GUARANTEED ISSUE

COLUMBIAN LIFE INSURANCE COMPANY
HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: 4704 VESTAL PARKWAY EAST
PO BOX 1381, BINGHAMTON, NY 13902-1381
TELEPHONE: (607) 724-2472 / www.cfglife.com

APPLICATION FOR INDIVIDUAL GRADED BENEFIT WHOLE LIFE INSURANCE

MAIL POLICY TO: ☐ General Agent / Agent ☐ Owner FGN: _____

1. PROPOSED INSURED: First Name	Middle Initial	Last Name		
Citizen of What Country	Social Security No. / Green Card No.	Sex	Date of Birth	Age
Residence Address (Street, City, State, Zip Code)			Contact Information Home: Cell: Email:	
Mailing Address; If Different From Street Address				

2. OWNER Name & Address	Relationship	Social Security No. / Green Card No.	Email
3. BENEFICIARY Name & Address	Relationship	Social Security No. / Green Card No.	Telephone No.
Primary			
Contingent			

4. POLICY INFORMATION

Send Premium Notices to: ☐ Insured ☐ Owner ☐ Other
If Other, Name & Address:

Payment Mode
☐ Annual $_____ ☐ Semi-Annual $_____ ☐ Quarterly $_____
☐ Monthly EFT $_____ ☐ Monthly (Debit Collection) $_____
☐ Draft 1st Premium? (Specify draft date, must be within 30 days of application date.) Draft Date _____

Face Amount $_____

Premium Paid $_____

5. REPLACEMENT:

Do you have any existing life insurance or annuities?	☐ Yes	☐ No
Is this application for insurance intended to replace any life insurance or annuities now in force? (If "Yes", Submit any special forms required by the state in which the application is signed)	☐ Yes	☐ No

6. REMARKS: (Attach a separate sheet if more space is needed.)

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, make or alter any contract, or waive any of Columbian Life Insurance Company's ("the Company") other rights or requirements. Any policy applied for shall not take effect (except as provided in the Conditional Receipt) unless and until the policy has been issued and delivered and the first full premium, according to the mode of payment selected by me (as permitted by the Company) and stipulated in the policy, has been paid and accepted by the Company during the lifetime of the Proposed Insured. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

_____ X _____
Date of Application Proposed Insured

_____ X _____
Dated At (City & State) Applicant/Owner (If Other than Proposed Insured)

REPORT OF LICENSED AGENT:

Does the proposed insured have any existing life insurance or annuities?	☐ Yes	☐ No
Is this application for insurance intended to replace, in whole or part, any life insurance or annuities? (If "YES", submit any special forms required by the state in which the application is signed.)	☐ Yes	☐ No

I hereby affirm that I have physically seen the Proposed Insured, and: (1) the Proposed Insured is not confined at home, or to a hospital, hospice, clinic, assisted living facility, nursing home or convalescent home; (2) I have no knowledge of any terminal illness of the Proposed Insured; and (3) I have no knowledge of intravenous drug abuse (IVDA) of the Proposed Insured.

_____ X _____
Date Signature of Licensed Agent

_____ _____
Name of GA (Print) GA # Name of Licensed Agent (Print) Agent #

_____
Florida License Identification No.

MISCELLANEOUS — Complete, If Applicable – Not Required In All States

SECONDARY ADDRESSEE / THIRD PARTY DESIGNEE

☐ Not Electing A Secondary Addressee/Third Party At this Time.

(The Applicant/Owner may designate a Secondary Addressee/Third Party to receive a copy of Important Notices.)

Name & Address:

Secondary Addressee / Third Party Authorization

I hereby agree to accept any Important Notices on behalf of the named Proposed Insured.

X _____

Signature of Secondary Addressee/Third Party (If Required)

INITIAL PREMIUM OPTIONS - DO NOT USE FOR DRAFT 1st PREMIUM

☐ AGENT COLLECTION
☐ CHECK ENCLOSED
☐ ONE TIME ELECTRONIC FUNDS TRANSFER – IMMEDIATE WITHDRAWAL (Must Complete In Full.)

For the one time Electronic Funds Transfer, your agent will submit your application for insurance and this authorization for payment to Columbian Life Insurance Company ("the Company"). By signing this form, you authorize the Company to initiate an electronic funds transfer from your bank account.

Please note that your bank account may be debited the same day your agent submits this authorization. The below hereby authorizes the Company to draw an electronic fund transfer from my bank account for payment of new life insurance.

This will be a one time withdrawal from my account in the amount of $ _____ from the account detailed below.

Financial Institution _____ Name of Bank Account Holder: _____

Account Type ☐ Checking or ☐ Savings

Transit / Routing # | | | | | | | | | | Must have 9 digits in routing #

Account Number | | | | | | | | | | | | | | | | | Can have up to 17 positions in account #

_____ X _____

Date — Authorized Signature as it appears on Bank Records (one time withdrawal)

IF YOU WISH TO CONTINUE MAKING PREMIUM PAYMENTS VIA ELECTRONIC FUNDS TRANSFER, PLEASE COMPLETE THE INFORMATION BELOW AND SIGN. PLEASE NOTE: YOU NEED ONLY INCLUDE THE ACCOUNT INFORMATION IF IT IS DIFFERENT THAN STATED ABOVE.

REQUEST FOR ELECTRONIC FUNDS TRANSFER PLAN

☐ DRAFT FIRST
☐ ONGOING EFT DRAFT

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

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

This plan shall continue in effect until terminated by the Company or by me by thirty days written notice to the other party. The Company may terminate the EFT plan if any check or electronic fund transfer is not paid on presentation. Upon termination of the Electronic Funds Transfer plan, premiums due under the policy after such termination shall be payable directly to the Company at the minimum modal premium available at the time of issue.

Financial Institution _____ ☐ Checking (Attach voided check if available.) or ☐ Savings

Transit / Routing # | | | | | | | | | | Must have 9 digits in routing #

Account # | | | | | | | | | | | | | | | | | Can have up to 17 positions in account #

I request withdrawal of payments on: Date (1st - 28th)_____ beginning in the month of _____ .

_____ _____ X _____

Name of Bank Account Holder — Date — Authorized Signature as it appears on Bank Records (ongoing withdrawals)

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 date the application is signed.

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) The Company is able to issue the policy as applied for; and
(3) The amount of insurance applied for, with respect to any Proposed Insured, is not in excess of the Company's maximum issue limit.

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.

_____ X _____

Date Signature of Licensed Agent

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

FORM NO. A561FL-CL RECEIPT
LEAVE WITH PROPOSED INSURED/OWNER