. Further, I agree that any values shown, other than guaranteed minimum values, are not guarantees, promises, or warranties.

Owner(s) Signature: By signing below, I (or we if Joint Owners) certify that I agree to the above elections, and confirm that I have reviewed, read and understand the above conditions and disclosures.

The S&P 500® is a product of S&P Dow Jones Indices LLC or its affiliates (“SPDJI”) and has been licensed for use by Columbus Life Insurance Company. S&P® is a registered trademark of Standard & Poor’s Financial Services LLC (“S&P”) and this trademark has been licensed for use by SPDJI for certain purposes by Columbus Life Insurance Company. This policy is not sponsored, endorsed, sold or promoted by SPDJI, S&P, or any of their respective affiliates and none of such parties makes any representation regarding the advisability of purchasing this policy nor do they have any liability for any errors, omissions or interruptions of the S&P 500®.

**TELEPHONE TRANSACTION AUTHORIZATION**

I (or we, if Joint Owners), hereby authorize Columbus Life to act on telephone instructions to 1) transfer values from the Fixed Account to the Indexed or DCA Accounts; 2) to change allocations for future premium payments; or 3) to complete other financial transactions as may be allowed by Columbus Life at the time of request given by the person(s) selected.

To make a selection, place your initials (Owner and Joint Owner, if applicable) on the lines below.

\_\_\_\_\_ Policy Owner(s) - If Joint Owners, either of us acting independently

\_\_\_\_\_ Producer

\_\_\_\_\_ Other



**TELEPHONE TRANSACTION AUTHORIZATION - Continued**

**NAME** (First, Middle, Last)

**SOCIAL SECURITY NUMBER**

**ADDRESS**

**CITY**

**STATE**

**ZIP**

Columbus Life will not be liable for following instructions communicated by telephone that it reasonably believes to be genuine. Columbus Life will employ reasonable procedures of verification, including requiring the policy number to be stated and recording all instructions. This telephone transaction authorization will remain in effect until Columbus Life receives written notification of cancellation from the policy Owner, or in the event a Producer has been authorized, until the named Producer is no longer contracted and appointed with Columbus Life.

Owner(s) Signature: By signing below, I (or we if Joint Owners) certify that I agree to the Telephone Transaction Authorization.

**POLICY NUMBER**

Sign Here \_\_\_\_\_  
SIGNATURE OF PROPOSED OWNER

Date \_\_\_\_\_

Sign Here \_\_\_\_\_  
SIGNATURE OF PROPOSED JOINT OWNER

Sign Here \_\_\_\_\_  
SIGNATURE OF PRODUCER

**QUESTIONS REGARDING THIS FORM? Please contact the Sales Desk at 1-800-677-9696, option 4.**

