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

☐ New Business ☐ Reinstatement of Policy #_____

**APPLICATION FOR LIFE INSURANCE – PART 1** For reinstatement, complete Sections A, B, I, J, K, L, M. N

**A. Proposed Insured 1**

1. Name of Proposed Insured Male ☐ Female ☐
First Middle Last
2. Date of Birth _____ (mm/dd/yyyy) Age _____
3. Place of Birth (state/country) _____
4. Social Security No. or Tax I.D. _____
5. Drivers License No. and State _____
6. Marital Status _____
7. Employer _____
Length Of Employment At This Business _____
Occupation _____
Duties _____
Earned Income _____ Net Worth _____
8. U.S. Citizen ☐ Yes ☐ No
**If No, complete the Citizenship Supplement.**
9. Home Address: Years at Address _____ E-mail _____
Street/Apt No.
City State Zip Code
10. Home Phone _____ Alternate Phone _____

**B. Proposed Insured 2 (For Survivorship or Other Insured Rider)**

1. Name of Proposed Insured Male ☐ Female ☐
First Middle Last
2. Date of Birth _____ (mm/dd/yyyy) Age _____
3. Place of Birth (state/country) _____
4. Social Security No. or Tax I.D. _____
5. Drivers License No. and State _____
6. Marital Status _____
7. Employer _____
Length Of Employment At This Business _____
Occupation _____
Duties _____
Earned Income _____ Net Worth _____
8. U.S. Citizen ☐ Yes ☐ No
**If No, complete the Citizenship Supplement.**
9. Home Address and Phone Information: E-mail _____
☐ Same as Proposed Insured 1
☐ Different; Provide information below:

**C. Coverage Applied For. (If VUL, complete VUL Supplement; If Indexed UL, complete Premium Allocation Election.)**

Plan of Insurance _____
If UL or VUL, select Death Benefit Option:
☐ 1 – Level Death Benefit
☐ 2 – Specified Amount plus Cash Value
If UL, select Life Insurance Qualification Test
☐ Cash Value Accumulation (default, if none selected; not available for all plans)
☐ Guideline Premium (automatic if Cash Value Accumulation is not available)

Term Plans Only,
Select Term Period:
☐ Ten Year
☐ Fifteen Year
☐ Twenty Year
☐ Thirty Year

$ _____ Base Amount
$ _____ Supplemental Coverage Rider (SCR) Amount (if applicable)
$ _____ Total Base Plus SCR Amount

**D. Optional Benefits and Riders.**

Universal Life Only:
☐ No-Lapse Guarantee: ☐ Intermediate ☐ Lifetime
☐ Income Rider (Enhanced Value Rider)
☐ Disability Credit: indicate Monthly Credit Amount $ _____
☐ Extended Maturity Plus: ☐ Pay at Issue, or ☐ Pay at Age 80
☐ Change of Insured
☐ Enhanced Cash Value
☐ Estate Protection Rider
☐ Capital Transfer (Enhanced No-Lapse Guarantee) must select one below:
☐ Death Benefit ☐ Return of Premium ☐ Accumulation

Term Plans Only:
☐ Return of Premium ☐ Waiver of Premium
☐ Accidental Death/Specific Loss

Universal Life and Term:
☐ Accidental Death $_____
☐ Insured Insurability $_____
☐ Other Insured $_____
☐ Children's Term **(complete Child Term Rider supplement)**

For Voyager only, you may select a shorter No-Lapse Guarantee than the Lifetime No-Lapse:
☐ To age 90 ☐ To age 95

**E. 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 |

**F. Owner of Policy. Complete only if Owner is other than Proposed Insured 1.**

If Trust Owner, complete questions 1 A), D) and F) and attach declarations and signature pages of Trust Agreement.

1. A) Name _____
   First Middle Last
   B) Date of Birth (mm/dd/yyyy)_____ C) Relationship to Proposed Insured 1 _____
   D) Social Security/Tax ID Number _____ E-mail address _____
   E) Place of Birth (State/Country)_____
   F) Address _____
   Street No. and Name Apt. No. City State Zip Code
2. Multiple Owners: provide all details as above for other Owner in Additional Remarks section. E-mail _____
   Type of Ownership: ☐ Joint with right of survivorship ☐ Tenants in common _____

**G. Beneficiaries**

| | Name | Relationship | % |
|---|---|---|---|
| Primary: | | | |
| Primary ☐ Secondary ☐ | | | |
| Primary ☐ Secondary ☐ | | | |

**H. Premium Amount, Mode of Premium Payment, Payer Information.**

Modal Premium Amount $ _____ Mode _____ (Note: 2 months premium required for monthly PAT mode)

Total Amount Paid at time of Application. If none, indicate zero or leave blank $_____

**Payer Name and Address if other than Owner** (if not the same as home address in section A) – please print.

First Name M.I. Last Name Street Address or P.O. Box Number

City State Zip Code

Relationship to Proposed Insured _____

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

| | Proposed Owner | Proposed Insured 1 If other than Owner | Proposed Insured 2 If other than Owner |
|---|---|---|---|
| 1. Have you been involved in any discussion about the possible sale or assignment of this policy to a life, settlement, viatical or other secondary market provider? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. Have you ever sold a policy to a life, settlement, viatical or other secondary market provider? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

3. Will any portion of the premiums for this policy be financed? ..... ☐ Yes ☐ No
4. Will any insured or policy owner receive any payment in connection with insurance issued on the basis of this application? ..... ☐ Yes ☐ No
   For **Yes** answers to questions 1, 2, 3 or 4, please give details:

| **J. Life Insurance In Force, Pending or Replacement.** | **Proposed Insured 1** | **Proposed Insured 2** |
|---|---|---|
| 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? | ☐ Yes ☐ No | ☐ Yes ☐ 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? | ☐ Yes ☐ No | ☐ Yes ☐ No |

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

3. a) Does anyone proposed for insurance now have life insurance policies or annuity contracts with any company (excluding group coverage?) ..... ☐ Yes ☐ No
   b) Will this insurance replace, or will it cause a change in, or involve a loan under, any insurance policy or annuity contract on anyone proposed for insurance, or in any insurance policy or annuity contract owned by the Owner? ..... ☐ Yes ☐ No

4. List all insurance in force for any Proposed or Other Insured. **If none, check here or leave blank ☐ Note below if it is a replacement.**

| Proposed Insured Name | Company | Check If Repl | Check If 1035 | B – Bus. P – Pers. | Face Amount | Policy Number | Issue Year | Purpose |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

**K. Lifestyle Information on Proposed Insured 1 and Proposed Insured 2.**

| For **Yes** answers, complete Details section below. | **Proposed Insured 1** Yes | No | **Proposed Insured 2** Yes | No |
|---|---|---|---|---|
| **1.** In the past year has anyone proposed for insurance used tobacco or any other product containing nicotine? If **No,** select the answer that best describes tobacco/nicotine product history.<br>**Proposed Insured 1:** Quit: Over ☐ 5, ☐ 2, ☐ 1 year(s) ago ☐ Never Used<br>**Proposed Insured 2:** Quit: Over ☐ 5, ☐ 2, ☐ 1 year(s) ago ☐ Never Used | ☐ | ☐ | ☐ | ☐ |
| **2.** Ever used illegal drugs or controlled substances except as legally prescribed by a licensed member of the medical profession? | ☐ | ☐ | ☐ | ☐ |
| **3.** Do you consume alcoholic beverages? If Yes:<br>Type _____ Frequency _____ Amount _____ | ☐ | ☐ | ☐ | ☐ |
| **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 health professional to reduce the use of alcohol? | ☐ | ☐ | ☐ | ☐ |
| **5.** Ever had a drivers license suspended or revoked, or within the last 5 years, been convicted of reckless or negligent driving or driving under the influence of alcohol or drugs? | ☐ | ☐ | ☐ | ☐ |
| **6.** Are you currently receiving, or within the past 3 years have you received or applied for, any disability benefits, including Workers Compensation, Social Security Disability Insurance, or any other form of Disability insurance? | ☐ | ☐ | ☐ | ☐ |
| **7.** In the past 2 years have you been unable to work, attend school or been disabled for one month or more? | ☐ | ☐ | ☐ | ☐ |
| **8.** Does anyone proposed for this insurance intend to travel or reside outside the U.S. or Canada within the next two years? If **Yes**, list where, when, purpose and duration in the Details section. **If Yes, complete a Supplemental Questionnaire.** | ☐ | ☐ | ☐ | ☐ |
| **9.** In the past 2 years, flown as a pilot, crew member, or with any duties aboard an aircraft, or is there any intention of doing so within the next two years? **If Yes, complete a Supplemental Questionnaire.** | ☐ | ☐ | ☐ | ☐ |
| **10.** In the past 2 years, engaged in any motor racing on land or water, parachuting, skydiving, ballooning, gliding (kite or other), flying ultra-light aircraft, underwater or scuba diving, mountain climbing, or other hazardous sports or hobbies, or is there any intention of doing so within the next two years? **If Yes, complete a Supplemental Questionnaire.** | ☐ | ☐ | ☐ | ☐ |
| **11.** Have you ever been convicted of, are you awaiting trial for, or have you pled no contest to a felony? If **Yes,** indicate in Details section type, date and city/state of felony and if currently on probation or parole. | ☐ | ☐ | ☐ | ☐ |
| **12.** Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? If **Yes**, please list branch of service, rank, duties, and current duty station. | ☐ | ☐ | ☐ | ☐ |

**Details:** List details to question above, listing question number and the Proposed Insured details apply to.

| **Question No. and Proposed Insured** | **Details** |
|---|---|
| | |

**L. Personal Physician Information**

| | **Proposed Insured 1** | **Proposed Insured 2** |
|---|---|---|
| Name of personal physician: | | |
| Address: | | |
| Telephone number: | | |
| Date last consulted: | | |
| Reason last consulted: | | |
| Treatment or medication prescribed: | | |

**M. Additional Remarks**

**Complete this section unless a full paramedic exam or medical exam is required on the Proposed Insured(s). DO NOT remove this page from the application.**

**N. Medical Information on Proposed Insured 1, Proposed Insured 2.**

| **For YES answers, complete Details section below.** | **Proposed Insured 1** Yes | No | **Proposed Insured 2** Yes | No |
|---|---|---|---|---|
| **1.** Has any person proposed for insurance 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? | ☐ | ☐ | ☐ | ☐ |
| b) Heart disease or disorder, heart attack, heart murmur, angina or chest pain, palpitations, irregular heart beat or coronary artery disease? | ☐ | ☐ | ☐ | ☐ |
| c) Circulatory system disorder, thrombophlebitis, aneurysm, embolism, peripheral vascular disease or edema? | ☐ | ☐ | ☐ | ☐ |
| d) Chronic headaches, carotid artery blockage, seizures, fainting, dizziness, epilepsy, stroke or mini stroke (TIA – transient ischemic attack), paralysis or other nervous system or brain disorder? | ☐ | ☐ | ☐ | ☐ |
| e) Any tumor, masses, cysts, cancer, melanoma, pre-cancerous lesion, lymphoma, or disorder of the lymph nodes? | ☐ | ☐ | ☐ | ☐ |
| f) Anemia, leukemia, clotting disorder, or any other blood disorder (excluding HIV)? | ☐ | ☐ | ☐ | ☐ |
| g) Diabetes, elevated blood sugar, a disorder of the urinary tract or findings of sugar, protein or blood in the urine? | ☐ | ☐ | ☐ | ☐ |
| h) Asthma, emphysema, chronic obstructive pulmonary disease (COPD), shortness of breath, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or bronchitis, spitting up blood or any other disorder of the lungs or respiratory system? | ☐ | ☐ | ☐ | ☐ |
| i) Arthritis, gout, fibromyalgia or any disorder of the back, spine, muscles, nerves, bones, joints or skin? | ☐ | ☐ | ☐ | ☐ |
| j) Ulcers, colitis, Crohn's disease, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder or pancreas? | ☐ | ☐ | ☐ | ☐ |
| k) Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder? | ☐ | ☐ | ☐ | ☐ |
| l) Thyroid, pituitary or other endocrine or glandular disorder? | ☐ | ☐ | ☐ | ☐ |
| m) Any nervous, mental, emotional, mood, anxiety or eating disorders, or received counseling for anxiety, depression, stress or any other emotional condition? | ☐ | ☐ | ☐ | ☐ |
| n) Any disorder of the eyes, ears, nose or throat? | ☐ | ☐ | ☐ | ☐ |
| **2.** Have you ever been told by a health care professional that you had AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS-Related Complex) or any other immune deficiency disorder or has any HIV test done in the connection with a previous insurance application indicated a positive result for exposure to HIV? | ☐ | ☐ | ☐ | ☐ |
| **3.** In the past 12 months have you been prescribed any medications other than contraceptives? | ☐ | ☐ | ☐ | ☐ |
| **4.** Are you planning to seek medical advice or treatment for any reason; are you scheduled for a medical test or appointment or have you been advised to schedule a follow up medical appointment or test (excluding any HIV test)? | ☐ | ☐ | ☐ | ☐ |
| **5.** Has any immediate family member (parents, sisters or brothers) died as a result of, or been diagnosed with, heart disease prior to age 60? | ☐ | ☐ | ☐ | ☐ |
| **6.** What is your height and weight? If weight changed in the past 12 months, indicate pounds lost or gained. | Ht _____ Wt _____ Loss _____ Gain _____ | | Ht _____ Wt _____ Loss _____ Gain _____ | |

**Medical Information Details**

Details of **Yes** answers to the above questions 1-5.

| Question No. and name of proposed insured. | Physicians, hospitals, illness, treatment, medical information, reason for checkup. | Dates and duration of illness. | Name, address, phone number of medical professionals, hospitals. |
|---|---|---|---|
| | | | |

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (Complies with the HIPAA Privacy Rule):** The undersigned, individually (and/or on behalf of any children named in the application, individually), hereby consent and authorize any health plan, physician, medical practitioner, health care professional, hospital, clinic, pharmacy or pharmacy benefit manager, other medical or medically related facility, other health-care provider, MIB, Inc., consumer reporting agency, my employer, or other companies or institutions that has provided payment, treatment or services, or who has information about me, to disclose to Columbus Life Insurance Company or their authorized representatives any information from health care or medical records. This includes information relating to diagnosis, prognosis, or treatment relative to any physical, or mental condition, or treatment relative to drug or alcohol use, but excludes psychotherapy notes; investigative consumer reports, other insurance coverage and details of employment.

The signature(s) below acknowledge that any agreements made to restrict my/our health information do not apply to this authorization and instruct any physician, medical practitioner, other health care professional, hospital, clinic, pharmacy or pharmacy benefit manager, other medical or medically related facility, or other health-care provider to release and disclose my/our health information without restriction. This authorization for disclosure of information is effective for 30 months following the date of signature(s) below. A copy of this authorization is as valid as the original.

The purpose for this disclosure is for Columbus Life Insurance Company to 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 that relate to any coverage I/we have or have applied for with Columbus Life Insurance Company.

I also authorize the Columbus Life Insurance Company or its reinsurers to release any information collected about me or my minor child(ren) to MIB, Inc. and to other insurance companies with whom I may apply for insurance.

I, each Proposed Insured, Named Child or Legal Representative, understand that: a) I have the right to obtain a copy of and revoke this authorization at any time by notifying Columbus Life Insurance Company (hereafter, 'the Company') in writing at 400 East Fourth Street, P.O. Box 5737, Cincinnati, Ohio, 45201-5737, Attention: Privacy Officer; b) the revocation is only effective after it is received by the Company; c) any use or disclosure prior to the revocation will not be affected by a revocation d) a revocation is not effective to the extent that the Company has a legal right to contest a claim under a policy or to contest the policy itself; e) after health information is disclosed, federal law might not protect it, and the recipient might redisclose it; f) health care and payment for health care will not be affected by refusal to sign this authorization; g) on refusal to sign this authorization, the Company may not be able to process an application, or if coverage has been issued, may not be able to make any benefit determinations or payments.

## AGREEMENT AND ACKNOWLEDGEMENT

**Each of the Undersigned declares that:** This Application consists of: a) Part I Application; b) Part II Medical Application, if required; c) any amendments to the application(s) attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. Except as provided in any Temporary Insurance Agreement, any policy issued on this application shall take effect on the date it is delivered to the owner and the first premium is paid during the lifetime of each and every person proposed for insurance under such policy and then only if the health and other conditions affecting insurability remain as described in this application to the best of the applicant's knowledge and belief.

Any and all statements and answers provided anywhere in this application, together with those in any Part II and in any supplemental application made in connection herewith are full, complete and true to the best of my knowledge and belief and are made to the Company to induce it to issue the policy or policies applied for and will be attached to and made a part of any policy issued.

No agent is authorized to make or alter contracts, to extend the time for payment of premiums, or to waive any of the Company's rights or requirements. Corrections, additions or amendments to this application may be made by the Company. Acceptance of a policy issued with such changes will constitute acceptance of the changes. No changes, corrections or additions will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

The undersigned each represent that the applicant and proposed insured(s) each has read, or had read to each of them, the completed application and that they each realize that any false statement or misrepresentation which is material to the risk therein may result in loss of coverage under any policy issued hereunder, or if this is an application for reinstatement, the Company shall be under no liability except to return premiums paid in connection with such reinstatement.

I have read and understand 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.

Under penalties of perjury, I certify that (1) the number shown on this form is my correct Taxpayer Identification Number, and (2) I am not currently subject to backup withholding as a result of Internal Revenue Service notification. **The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

*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.

Signed at _____ Date _____ _____

(City and State) Signature of Proposed Insured 1 (if age 15 or older)

_____ _____

Signature of Applicant/Owner if other than Proposed Insured Signature of Proposed Insured 2

Agent/Producer's Certification - To the best of my knowledge, a replacement ☐ is ☐ is not involved in this transaction. I also certify that only Company approved sales material was used, and copies of all sales material and any disclosures or illustrations required by law have been given to the Applicant.

_____ _____

Agent's Name (Please Print) License No.

Signature of Agent _____ Date _____

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**Instruction to Agent:** This form is required in certain states. Please check the requirements for your state.

## AGENT STATEMENT

I certify that no illustration conforming to the policy applied for was provided to the Applicant/Owner. I am aware that a computer screen illustration does not fulfill the illustration requirements as dictated by the laws for my state. 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 STATEMENT

I certify that no illustration conforming to the policy applied for was provided to me. I am aware that a computer screen illustration does not fulfill the illustration requirements as dictated by the laws for my state. 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; one copy for the Applicant/Owner, return one copy to the Home Office.

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# STATE OF CALIFORNIA NOTICE AND CONSENT FORM FOR BLOOD TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN

Name of Proposed Insured (please print) _____ Birthdate of Proposed Insured _____

Examiner _____ Name of Agent (please print) _____

To determine your insurability, we (Columbus Life Insurance Company) have requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes us to withdraw blood and order laboratory tests only in regard to your present application for insurance.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to us. When necessary for business reasons in connection with insurance you have or have applied for with us, we may disclose test results to others involved solely in the underwriting process such as our affiliates, reinsurers, employees or contractors. If the test results for HIV antibodies/antigens are other than normal, we will report to the Medical Information Bureau, (MIB, Inc.) a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, we will contact you. We may also contact you if there are other abnormal test results which, in our opinion, are significant. Please furnish the name of a physician or other health care provider to whom you authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities 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.

I have read and I understand this Notice of Consent For Blood Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood, and the disclosure of the test results as described above.

I also acknowledge receipt of the American Red Cross pamphlet, “HIV AND AIDS,” and a list of California AIDS counseling resources.

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.

Date: _____ State of Residence _____

Signature of Proposed Insured or Parent/Guardian _____ Date of Birth _____

Name and address of designated Physician or other health care provider:

_____

_____ Signature of Agent _____

_____

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**STATE OF CALIFORNIA NOTICE AND CONSENT FORM FOR BLOOD TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN**

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The consent you give by signing this form authorizes us to withdraw blood and order laboratory tests only in regard to your present application for insurance.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to us. When necessary for business reasons in connection with insurance you have or have applied for with us, we may disclose test results to others involved solely in the underwriting process such as our affiliates, reinsurers, employees or contractors. If the test results for HIV antibodies/antigens are other than normal, we will report to the Medical Information Bureau, (MIB, Inc.) a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, we will contact you. We may also contact you if there are other abnormal test results which, in our opinion, are significant. Please furnish the name of a physician or other health care provider to whom you authorize disclosure and with whom you may wish to discuss the results.

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I also acknowledge receipt of the American Red Cross pamphlet, “HIV AND AIDS,” and a list of California AIDS counseling resources.

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.

Date: _____ State of Residence _____

Signature of Proposed Insured or Parent/Guardian _____ Date of Birth _____

Name and address of designated Physician or other health care provider:

_____

_____ Signature of Agent _____

_____

# HIV Antibody Test
# Information Form For Insurance Applicant

**AIDS**

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts of any of these persons. Aids does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25 — 50% change of developing AIDS over the next 10 years.

**The HIV antibody test:**

Before consenting to testing, please read the following important information:

1. **Purpose.** This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.
2. **Positive Test Results.** If you test positive, you should seek medical follow-up with your personal physician. If your test is positive, you may be infected with HIV.
3. **Accuracy.** An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:
   a. **False positives:** the test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.
   b. **False negatives:** the test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4—12 weeks for a positive result to develop after a person is infected.
4. **Side Effects.** A positive test result may cause you significant anxiety. A positive test may result in uninsurability for life, health, or disability insurance policies you may apply for in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.
5. **Disclosure of Results.** A positive test result will be disclosed to you. You may choose to have information about your HIV test results communicated to you through your physician, through the county health department, or directly.
6. **Confidentiality.** Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to the Medical Information Bureau, a national insurance data bank. Your insurance agent will provide you with additional written information about this subject at your request.
7. **Prevention.** Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.
8. **Information.** Your personal physician, local Health Department, or local chapter of the American Red Cross can provide you with additional information concerning HIV infection, the testing process, the interpretation of test results, the availability of counseling, and the availability of medical evaluation. You are strongly encouraged to contact any of these sources if you have any questions or desire additional information.

# Listing of California AIDS Counseling Resources

1. San Francisco AIDS Foundation
   10 United Nations Plaza, Suite 405
   San Francisco, CA 94102
   (415) 863-2437

2. Sacramento AIDS Foundation
   1330 21st Street #100
   Sacramento, CA 95814
   (916) 448-2437

3. Central Valley AIDS Team
   1999 Tuolumne Street #625
   Fresno, CA 93744
   (559) 264-2437

4. AIDS Project Los Angeles
   1313 North Vine Street
   Los Angeles, CA 90028
   (213) 993-1600

5. AIDS Services Foundation
   17982 Sky Park Circle #J
   Irvine, CA 92627
   (949) 253-1500

6. AIDS Emergency Assistance
   2440 Third Avenue
   San Diego, CA 92103
   (619) 291-1400

7. East Bay AIDS Foundation
   1970 Broadway
   Oakland, CA 94612
   (510) 433-1000

8. ARIS-ADIS Resources
   1550 The Alameda #100
   San Jose, CA 95008
   (408) 293-2747

# HIV AND AIDS

American Red Cross


AIDS is one of the leading causes of death of Americans age 25 to 44. Many people currently living with HIV, the virus that causes AIDS, did not believe they were at risk. But HIV is serious, and it will be with us for a long time. However, you can prevent HIV infection. This brochure gives you important information about HIV and AIDS that will help you learn to protect yourselves and others.

**FACT: AIDS is caused by a virus called HIV.**

HIV stands for human immunodeficiency virus. It is the virus that causes AIDS – Acquired Immunodeficiency Syndrome. HIV is spread from one person to another through sex and blood-to-blood contact. When someone becomes infected with HIV, the virus attacks that person's immune system (the system that defends the body from illness). A person develops AIDS when his or her immune system becomes so damaged that it can no longer fight off diseases and infections. These diseases and infections can be fatal.

Most people get infected with HIV by having sex or sharing needles with someone who already has the virus. **HIV does not discriminate. Anyone can get HIV.**

## ANYONE CAN GET HIV

**FACT: People infected with HIV may look and feel healthy for a long time.**

It may take more than 10 years for people who are infected with HIV to develop AIDS. They may look and feel healthy for years after becoming infected. They may not know they are infected. Even if they don't look or feel sick they can infect others.

## HIV CAN BE SPREAD THROUGH AN INFECTED PERSON'S BLOOD, SEMEN, VAGINAL FLUIDS, OR BREAST MILK

**FACT: When signs of illness do appear, they vary from person to person.**

When symptoms do appear, they can be like those of many common illnesses and may include swollen glands, fever, and diarrhea. In some women, recurrent, hard-to-treat vaginal yeast infection and cervical cancer may be related to HIV infection. Symptoms vary from person to person. None of the symptoms necessarily indicates HIV infection. When people develop AIDS, they may get illnesses that healthy people can usually resist. Only a test can tell if someone is infected with HIV. Only a doctor can diagnose AIDS.

**FACT: Most people with HIV or AIDS got the virus by having sex or sharing needles with someone who was already infected.**

The most common ways in which HIV is spread are –

- Having vaginal, anal, or oral sex with someone who has HIV.
- Sharing needles or syringes with someone who has HIV.
- From a woman with HIV to her baby during pregnancy or childbirth through breast feeding, HIV can be spread through infected person's blood, semen, vaginal fluids, or breast milk.

## YOU CANNOT GET HIV FROM GIVING BLOOD

**FACT: You cannot "catch" HIV like you do a cold or flu.**

HIV is not spread through the air or water. HIV is not spread through everyday casual contact.

**You cannot get HIV from –**

- Handshakes.
- Hugs.
- Coughs or sneezes.
- Sweat or tears.
- Mosquitoes or other insects.
- Pets.
- Eating food prepared by someone else.
- Being around an infected person.

**Or from using –**

- Swimming pools.
- Toilet seats.
- Phones or computers.
- Straws, spoons, or cups.
- Drinking fountains.

## HIV IS NOT SPREAD THROUGH EVERYDAY CASUAL CONTACT

**FACT: You can protect yourself and others from HIV.**

Not having sex is the only sure way to avoid the sexual transmission of HIV. However, if you decide to have sex, you can reduce your risk of infection in several ways.

- Have sex only with one partner who is not infected, who has sex only with you, and who does not share needles or syringes (Keep in mind that it is difficult to know these things about another person.)
- Avoid contact with your partner's blood, semen, or vaginal fluid.
- When having sex, using a latex condom the right way every time greatly reduces your risk of HIV infection. (See instructions for latex condom use in this brochure.)
- For vaginal or anal sex, use a water-based lubricant with the condom to reduce the risk of breakage.
- For oral sex on a man, use a condom without spermicide or lubricants.

The most effective way to prevent HIV infection through drug use is to stop injecting drugs. People who inject drugs can prevent HIV infection by –

- Using **new**, sterile equipment every time.
- **Never** sharing needles or syringes.

When more effective prevention is not possible, drug equipment may be cleaned with bleach to reduce the risk of HIV infection. Contact your local drug treatment center, health department, or AIDS service organization for more information on how to clean drug equipment.

**FACT: It is impossible for a donor to get HIV from giving blood or plasma.**

In the United States, every piece of equipment (needles, tubing, containers) used to draw blood is brand new. It is used only once, then destroyed. **You cannot get HIV from giving blood.**

**FACT: The chances of getting HIV from a blood transfusion in the United States are now extremely low.**

Since 1985, all donated blood and plasma have been tested for signs of HIV. The tests used are more than 99 percent accurate. People who are at risk of being infected with certain germs, including HIV, are not allowed to give blood. If signs of the virus are found in donated blood, the blood is destroyed. Before 1985, some people became infected with HIV through infected blood and certain blood products used for transfusion and for treating diseases such as hemophilia.

## YOU CAN PROTECT YOURSELF AND OTHERS FROM HIV.

**FACT: There are tests for HIV.**

If you think you may be infected with HIV, you are encouraged to seek HIV-antibody testing and counseling. Standard tests look for the presence of HIV antibodies, which are signs of the virus. The body almost always develops antibodies to fight off viruses that enter the blood stream.

Current tests are more than 99 percent accurate. However, it can take up to three months after a person becomes infected before antibodies can be detected by a test. For this reason, if someone was infected recently, the test may not yet show that the person is infected. Contact your local public health department, AIDS service organization, local Red Cross, or doctor's office for more information about HIV-antibody testing and counseling.

## YOU CAN'T GET HIV OR AIDS FROM BEING A FRIEND.

**FACT: There is no vaccine for HIV or a cure for AIDS.**

Some medicines are now available to help people with HIV live longer, healthier lives. None of these medicines can keep a person from becoming infected with HIV. None of the treatments can cure AIDS. But people can prevent HIV infection by learning the facts and acting on them.

**FACT: You can help fight the battle against HIV and AIDS by being a volunteer.**

Volunteers are always needed. They can answer AIDS hotlines and help teach others about HIV and AIDS. They can help people living with HIV and AIDS by shopping for them or bringing meals to their homes. They can help raise funds to fight this epidemic. Call your local Red Cross or AIDS service organization to learn how you can help.

**FACT: People with HIV and AIDS need your love and understanding.**

You can't get HIV or AIDS from being a friend. People who are living with HIV and AIDS need your support and caring. Ask them how you can help.

**What can I do to help?**
**Know the facts about HIV and AIDS.**

Use what you have learned to help protect yourself and others. Share the facts about HIV and AIDS with your family, friends, and co-workers.

**Set an example for others.**

Show support and caring for people who are living with HIV and AIDS. Remember, you can't get HIV from being a friend.

**Become a volunteer.**

**Sponsor an AIDS fund-raising event or donate money.**

**Become a Red Cross HIV/AIDS instructor.**

**For more information, contact –**

- Your local Red Cross.
- The National AIDS information hotline (toll free): 1-800-342-2437. For Spanish-speaking persons, Línea Nacional de SIDA: 1-800-344-7432. For deaf and hearing-impaired persons, TTY/TDD Hotline: 1-800-243-7889.
- Your doctor or other health care provider.
- Your local or state public health department
- Your local AIDS service organization.
- The American Red Cross Internet Web site : http://www.redcross.org/hss.

**Red Cross HIV / AIDS programs**

The Red Cross has Basic, African American, Hispanic, and Workplace HIV/AIDS Education programs. Youth materials, including Act SMART and The Party, are also available. Contact your local Red Cross for more information.

**How to use a condom ("rubber")**

Use condoms made of latex.*
Store condoms in a cool, dry place, away from heat and sun.
Use a new condom each time you have sex.** Check the expiration date on the condom. Do not use expired condoms or condoms that are yellowed, sticky, or brittle. Handle the condom carefully to avoid damaging it with fingernails, teeth, or other sharp objects.
Put on the condom when the penis is erect and before any vaginal, oral, or anal contact
Pinch the tip of the condom so that air will not be trapped, and unroll the condom all the way down the erect penis. If the condom does not have a receptacle and, leave space at the tip for semen ("cum").
Use a water-based lubricant on the outside of the condom so that it will be less likely to break. Do not use oil-based lubricants (such as petroleum jelly, shortening, mineral oil, massage oil, body lotion). Oil-based lubricants can cause a condom to break. Hold the condom at the base of the penis and withdraw while the penis is still erect to prevent slippage. Remove the condom, being careful not to spill the contents.
Throw the condom away. Do not use a condom more than once.

* Polyurethane (plastic) condoms are used by some people, including those who are allergic or sensitive to latex condoms. At the time of this writing, however, they were not yet thoroughly tested for HIV and sexually transmitted disease prevention.

** Latex condoms used the right way every time a person has sex greatly reduces the risk of HIV infection and other sexually transmitted diseases. Not having sex is the most effective way to prevent the sexual transmittal of HIV.

This publication was supported by Cooperative Agreement No. U62/CCU 303031 from the Centers for Disease Control and Prevention (CDC) of the U.S. Public Health Service. Its contents are solely the responsibility of the American Red Cross and do not necessarily represent the official views of the CDC.

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Columbus Life Insurance Company

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# CALIFORNIA FINANCIAL PRODUCTS DISCLOSURE

## NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY AND RECOVERY

If you or your spouse are considering purchasing a financial product based on its treatment under the Medi-Cal program, read this important message!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

### RECOVERY

An annuity purchased on or after September 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after September 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

### UNMARRIED RESIDENT

An unmarried resident may be eligible for Medi-Cal benefits if he or she has less than $2,000 in countable resources.

The Medi-Cal recipient is allowed to keep from his or her monthly income a personal allowance of $35 plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share of cost.

### MARRIED RESIDENT

COMMUNITY SPOUSE RESOURCE ALLOWANCE: If one spouse lives in a nursing facility, and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than $115,920 in community countable assets.

MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income, or $2,898 in monthly income, whichever is greater.

### FAIR HEARINGS AND COURT ORDERS

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than $115,920 in countable resources. The order also may allow the at-home spouse to retain more than $2,898 in monthly income.

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

**REAL AND PERSONAL PROPERTY EXEMPTIONS**
Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

**REAL PROPERTY EXEMPTIONS**
ONE PRINCIPAL RESIDENCE: One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday.

The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it.

Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.

REAL PROPERTY USED IN A BUSINESS OR TRADE: Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

**PERSONAL PROPERTY AND OTHER EXEMPT ASSETS**
IRAs, KEOGHs, AND OTHER WORK-RELATED PENSION PLANS: These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.

PERSONAL PROPERTY USED IN A TRADE OR BUSINESS.

ONE MOTOR VEHICLE.

IRREVOCABLE BURIAL TRUSTS OR IRREVOCABLE PREPAID BURIAL CONTRACTS.

THERE MAY BE OTHER ASSETS THAT MAY BE EXEMPT.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney who is not connected with the sale of this product.

I have read the above notice and have received a copy.

| | | |
|---|---|---|
| Owner's Signature | Owner's Printed Name | Date |
| Spouse's Signature (if any) | Spouse's Printed Name | Date |
| Legal Representative's Signature (if any) | Legal Representative's Printed Name | Date |
| Agent's Signature | Agent's Printed Name | Date |

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| | | |
|---|---|---|
| Owner's Signature | Owner's Printed Name | Date |
| Spouse's Signature (if any) | Spouse's Printed Name | Date |
| Legal Representative's Signature (if any) | Legal Representative's Printed Name | Date |
| Agent's Signature | Agent's Printed Name | Date |

Columbus Life
Insurance Company

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# NOTICE

In compliance with the Fair Credit Reporting Act, you are hereby notified that we may ask an independent reporting company for an investigative consumer report. We use Infolink Services, a division of Hooper Holmes, Inc. The address for Infolink is 3307 Northland Dr., Austin, TX 78731. Infolink may conduct personal interviews with you and your friends and others who know you. You can ask in writing for more details about the nature and scope of this investigation. You also have a right to request detailed results of your report. Direct your request to the New Business Department, Columbus Life Insurance Company, 400 East Fourth Street, Cincinnati, OH 45202.

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# 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.

## 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, Ohio 45202

# California Senior Home Visit

**The following notice is required by the State of California and applies only to California residents who are 65 years of age or older.**

## AGENT CONTACT INFORMATION
## (as it appears on my California insurance license)

**Name:** _____

**License Number:** _____ **Telephone Number:** _____

**Mailing Address:** _____

_____

**I am a licensed insurance agent. My purpose for coming to your home is to sell, discuss, and/or deliver one of the following (indicate all that apply):**

☐ **Life insurance, including annuities.**

☐ **Other insurance products (specify):** _____.

**You have the right to have other persons present at the meeting, including family members, financial advisors, or attorneys.**

**You have the right to end the meeting at any time.**

**You have the right to contact the Department of Insurance for information, or to file a complaint. You may contact the California Department of Insurance, Consumer Services Division at (800) 927-4357 or (323) 897-8921.**

**The following individuals will be coming to your home:**

| **Attendee's Name:** | **Insurance License Information:** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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# Certification of Notification Per California Insurance Code, Section 789.10b

I hereby certify that 24 hour advance notice as required by California Insurance Code, Section 789.10b was provided to the applicant named below, who is age 65 or older. If the 24 hour advance notice was not possible, I hereby certify that the required notice was delivered to the applicant prior to the meeting.

Name of Applicant

Date

Agent's Signature

Agent's Printed Name

Columbus Life Insurance Company
A member of Western & Southern Financial Group
400 East Fourth Street, Cincinnati, OH 45202

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

**IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS**

The benefits provided by this accelerated death benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance.

If you choose to accelerate a portion of your death benefit, doing so will reduce the amount that your beneficiary will receive upon your death.

Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, you should seek assistance from a qualified tax adviser.

Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

The Accelerated Death Benefit Rider provides the owner the right to receive accelerated payments of a portion of the death benefit in the form of an advance when the Insured has been diagnosed with any of the following qualifying events: (1) Critical Illness; (2) Chronic Illness; or (3) Terminal Illness.

For joint life policies, no advance may be taken until after the death of the first Insured and the surviving Insured has been diagnosed with one of the qualifying events.

**ACCELERATING CONDITIONS**

"Critically Ill" means that the Insured has a medical condition that is diagnosed while the rider is in force that would, in the absence of treatment, result in the Insured's death within 6 months.

"Chronic Illness" means the insured 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. Also, a Licensed Health Care Practitioner has determined that the insured's loss of ability to perform those Activities of Daily Living is expected to be permanent or the insured requires Substantial Supervision to protect himself or herself from threats to health and safety due to Severe Cognitive Impairment

"Terminal Illness" means an illness that is expected to result in the death of the Insured within 12 months.

**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 $250 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**

**ACCELERATED BENEFITS PAID FROM THIS RIDER ARE INTENDED TO QUALIFY FOR FAVORABLE TAX TREATMENT UNDER SECTION 101(g) OF THE INTERNAL REVENUE CODE, IF, ACCORDING TO FEDERAL DEFINITIONS, THE INSURED QUALIFIES AS TERMINALLY ILL, OR QUALIFIES AS CHRONICALLY ILL. THERE MAY BE TAX CONSEQUENCES FOR ACCEPTING AN ADVANCE ABOVE THE AMOUNT THAT WOULD BE TAX QUALIFIED UNDER THE INTERNAL REVENUE CODE. WE RECOMMEND THAT YOU CONTACT A TAX ADVISOR BEFORE REQUESTING AN ADVANCE UNDER THIS RIDER.**

## 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 Columbus Life Insurance Company.

| | |
|---|---|
| Signature of Applicant/Proposed Owner | Date |
| Applicant/Proposed Owner Printed Name | |
| 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 provided with my policy.

| | |
|---|---|
| Name of Insured | Policy Number |
| Signature of Owner | Date |
| Signature of Irrevocable Beneficiary | Date |
| Signature of Agent | Date |

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

Columbus Life Insurance Company
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**Columbus Life Insurance Company**
400 East Fourth Street
Cincinnati, OH 45202-3302
toll free 800.677.9696
www.columbuslife.com

# Privacy Policy Statement

Our privacy policy statement explains how we collect, use, share, and protect your personal information. So just how do we protect your privacy? Simply put, we respect your right to privacy and promise to treat your personal information responsibly. It's as simple as that. Here's how.

**Our Pledge to our Customers**

- We collect only the information we need to serve you and administer our business.
- We are committed to keeping your information confidential and we place strict limits and controls on the use and sharing of your informaion.
- We make every effort to ensure the accuracy of information.

We collect information about you when you ask about or buy one of our products or services. The information comes from your application, business transactions with us, and consumer reports – but only if applicable to the product or service that you choose. Please know that we only use that information to sell, service, or market products to you.

We may share information with our affiliated companies, such as: name and address, social security number, assets and income, property address and value, account and policy information, consumer report information, family member and beneficiary information and medical information you granted us permission to collect.

**How we use information**

When you enter into a business relationship with us, we may share your personal information with your agent, producer, or advisor and our companies and business partners so that they can service your policy or account. Some examples of when we may share this information include mailing your statement or processing transactions that you request. You cannot opt out of our sharing of this information for such purposes. We may also share your personal information where federal and state law requires.

We don't sell your information for marketing purposes. We may disclose the information we collect to companies that perform marketing services on our behalf or to other financial institutions with which we have joint marketing agreements. Any company with which we team must conform to our privacy standards. If we change our policy, we'll tell you and give you the opportunity to opt out before we share your information.

**Confidentiality and security**

We follow the data security laws that apply to us. We protect your information by using physical and technical safeguards. We limit access to your information to those who need it to do their jobs. Our business partners are also legally bound to use your information for our purposes only. They may not share it or use it in any other way.

**Who we are**

We are a member of the Western & Southern Financial Group, Inc ("Western & Southern Financial Group"). The member companies are:
Columbus Life Insurance Company; Fort Washington Investment Advisors, Inc.; IFS Financial Services, Inc.; Integrity Life Insurance Company; The Lafayette Life Insurance Company; National Integrity Life Insurance Company; Touchstone Securities, Inc.; Touchstone Advisors, Inc.; The Western and Southern Life Insurance Company; Western & Southern Agency, Inc.; Western-Southern Life Assurance Company; and W&S Brokerage Services, Inc.

**Accessing your information**

You can request a copy of your personal information by sending us a written request. For your protection, we will verify your identity before providing you with your information. We can only provide information that we control. We don't charge a fee for a copy of your information now, but we may charge a small fee in the future. You can call your agent or producer to change your personal information. We can't update information that other companies provide to us; so you'll need to contact these other companies to change your information. Please call us at (800) 677-9595 for questions about our privacy policy statement.

**Important notice about opting out**

The Western & Southern Financial Group also provides this opt out notice. Federal law gives you the right to limit some but not all marketing from the Western & Southern Financial Group companies. Federal law also requires us to give you this notice to tell you about your choice to limit marketing from the Western & Southern Financial Group companies.

You may limit the Western & Southern Financial Group member companies, such as its insurance and securities affiliates, from marketing their products or services to you based on your personal information that they receive from other Western & Southern Financial Group companies. This information may include your assets and income, property address and value, account and policy information, and consumer report information.

To limit marketing offers, contact us by telephone at (866) 590-1349. If you own a financial product jointly with someone else, any owner can opt out. Your choice to limit marketing offers from the Western & Southern Financial Group companies will apply for at least 5 years from when you tell us your choice. Once that period expires, you will receive a renewal notice that will allow you to continue to limit marketing offers from the Western & Southern Financial Group companies for at least another 5 years.

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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.

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

**Essential Forms**

| | | |
|---|---|---|
| ☐ Life Insurance Application | CL 45.300 | **New Business:**<br>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.)<br>Complete if Applicable: B – Survivorship or Other Insured only.<br>D – For any optional benefits/riders.<br>E – Proposed Insured under 18.<br>F – Owner other than Proposed Insured.<br>M – Additional remarks. Attach a separate page if more space is needed.<br>**Reinstatements:** 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.<br>**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.**<br>Account Bill: Three policies must be listed for one account to set up Account Bill. |
| ☐ 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. |
| ☐ 1035 Exchange | CL 45.172 | If existing policy has a loan, indicate if the loan is to be carried over to the new policy. |
| ☐ 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) |
| ☐ 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. |
| ☐ Temporary Insurance Agreement | 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. |
| ☐ Information Practices Disclosure | CL 45.456 | Must always be given to the Applicant. |
| ☐ Agent's Report | CL 45.459 | Complete sections that apply. Always complete Writing Agent Report section and sign. |
| ☐ UL Accelerated Death Benefit Disclosure | CL 45.924 | Provide copy to Applicant, Signed copy to Home Office with application. For Explorer Plus ages 80 – 85 provide CL 45.921 to the Applicant. |
| ☐ Accelerated Death Benefit Disclosure | CL 45.925 | Provide copy to Applicant, Signed copy to Home Office with application. |
| ☐ Privacy Policy Disclosure | CL 5.850-NB | Always give to the Applicant. |

**Supplemental Forms**

| | | |
|---|---|---|
| ☐ Indexed UL Supplement | CL 45.452 | Complete to designate premium allocation. |
| ☐ VUL Supplement | CL 45.265 | Complete to designate sub-accounts and to select other optional features. Always complete the suitability section of this form. |
| ☐ Children's Term | CL 45.458 | Complete only when Children's Term rider is applied for. |
| ☐ 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. |
| ☐ Citizenship Supplement | CL 45.-918 | Complete for any Proposed Insured who is not a U.S. citizen (not used in Florida). |

**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:**

- ☐ Estate Planning
- ☐ Family Income Replacement
- ☐ Final Expenses
- ☐ Mortgage Coverage
- ☐ Split Dollar
- ☐ Retirement Plan
- ☐ Buy/Sell
- ☐ Deferred Comp.
- ☐ Employee Bonus
- ☐ Key Person
- ☐ Stock Redemption
- ☐ Required by Creditor (debt protection)
- ☐ 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:

- ☐ **None – Lump Sum** _____
- ☐ **Direct Bill**
  - ☐ Quarterly ☐ Semi-Annually ☐ Annually
- ☐ **Pre-Authorized Transfer**
  - ☐ New Plan ☐ Existing Plan
  - ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Complete PAT form CL 35.47-NB. Please follow all instructions in that form.

- ☐ **Account Bill**
  - ☐ New Plan (Will be assigned by H.O.)
  - ☐ Existing Plan No. _____ (Policy Number or Account Number)
- Payable: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually
- ☐ **Government Allotment** (See Marketing Manual Rules.)
  - ☐ New Plan
  - ☐ Existing Plan No. _____ (Policy Number or Account Number)

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

| | % of App (whole numbers only) | CLIC Producer Number |
|---|---|---|
| **Writing Agent** _____ | _____ | CL000 _____ |
| Agent #2 _____ | _____ | CL000 _____ |
| Agent #3 _____ | _____ | CL000 _____ |

**Writing Agent Information:**

Phone No. _____ Fax No. _____ E-Mail _____

## WRITING AGENT REPORT

| | | Yes | No |
|---|---|---|---|
| **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. ..... | ☐ | ☐ |
| **B.** | I declare that I have accurately answered any questions contained in the Agent's Report completed by me in connection with this application. ..... | ☐ | ☐ |
| **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. ..... | ☐ | ☐ |
| **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. ..... | ☐ | ☐ |

_____
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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## NOTICE TO APPLICANT REGARDING REPLACEMENT OF LONG-TERM CARE INSURANCE OR LIFE INSURANCE INCLUDING ACCELERATED DEATH BENEFITS

According to your application or information you have furnished, you intend to lapse or otherwise terminate existing life insurance or long-term care insurance and replace it with a life insurance policy with an accelerated death benefit to be issued by the Columbus Life Insurance Company. Your new policy, which will include accelerated death benefit coverage, provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of, and seriously consider, certain factors that may affect the insurance protection available to you under the new coverage.

This accelerated death benefit is NOT Nursing Home, Home Care, or Long-Term Care Insurance, and it is not intended or designed to eliminate your need for that coverage. There are no restrictions or limitations on the use of the accelerated death benefit proceeds.

If you want long-term care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) that provides information regarding long-term care insurance.

If you want to replace existing coverage with life insurance that includes an accelerated death benefit, you should note the following:

(1) Receipt of accelerated death benefits may be taxable. Prior to electing to buy a policy that includes the accelerated death benefit, policyholders or certificate holders should seek assistance from a qualified tax adviser.

(2) Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy a policy that includes the accelerated death benefit, the applicant/buyer should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

The above “Notice to Applicant” was delivered to me on:

_____
Date

_____
Applicant’s Signature

_____
Applicant Printed Name

COMPARISON TO YOUR CURRENT COVERAGE: I have reviewed your current coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:

_____ Additional or different benefits (please specify) _____

_____

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ Other (please specify) _____

_____

_____ _____
Signature of Agent Name of Insurer

_____
Applicant’s Signature

_____
Date

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

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## IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

The benefits provided by this accelerated death benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance.

If you choose to accelerate a portion of your death benefit, doing so will reduce the amount that your beneficiary will receive upon your death.

Receipt of accelerated death benefits may be taxable. Prior to electing to buy a policy that includes the accelerated death benefit, you should seek assistance from a qualified tax adviser.

Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy a policy that includes the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

_____ _____

Signature of Applicant/Proposed Owner Date

_____

Applicant/Proposed Owner Printed Name

_____ _____

Signature of Agent Date

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

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# Application Supplement Regarding Accelerated Death Benefits

Name of Proposed Insured _____ Date of Birth _____

Will the accelerated death benefit, if any, included with the life insurance policy you are applying for replace an existing long-term care policy or an existing life insurance policy that includes an accelerated death benefit?

☐ YES ☐ NO

Instructions to Agent:

1. Always send this application supplement to the Home Office with the application.
2. If the question above is answered **YES**, complete and sign form CL 45.941, Notice to Applicant (2 copies).

*[Note to Agent: Please detach last completed copy of the Notice to Applicant and leave it with the Applicant].*

**Caution:** If your answers on your application are misstated or untrue, we may have the right to deny benefits or rescind your accelerated death benefit coverage.

Applicant Signature _____ Date _____

Applicant Printed Name _____

Agent Signature _____ Date _____

Agent Printed Name _____

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# CERTIFICATION FORM FOR SALES TO APPLICANTS OUTSIDE OF THEIR RESIDENT STATE

The Agent/Registered Representative confirms the following:

Name of Owner/Joint Owner ("Applicant"): _____

Name of Insured/Annuitant (if different): _____

Policy/Contract number (if known): _____

Resident State of Applicant*: _____ Application State: _____

**The Applicant's valid reason for purchasing an insurance or annuity product outside of their resident state is (check all that apply):**

- ☐ The Applicant owns a second home in the application state.
- ☐ The Applicant is employed, has a business address or regular business dealings in application state.
- ☐ The Applicant is a relative of or is an existing client of the agent in the application state, which is a state where the Applicant formerly lived.
- ☐ The Applicant is different than the Insured/Annuitant and the Insured/Annuitant's primary residence is in the application state.
- ☐ The Applicant is a trust and the trustee's primary residence is in the application state.
- ☐ The Applicant has a power of attorney ("POA") acting on their behalf and the POA's primary residence is in the application state.
- ☐ Other reason (provide a detailed explanation) _____

_____

_____

**The undersigned certifies that:**

- The above information is true and complete.
- The solicitation and signing of the application occurred within the application state.
- The policy/contract will be delivered to the Applicant in the application state.
- All other sales activity, including initial premium collection and paramedic exam, occurred or will occur in the application state.

*The Company reserves the right to decline to issue the life insurance policy or annuity contract for which the Applicant is applying.*

**Signature of Agent/ Registered Representative** _____ **Date** _____

**Name of Agent/ Registered Representative** _____

**Residents of the following states are prohibited from purchasing an insurance or annuity product outside of their resident state:* ***Arkansas, Idaho, Massachusetts, Minnesota, Mississippi, Utah, Wisconsin.***



# Guidance on Sales to Applicants Outside of Their Resident State

**Purpose:** The purpose of this document is to provide guidance when selling insurance or annuity products to applicants outside of their resident state (e.g., a Florida resident purchases a Georgia insurance or annuity product in Georgia).

**How do I determine the applicant's resident state?** The resident state is defined as the primary residence of an individual, for purposes of income tax calculation or for acquiring a mortgage. Generally, a person's primary residence is determined by where they receive mail on a regular basis, time spent at the residence per year, and such other factors. A person can only have one primary residence at any given time.

**Am I allowed to sell to applicants outside of their resident state?** Yes, in some cases you are allowed to sell to applicants outside of their resident state, provided you meet the requirements in this guidance.

**When am I allowed to sell to applicants outside of their resident state?** If an applicant purchases an insurance or annuity product outside of their resident state, the applicant must have a valid connection to that state. Having an applicant cross the border to a neighboring state for the purpose of purchasing an insurance or annuity product is strictly prohibited.

| Acceptable reasons to sell outside of the applicant's resident state may include: | Unacceptable reasons to sell outside of the applicant's resident state may include: |
|---|---|
| • The applicant owns a second home in that state.<br>• The applicant is employed, has a business address or regular business dealings in that state.<br>• The applicant is a relative of or is an existing client of the agent in that state, which is a state where the applicant formerly lived.<br>• The applicant is different than the insured/annuitant and the insured/annuitant's primary residence is in that state.<br>• The applicant is a trust and the trustee's primary residence is in that state.<br>• The applicant has a power of attorney (POA) acting on their behalf and the POA's primary residence is in that state. | • The applicant is only in that state for the purpose of purchasing an insurance product that is not approved in their resident state.<br>• The agent invites a potential applicant from one state to a seminar in another state due to insurance product unavailability in the applicant's resident state.<br>• The applicant was shopping or vacationing in that state.<br>• The applicant is visiting a relative or friend who is not the agent in that state.<br>• The applicant is a resident of one of the states listed below that the Company prohibits from purchasing its insurance or annuity products outside of their resident state. |

**Where must the sales activity occur if I am selling to applicants outside their resident state?** All sales activity (including the solicitation, signing the application, paramedic exam (if applicable), initial premium collection, and policy or contract delivery) must occur in the state identified on the application. **NO** sales activity can occur in the applicant's resident state.

**Are there states that prohibit selling to applicants outside their resident state?** Based upon legal restrictions in effect, the Company prohibits residents of the following states from purchasing its insurance or annuity products outside of their resident state. Therefore, residents of these states are only permitted to purchase insurance or annuity products available for sale in their resident state:

- *Arkansas*
- *Idaho*
- *Massachusetts*
- *Minnesota*
- *Mississippi*
- *Utah*
- *Wisconsin*

**What additional documentation is required if I meet the requirements above and am selling to applicants outside of their resident state?** The "Certification Form - Sales to Applicants Outside of Their Resident State (EF-054 or CL 45.945)" must be completed and submitted with the application. In the scenario of joint owner applicants, this form must be completed for one of the applicants. There may be times when we confirm the information in this form with the applicant directly. Even in cases where the form is submitted, we reserve the right to decline applications for sales to applicants outside of their resident state.

*As with any sale, you must be appropriately licensed and appointed, and if applicable, registered. If you have any further questions, please contact your Sales Desk.*

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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 _____

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## TEMPORARY INSURANCE AGREEMENT

The life insurance policy you have applied for will not become effective unless and until a policy is delivered to you and you accept it. However, if you have paid our agent at least one-twelfth of the annual premium for the policy you applied for, we will provide temporary insurance on the lives of the proposed insureds listed below. The amount, duration and conditions of this temporary insurance are described below.

**Amount of Coverage - $500,000 Maximum for All Applications or Agreements**

If money has been accepted by the Company as advance payment with an application for Life Insurance and any Person proposed for coverage listed below dies while this temporary insurance is in effect, the Company will pay to the designated beneficiary the lesser of (a) the amount of all death benefits applied for in the Application, including any accidental or supplemental death benefits, if applicable, or (b) $500,000. This total benefit limit applies to all insurance applied for under this and any other current applications to the Company and any other Temporary Insurance Agreements.

**Insurability Preserved If Change In Health While Covered**

If any person listed below suffers a change in health after the effective date of this Agreement, but before coverage terminates as set forth below, and if the person is determined to have been insurable as of the date of the application, the Company will offer the insurance applied for on such person at the appropriate rate on the basis of such person's insurability as of the effective date of the insurance applied for if such person is living after the termination date of this Agreement.

**Date Coverage Begins**

Temporary Life Insurance under this Agreement will begin on the date of this Agreement, but only if the Application for insurance and the Health Questions listed below have been completed on the same date or prior to the date of this Agreement.

**Date Coverage Terminates - 90-Day Maximum**

Temporary Life Insurance under this Agreement will terminate automatically on the earliest of

a. 90 days from the date of this Agreement, or
b. the date that insurance takes effect under the policy applied for, or
c. the date a policy, other than as applied for, is offered to the Applicant, or
d. the date the Company mails notice of termination of coverage to the premium notice address designated in the Application for insurance. The Company may terminate coverage at any time.

**Special Limitations**

- This Agreement does not provide benefits for disability.
- Fraud or material misrepresentations in the Application or in the answers to the Health questions of this Agreement will invalidate this Agreement and the Company's only liability is for refund of any payment made.
- No one is authorized to accept money on Persons proposed for coverage under 15 days of age or over age 70 (last birthday) on the date of this Agreement, nor will any coverage take effect.
- If any Person proposed for coverage dies by suicide, the Company's liability under this Agreement is limited to a refund of the payment made.
- There is no coverage under this Agreement if the check or draft submitted as payment is not honored by the bank.
- The minimum advance payment acceptable for this Agreement is 1/12 the minimum annual premium for the insurance applied for.
- No one is authorized to waive or modify any of the provisions of this Agreement.
- Do not collect any premium if total death benefit applied for exceeds $1,000,000.

All Checks Must Be Made **Payable To Columbus Life. Do Not Make Check Payable To The Agent** Or Leave The Payee Blank.

Names of Persons Proposed for Coverage _____

Date of Birth: _____ Payment Amount _____

**HEALTH QUESTIONS** - Has any Person listed above:

| | | YES | NO |
|---|---|---|---|
| a. | within the past 6 months, been admitted to a hospital or other medical facility, or been advised to be admitted? | ☐ | ☐ |
| b. | within the past 3 years, been treated for chest pain, heart disease or disorder, cancer, drug or alcohol use, or any disorder of the liver, or had such treatment recommended by a physician or other medical practitioner? | ☐ | ☐ |

If either of these questions is answered "YES" or left blank, no representative of the Columbus Life Insurance Company is authorized to accept money, and NO COVERAGE will take effect under this agreement.

This agreement provides a limited amount of life insurance protection, for a limited period of time, subject to the terms of this Agreement. I have received a copy of, and have read the above terms and conditions of this Temporary Insurance Agreement and declare that the answers are true to the best of my knowledge and belief. I understand and agree to all the terms and conditions of this Agreement.

_____ _____ _____

Signature of Agent | Date | Signature of Applicant (if other than Proposed Insured)

Signature(s) of Proposed Insured(s) _____

HOME OFFICE COPY

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## TEMPORARY INSURANCE AGREEMENT

The life insurance policy you have applied for will not become effective unless and until a policy is delivered to you and you accept it. However, if you have paid our agent at least one-twelfth of the annual premium for the policy you applied for, we will provide temporary insurance on the lives of the proposed insureds listed below. The amount, duration and conditions of this temporary insurance are described below.

**Amount of Coverage - $500,000 Maximum for All Applications or Agreements**

If money has been accepted by the Company as advance payment with an application for Life Insurance and any Person proposed for coverage listed below dies while this temporary insurance is in effect, the Company will pay to the designated beneficiary the lesser of (a) the amount of all death benefits applied for in the Application, including any accidental or supplemental death benefits, if applicable, or (b) $500,000. This total benefit limit applies to all insurance applied for under this and any other current applications to the Company and any other Temporary Insurance Agreements.

**Insurability Preserved If Change In Health While Covered**

If any person listed below suffers a change in health after the effective date of this Agreement, but before coverage terminates as set forth below, and if the person is determined to have been insurable as of the date of the application, the Company will offer the insurance applied for on such person at the appropriate rate on the basis of such person's insurability as of the effective date of the insurance applied for if such person is living after the termination date of this Agreement.

**Date Coverage Begins**

Temporary Life Insurance under this Agreement will begin on the date of this Agreement, but only if the Application for insurance and the Health Questions listed below have been completed on the same date or prior to the date of this Agreement.

**Date Coverage Terminates - 90-Day Maximum**

Temporary Life Insurance under this Agreement will terminate automatically on the earliest of

a. 90 days from the date of this Agreement, or
b. the date that insurance takes effect under the policy applied for, or
c. the date a policy, other than as applied for, is offered to the Applicant, or
d. the date the Company mails notice of termination of coverage to the premium notice address designated in the Application for insurance. The Company may terminate coverage at any time.

**Special Limitations**

- This Agreement does not provide benefits for disability.
- Fraud or material misrepresentations in the Application or in the answers to the Health questions of this Agreement will invalidate this Agreement and the Company's only liability is for refund of any payment made.
- No one is authorized to accept money on Persons proposed for coverage under 15 days of age or over age 70 (last birthday) on the date of this Agreement, nor will any coverage take effect.
- If any Person proposed for coverage dies by suicide, the Company's liability under this Agreement is limited to a refund of the payment made.
- There is no coverage under this Agreement if the check or draft submitted as payment is not honored by the bank.
- The minimum advance payment acceptable for this Agreement is 1/12 the minimum annual premium for the insurance applied for.
- No one is authorized to waive or modify any of the provisions of this Agreement.
- Do not collect any premium if total death benefit applied for exceeds $1,000,000.

All Checks Must Be Made **Payable To Columbus Life. Do Not Make Check Payable To The Agent** Or Leave The Payee Blank.

Names of Persons Proposed for Coverage _____

Date of Birth: _____ Payment Amount _____

**HEALTH QUESTIONS** - Has any Person listed above:

| | | YES | NO |
|---|---|---|---|
| a. | within the past 6 months, been admitted to a hospital or other medical facility, or been advised to be admitted? | ☐ | ☐ |
| b. | within the past 3 years, been treated for chest pain, heart disease or disorder, cancer, drug or alcohol use, or any disorder of the liver, or had such treatment recommended by a physician or other medical practitioner? | ☐ | ☐ |

If either of these questions is answered "YES" or left blank, no representative of the Columbus Life Insurance Company is authorized to accept money, and NO COVERAGE will take effect under this agreement.

This agreement provides a limited amount of life insurance protection, for a limited period of time, subject to the terms of this Agreement. I have received a copy of, and have read the above terms and conditions of this Temporary Insurance Agreement and declare that the answers are true to the best of my knowledge and belief. I understand and agree to all the terms and conditions of this Agreement.

_____ _____ _____

Signature of Agent | Date | Signature of Applicant (if other than Proposed Insured)

Signature(s) of Proposed Insured(s) _____

APPLICANT COPY

Columbus Life Insurance Company

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## NOTICE REGARDING REPLACEMENT

## REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one--or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

| _____ | _____ | _____ |
|---|---|---|
| applicant | agent | date |

Information on Policies which may be replaced.

| Company Name and Address | Policy/Contract Number | Name of Insured |
|---|---|---|

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## IMPORTANT INFORMATION

To: All Agents licensed in CALIFORNIA

Re: Life Insurance and Annuity Replacement Law

Part of California's replacement law (a definition of replacement, exemptions and duties of agents) is shown on the reverse side of this notice. Please note that when more than 25% of an existing policy's loan value is borrowed to purchase new life insurance, it is considered replacement.

We believe replacement of permanent life insurance is seldom, if ever, in the best interest of a policyholder. However, if and when you find it logical or necessary that existing life insurance be replaced, please be sure to:

(1) Answer "yes" to replacement questions on the application.
(2) Obtain the applicant's signature on two copies of the "Notice" form.
(3) Leave one copy of the "Notice" and a copy of all written or printed communications with the applicant. If the policy being replaced is a Columbus Life policy, you must give the applicant a written statement about the existing and proposed life policy or annuity. The type of information which must be given is shown on the reverse side of this notice. Please see subsection 10509.3 (5)(B).
(4) Send to us with the application: the other copy of the "Notice," a copy of the written or printed communications and a list of all existing insurance to be replaced.

A few copies of the "Notice Regarding Replacement" form CL 65.152 for use in California are provided with this notice. You can order more copies from Supply Services.

You should know that insurance regulators in some states require the use of their state's replacement forms for their residents, even though the application was taken in another state. To avoid problems you may want to get completed forms for both states at time of application. Let us know if you need replacement forms or information for the applicant's state of residence.

If you have questions or want a complete copy of California's replacement law, please contact the Client Services Service Center.

Sincerely,

Steven J. Sanders, LLIF
Senior Vice President
Chief Marketing Officer

(See other page for detailed replacement information.)

## CALIFORNIA

*Article & Requirements for Replacement of Life Insurance and Annuity Policies*

### §10509.2 Definitions

(a) "Replacement" means any transaction in which new life insurance or a new annuity is to be purchased and it is known or should be known to the proposing agent, or to the proposing insurer if there is no agent, that by reason of that transaction, the existing life insurance or annuity has been or is to be any of the following:

(1) Lapsed, forfeited, surrendered, or otherwise terminated.

(2) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values.

(3) Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid.

(4) Reissued with any reduction in cash value.

(5) Pledged as collateral or subjected to borrowing, whether in a single loan or under a schedule of borrowing over a period of time for amounts in the aggregate exceeding 25 percent of the loan value set forth in the policy.

### §10509.3 Inapplicability of article to certain policies

(a) Unless otherwise specifically included, this article does not apply to the following:

(1) Credit life insurance.

(2) Group life insurance or group annuities.

(3) An application to the existing insurer that issued the existing life insurance when a contractual change or a conversion privilege is being exercised.

(4) Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company.

(5) Transactions where the replacing insurer and the existing insurer are the same; provided, however, that agents proposing replacement shall:

(A) Comply with the requirements of subdivisions (a) and (d) of Section 10509.4.

(B) Provide and leave with the applicant a written statement containing information relating to premiums, cash values, death benefits, and outstanding indebtedness, and dividends and dividend accumulations, if any, for the existing policy, both immediately before and after replacement, and for the proposed life insurance or annuity.

### §10509.4 Duties of agents

(a) Each agent who accepts an application shall submit to the insurer with which an application for life insurance or annuity is presented, or as part of each application, both of the following:

(1) A statement signed by the applicant as to whether replacement of existing life insurance or annuity is involved in the transaction.

(2) A signed statement as to whether or not the agent knows replacement is or may be involved in the transaction.

(b) Where a replacement is involved, the agent shall do all of the following:

(1) Present to the applicant, not later than at the time of taking the application, a "Notice Regarding Replacement of Life Insurance" in the form as described in subdivision (d). The notice shall be signed by both the applicant and the agent and left with the applicant. Obtain with or as part of each application a list of all existing life insurance or annuities to be replaced and properly identified by name of insurer, the insured and contract number. If a contract number has not been assigned by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.

(2) Leave with the applicant the original or a copy of all printed communications used for presentation to the applicant.

(3) Submit to the replacing insurer with the application a copy of the replacement notice.

(c) Every agent who uses written or printed communications in conservation shall leave with the applicant the originals of any materials used.

(d) Each agent or broker shall present to the applicant the following notice: *(see NOTE below)*

NOTE: Wording of the notice referred to under §10509.4 Duties of Agents (d) is printed on Columbus Life form CL 65.152.

(See IMPORTANT INFORMATION on other page)