

Telephone Application with Voice Signature Indiana

Dear Insured/Applicant:

Thank you for your application for SafeShield® Term life insurance. Your verbal answers were obtained by phone and used to complete the questions on the life insurance application, and your voice signature was secured by digital recording. The completed application and your voice signature have been submitted to the Company's administrative service office for processing.

To protect the privacy of information collected and transmitted during the application process, the data is encrypted and stored in secured databases. All of the Company's data and systems are secured using current technology standards and procedures that undergo a variety of internal and external audits and reviews of the process and systems to ensure they are kept current.

I am providing you with printed versions of the following documents, which were read to you during the application process. Please keep these documents with your important insurance papers.

- Application Authorization & Acknowledgment
- Information Practices Relating to Underwriting Your Application
- Conditional Receipt (applicable if initial premium is to be paid by immediate bank draft)
- Living Benefit Rider Disclosures, Form No. 5419CFG (IC)
(applicable if applying for Accelerated Benefit – Terminal Illness, Critical Illness, or Chronic Illness Rider(s) with a *Non-Return of Premium* policy)
- Accelerated Benefit Rider Disclosures, Form No. 6180-CL (IC)
(applicable if applying for the Accelerated Benefit Rider in states where the disclosure is required)
- Important Notice: Replacement of Life Insurance or Annuities, Form No. 1527CFG
(applicable if the new policy is intended to replace an existing policy or contract)

Thank you for giving us the opportunity to serve you and your insurance needs. We appreciate your business and are dedicated to providing you with the highest level of service.

Form No. 5376CFG-IN-SIT

7. REPLACEMENT:		YES	NO
Does any Proposed Insured have any existing life insurance or annuities?	<input type="checkbox"/>	<input type="checkbox"/>	
Is this application for insurance intended to replace or change any life insurance or annuities now in force?	<input type="checkbox"/>	<input type="checkbox"/>	
<i>(If "YES," submit any special forms required by the state in which the application is signed.)</i>			
8. SPECIAL REQUESTS / REMARKS:			
9. CONDITIONS RELATING TO THE APPLICATION:			
I have read the questions and answers in all parts of this application and agree that they are complete and true to the best of my knowledge and belief. I agree that this application shall form a part of any policy issued. I understand and agree that no agent has the authority to waive a complete answer to any question in the application, pass on insurability, make or alter any contract, or waive any of the Company's other rights or requirements; that any policy applied for shall not take effect (except as provided in the Conditional Receipt bearing the same number as this application) unless and until the policy has been issued and delivered and the full first premium, according to the mode of payment selected by the applicant (as permitted by the Company) and stipulated in the policy, has been paid and accepted by the Company during the lifetime and condition of health of the Proposed Insured as stated in the application.			
10. AUTHORIZATION & ACKNOWLEDGMENT:			
I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance company, MIB, Inc., consumer reporting agency, or other organization, institution or person that has any records or knowledge of me or any proposed insured, to give any such information to Columbian Life Insurance Company ("the Company") or its reinsurers for underwriting or claims purposes. This authorization also includes information about drugs, alcoholism, prescription drug records, or any other medical history information. To facilitate rapid submission of such information, I authorize all said sources, except MIB, Inc., to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand my information may be subject to redisclosure to a third party and may no longer be protected by federal privacy laws. I authorize Columbian Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. I understand a telephone interview may be necessary to verify or supplement information given to the Company on this application. This interview may be made from the Administrative Service Office or from a consumer-reporting agency by a trained interviewer acting on the Company's behalf. A photocopy of this form will be as valid as the original; this authorization will be valid for two (2) years from the date shown below, or the time limit permitted by applicable law in the state where the policy is delivered or issued for delivery. You may revoke this authorization by contacting us at PO Box 1381 Binghamton, NY 13902-1381 however, we retain the right to use any information obtained under your authorization prior to your revocation. I have read and understand the Conditions Relating to the Application and the Authorization & Acknowledgment. I acknowledge receipt and review of the Information Practices Relating to Underwriting Your Application. I have read and understand the fraud warning in Section 5 of this application.			
<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> Date of Application	X	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> Signature of Proposed Insured	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> (Date)
<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> Signed At (City, State)	X	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> Signature of Owner (If other than Insured)	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> (Date)
	X	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> Officer Signing for Corporation, Partnership, or Trust & Title	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> (Date)
11. REPORT OF LICENSED AGENT:			
Does any Proposed Insured have any existing life insurance or annuities?.....		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is this insurance intended to replace, in whole or part, any life insurance or annuities?.....		<input type="checkbox"/> YES	<input type="checkbox"/> NO
<i>(If "YES," submit any special forms required by the state in which the application is signed.)</i>			
Is the agent related to the Proposed Insured or Owner? If "YES," please provide relationship		<input type="checkbox"/> YES	<input type="checkbox"/> NO
I hereby affirm that I personally solicited and completed this application and all answers given above are true and correct to the best of my knowledge. The application was signed in my presence.			
<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> Name of Licensed Agent (Print)	X	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> Signature of Licensed Agent <i>(required)</i>	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> (Date)
<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> Primary Agent Name	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> Agent Number	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> % of Commission (Enter 100% if you are NOT splitting commission)	
<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> Secondary Agent Name	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> Agent Number	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> % of Commission (Amount of 1 st and 2 nd Agent must equal 100%)	

INFORMATION PRACTICES RELATING TO UNDERWRITING YOUR APPLICATION

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

INVESTIGATIVE CONSUMER REPORT

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

IDENTIFICATION

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

ACCESS TO INFORMATION

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

WHERE TO WRITE US

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

MIB, INC. PRE-NOTICE

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

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

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

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

CONDITIONAL RECEIPT

Complete Only When Full Modal Premium Is Received With Application

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

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

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

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

- (1) You had paid the full first modal premium on the policy applied for; and
- (2) All Proposed Insureds were insurable at standard rates on the date of the application; and
- (3) The Company is able to issue the policy as applied for; and
- (4) The amount of insurance applied for, with respect to any Proposed Insured, is not in excess of \$500,000.

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

Date

X

Signature of Licensed Agent

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

COLUMBIAN MUTUAL LIFE INSURANCE COMPANY

Home Office:

Box 1381, Binghamton, NY 13902-1381

COLUMBIAN LIFE INSURANCE COMPANY

Home Office: Chicago, IL

Administrative Service Office:

P.O. Box 1381, Binghamton, NY 13902-1381

Accelerated Death Benefit Rider Disclosure

The insurance contract you are applying for may include one or more of the riders described below. The riders allow the Policyowner to receive a portion of the policy's death benefit during the lifetime of the Insured if the Insured is diagnosed by a physician with a qualifying condition as defined in the Rider. Please read your Policy and Rider(s) carefully and consult your Rider(s) for specific information.

Accelerated Death Benefit - Terminal Illness: This Rider allows the Owner to request payment of a portion of the death benefit of the policy if the Insured is diagnosed with a non-correctable medical condition which, in the best medical judgment of a physician, will result in the death of the Insured within twelve (12) months from the date of the diagnosis.

Accelerated Death Benefit - Critical Illness: This Rider allows the Owner to request payment of a portion of the death benefit of the policy if the Insured is diagnosed with one or more of the following as defined in the rider: Amyotrophic Lateral Sclerosis (ALS), Life Threatening Cancer, End Stage Renal Failure (Kidney Failure), Myocardial Infarction (Heart Attack), Major Organ Failure, or Stroke.

Accelerated Death Benefit - Chronic Illness: This Rider allows the Owner to request payment of a portion of the death benefit of the policy if the Insured is diagnosed with a Chronic Illness. Chronic Illness means the Insured is (a) unable to perform, without substantial assistance from another person, at least two of the activities of daily living for a period of at least 90 days due to a loss of functional capacity or, (b) requires substantial supervision by another person to protect the Insured from threats to health and safety due to the insured's severe cognitive impairment for a period of at least 90 days.

Premium Charge

There is no additional premium charge for the Riders; however, an administrative fee will be deducted from the accelerated benefit payment each time a Rider benefit is exercised.

Accelerated Benefit Payment

The request for a benefit must be made in writing and signed by the Owner. Consent of any assignee or irrevocable beneficiary will be required. A spousal release will be required, if applicable, in community property states.

The Acceleration Amount is chosen by the Owner, subject to minimum and maximum limits. Each Acceleration Amount must be at least \$5,000 and must allow for at least \$5,000 residual face amount. The aggregate maximum for all Acceleration Amounts under all Riders is 95% of the eligible death benefit of the Policy on the date of the first acceleration. Under the Chronic Illness Rider, the maximum amount that may be accelerated in any 12-month period is 24% of the eligible death benefit.

The Acceleration Benefit Amount will be based on the Insured's expected mortality at the time of claim as determined by the Company. **Some qualifying events can impact the Insured's quality of life without having a material impact on their mortality and, therefore, the acceleration benefit may be quite small or there may be no acceleration benefit payable at all.**

Upon receipt of a request for rider benefits, the Company will provide the Owner and any irrevocable beneficiary with a written offer showing the amount of the rider benefit as well as the impact of the acceleration on the death benefit and premium amounts. The Owner may accept or decline the offer. If the offer is accepted, the Owner and any irrevocable beneficiary will be provided a statement demonstrating the effect of the acceleration. The policy will be modified with an endorsement indicating the new death benefit and premium amounts.

Effects of Accelerated Benefit Payment

An accelerated death benefit payment will result in a reduction in face amount and base policy premium. There will be no reduction in the annual policy fee, if applicable. Payment of the benefit will have no effect on any Children's Term Insurance or Accidental Death Benefit. Any Waiver of Premium coverage and the associated premiums will reduce due to the reduction in face amount.

The following examples are hypothetical and intended only to demonstrate how an individual assessment of mortality could affect an Acceleration Benefit Amount. The examples bear no relationship to any actual claims you may make or benefit amounts you may receive. They demonstrate the effects of acceleration and are provided for illustrative purposes only, and have no relationship to your policy premiums or values. In both examples, the Owner has a term policy and has elected an acceleration of \$60,000, or 60% of the policy's eligible death benefit. For policies that have cash values, policy loans or dividends at the time of acceleration, those values will typically be reduced proportionately to the reduction in face amount.

In this example, the Insured has a qualifying condition that makes his likelihood of death 3 times what it was without the condition.

	<u>Before Acceleration</u>	<u>After 60% Acceleration</u>
Base Policy Face Amount	\$100,000.00	\$40,000.00
Base Policy Annual Premium (excluding policy fee)	\$979.00	\$391.60
Annual Policy Fee	\$60.00	\$60.00
Total Base Policy Annual Premium (including Policy Fee)	\$1,039.00	\$451.60
Accelerated Benefit Payment (after administrative fee)	\$12,923.20	

Same as the above example, except the qualifying condition makes his likelihood of death 8 times what it was without the condition.

	<u>Before Acceleration</u>	<u>After 60% Acceleration</u>
Base Policy Face Amount	\$100,000.00	\$40,000.00
Base Policy Annual Premium (excluding policy fee)	\$979.00	\$391.60
Annual Policy Fee	\$60.00	\$60.00
Total Base Policy Annual Premium (including Policy Fee)	\$1,039.00	\$451.60
Accelerated Benefit Payment (after administrative fee)	\$34,731.11	

RECEIPT OF ACCELERATED DEATH BENEFITS MAY BE TAXABLE. YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR TO DETERMINE THE CURRENT TAX CONSEQUENCES PRIOR TO MAKING ANY ELECTION.

These Riders are not long-term care insurance and do not provide long-term care benefits. The benefits are not intended to qualify for favorable tax treatment. The Riders may affect your ability to receive certain government benefits or entitlements. The Accelerated Death Benefit may be considered an asset in determining eligibility. You should contact your local Medicaid Unit and the Social Security Administration for more information.

I hereby acknowledge that I have read and understand these disclosures and have received a copy for my records.

Signature of Applicant/Owner

Date

Printed Name of Applicant/Owner

Social Security Number

I certify that I have provided a copy of this statement to the Applicant/Owner.

Signature of Licensed Agent

License No.

Date

Applicant Copy

Important Disclosures
Accelerated Benefit Rider

This briefly describes the provisions of the Accelerated Benefit Rider. Consult your rider for specific information. Please read your policy and rider carefully.

The Accelerated Benefit Rider allows you to elect to receive an advance on the death benefit of the policy when the Insured is diagnosed as having a non-correctable terminal illness which, in the best medical judgment of a physician, will result in the death of the insured within twelve (12) months from the date of the diagnosis. Diagnosis must be made during the time the rider and the policy are in force.

The Accelerated Benefit is equal to fifty percent (50%) of the insured's base policy death benefit. We will pay this amount less any loan (and unpaid loan interest) on the policy, any due and unpaid premium, and an Administrative Service Fee of \$250.00. The policy loan and unpaid loan interest will be repaid. There will be no change in premiums. Regular premium payments as specified in the policy will be required in order to keep the policy in force. We will establish a lien against the death benefit of the policy equal to the amount of the Accelerated Benefit, plus accrued interest at the Accelerated Benefit interest rates. At the death of the insured, we will deduct the lien from the death benefit of the policy. If the Policy has a Surrender Value, the total amount of the lien and any policy loans and loan or lien interest will be deducted from the Surrender Value of the policy. If the total of all liens, loans and loan interest equals or exceeds the death benefit of the Policy, the Policy will terminate.

IF AN ACCELERATED BENEFIT IS PAID THE POLICY DEATH BENEFIT AND SURRENDER VALUE WILL BE REDUCED. RECEIPT OF ACCELERATED BENEFITS MAY BE TAXABLE. YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR TO DETERMINE THE CURRENT TAX CONSEQUENCES PRIOR TO MAKING ANY ELECTION.

The rider may affect your ability to receive certain government benefits or entitlements. The Accelerated Benefit may be considered an asset in determining eligibility. You should contact your local Medicaid Unit and the Social Security Administration for more information.

The Accelerated Benefit Rider is not long-term care insurance and does not provide long-term care benefits.

There is no premium charge for the rider; however, there is a \$250 Administrative Service Fee for processing an Accelerated Benefit payment.

I hereby acknowledge that I have received a copy of this statement. I understand that there is no premium charge for the rider, but there will be a \$250 Administrative Service Fee for processing an Accelerated Benefit payment. I understand that the rider may affect my ability to receive certain government benefits or entitlements and that receipt of an Accelerated Benefit may be taxable.

Signature of Applicant/Owner

Date

Printed Name of Applicant/Owner

Social Security Number

Signature of Licensed Agent

License No.

Date

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE AND ANNUITIES

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

IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

If you are thinking about DISCONTINUING or CHANGING an existing life insurance policy or annuity contract and BUYING a replacement, your decision could be a good one – or possibly a mistake. Make sure that you understand the facts. You should:

- Make a careful comparison of your existing policy and the proposed policy.
- Ask the company agent that sold you your existing policy to provide you with complete information about it.
- Consider both sides before you decide.
- Determine what you want your insurance program to do.
- Consider your present health. You may have had a change which could affect your insurability, so make sure to continue your present policy until a new policy is delivered to you and accepted by you.

This form must be completed in triplicate and the original given to you by the agent proposing replacement no later than at the time you apply for the new policy. (This form must be completed and given to you even though the proposed replacement policy is with the same company that sold you your existing policy.)

EXISTING POLICY INFORMATION ON _____
(Name of Insured)

COMPANY	TYPE OF POLICY*	POLICY NO.	DATE OF ISSUE	FACE AMOUNT OF BASIC POLICY	TYPE OF OPTIONAL BENEFITS
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

(If more policies are involved, use additional sets of forms)

PROPOSED POLICY INFORMATION ON _____
(Name of Insured)

COMPANY	TYPE OF POLICY*	FACE AMOUNT OF BASIC POLICY	TYPE OF OPTIONAL BENEFITS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Indiana Department of Insurance Regulation 760 IAC 1-16.1 requires that the company making the replacement notify your existing insurance company that you may be replacing your existing policy. (You have the right, within twenty days after delivery of a replacement policy, to return it to the company and to claim an unconditional refund of all premiums paid on it.)

Applicant's / Insured's Signature

Replacing Agent's Signature

Date

Address

Telephone Number

Indiana License Number

*As shown on face of policy.