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 Indexed UL, complete Premium Allocation Election.)

Plan of Insurance _____

If UL, select Death Benefit Option:
- ☐ 1 – Level Death Benefit
- ☐ 2 – Specified Amount plus Cash Value

If UL, select Life Insurance Qualification Test
- ☐ Guideline Premium (default, if none selected)
- ☐ Cash Value Accumulation (not available for all plans)

$ _____ Base Amount

$ _____ Supplemental Coverage Rider (SCR) Amount (if applicable)

$ _____ Total Base Plus SCR Amount

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

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
- ☐ Premium Deposit Account Rider (Available in approved states)
- ☐ Change of Insured
- ☐ Enhanced Cash Value
- ☐ Estate Protection Rider

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)_____ Phone Number _____
   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 the applicant (proposed owner) have any existing annuity contracts or life insurance policies in force with any insurer? ☐ Yes ☐ No
   If yes, the total amount of existing coverage in force is: $_____
   b) Will you replace any existing life insurance or annuities, including taking a loan from an existing insurance policy or surrendering, partially surrendering, modifying, amending or otherwise terminating any existing life insurance policy or annuity contract as a result of this application? If yes, list the company: _____ ☐ 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	Proposed Insured 1 No	Proposed Insured 2 Yes	Proposed Insured 2 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. **Proposed Insured 1:** Quit: Over ☐ 5, ☐ 2, ☐ 1 year(s) ago ☐ Never Used **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: 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 physician 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 perform the normal activities of like age and gender, or been confined at home?	☐	☐	☐	☐
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, have pending charges for, or have you pled guilty 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 military, 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.

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

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

AGREEMENT AND ACKNOWLEDGEMENT

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

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

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

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

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

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 Statement

Does the applicant (proposed owner) have any existing annuity contracts or life insurance policies in force with any insurer? ☐ Yes ☐ No

Will this replace any existing life insurance or annuities, including taking a loan from an existing insurance policy or surrendering, partially surrendering, modifying, amending or otherwise terminating any existing life insurance policy or annuity contract as a result of this application? ☐ Yes ☐ No

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

_____ _____

Agent's Name (Please Print) License No.

Signature of Agent _____ Date _____

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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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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.

ISBN 0-86536-088-X.

Stock No. 329560
Rev. March 1998

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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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.

Columbus Life Insurance Company

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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, 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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VOLUNTARY ELECTRONIC OPT-IN CONSENT DISCLOSURE - CALIFORNIA

If you consent, we may transmit documents related to your policy or contract by electronic means, to the extent that electronic transmission is consistent with applicable state and federal law. Any document that we send by electronic means, which complies with applicable law, will have the same force and effect as if that document were sent in paper format.

We may transmit documents including your application, replacement forms, disclosures, and certain reports.

We will only transmit documents to you electronically if you consent. Your consent is voluntary. If you have permitted electronic transactions in the past, that authorization does not obligate the same procedure regarding this policy as well.

If you decide that you want to receive documents electronically, we will provide one paper copy per year of any document, at no charge to you, upon your request.

You can change your mind at any time and have us transmit documents via regular mail by notifying us by any one of these methods.

If you wish to correct or change the email address we use to send you documents, you may do so at any time by notifying us by any one of these methods:

Email: clcaseanalysts@columbuslife.com

Phone: 1-800-677-9696, option 2

Mail: 400 E. 4th Street, Cincinnati, Ohio 45202

www.columbuslife.com

For purposes of receiving electronic transmission of documents from us, as set forth above, my email address is _____.

☐ I consent to receive transmissions electronically.

☐ I do not wish to receive transmissions electronically.

_____

Owner Name

X _____ _____

Owner Signature Date

_____

Joint Owner Name

X _____ _____

Joint Owner Signature Date

Western & Southern Financial Group

Rev. 06/06/2016

FACTS	**WHAT DOES WESTERN & SOUTHERN FINANCIAL GROUP DO WITH YOUR PERSONAL INFORMATION?**
Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: • Social Security number and address • Account balances and transaction history • Assets, income, and credit reports
How?	All financial companies need to share customers' personal information to run their everyday business and provide applicable products and services. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Western & Southern Financial Group chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Western & Southern Financial Group share?	Can you limit this sharing?
For our everyday business purposes— such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes— to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes— information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes— information about your creditworthiness	Yes	Yes
For our affiliates to market to you	Yes	Yes
For nonaffiliates to market to you	No	We don't share.

To limit our sharing of the applicable items above	• Call (866) 590-1349 and follow the instructions provided **Please note:** If you are a *new* customer, we can begin sharing your information 30 days from the date we sent this notice to you. When you are *no longer* our customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing of the applicable items above.
Questions?	Call (800) 926-1993

Who we are	
Who is providing this notice?	Companies owned by Western & Southern Financial Group, Inc. A list of companies is located at the end of this notice.

What we do	
How does Western & Southern Financial Group protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. Except as authorized by you in writing, we limit access to your information to those who need it to do their jobs.
How does Western & Southern Financial Group collect my personal information?	We collect your personal information when, for example, you • apply for insurance • provide account information • pay insurance premiums • purchase products or services from us We may also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only • sharing for affiliates' everyday business purposes—information about your credit worthiness • affiliates from using your information to market to you • sharing for nonaffiliates to market to you State laws and individual companies may provide you additional rights to limit sharing.
What happens when I limit sharing for an account I hold jointly with someone else?	Your choices will apply to everyone on your account—unless you tell us otherwise.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. • *Our affiliates include companies with the Western & Southern name, financial companies such as Fort Washington Investment Advisors, Inc., Touchstone Securities, Inc. and others, as listed at the end of this notice.*
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. • *We do not share with nonaffiliates so they can market to you.*
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. • Our joint marketing partners include other financial service companies, such as banks.

Other important information
You may have other privacy protections under applicable state laws. To the extent these state laws apply, we will comply with them when we share information about you.
For California residents: In accordance with California law, we will not share information we collect about you except for our everyday business purposes, for marketing our products and services to you, except as permitted by law or otherwise authorized by you, including, for example, with your consent or to service your account. We will limit sharing among our companies to the extent required by California law.
For Vermont residents: We will not disclose information about your creditworthiness to our affiliates and will not disclose your personal information, financial information, credit report, or health information to nonaffiliated third parties to market to you, other than as permitted by Vermont law, unless you authorize us to make those disclosures. Additional information concerning our privacy policies can be found at https://www.westernsouthern.com/ratings/privacy.html or call (800) 926-1993.
For Nevada residents: This notice is provided to you pursuant to state law. We may contact you by telephone to offer additional financial products that we believe may be of interest to you. You have the right to opt out of these calls by adding your name to our internal do-not-call list. To opt out of these calls, or for more information about your opt out rights, please contact our customer service department by telephoning (866) 590-1349. Nevada state law requires us to provide you with the following contact information: You may contact the Nevada Attorney General for more information about your opt out rights by calling 702-486-3132, emailing aginfo@ag.nv.gov, or by writing to: Office of the Attorney General, Nevada Department of Justice, Bureau of Consumer Protection, 100 North Carson Street, Carson City, NV 89701-4717.
Who is providing this notice?
The Western & Southern Financial Group , Inc. member companies are Columbus Life Insurance Company, The Western and Southern Life Insurance Company, Western-Southern Life Assurance Company, The Lafayette Life Insurance Company, Integrity Life Insurance Company, National Integrity Life Insurance Company, W&S Financial Group Distributors, Inc., Touchstone Securities, Inc., Touchstone Advisors, Inc., Western & Southern Agency, Inc., W&S Brokerage Services, Inc., Eagle Realty Capital Partners, LLC, and Eagle Realty Group, LLC.

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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

Name of Proposed Insured (Please print) _____

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

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

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

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

Not valid without both pages.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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

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

_____ _____

Signature of Proposed Insured or Legal Representative Date

_____

Printed Name of Proposed Insured or Legal Representative

_____ _____

Signature of Additional Proposed Insured Date

_____

Printed Name of Additional Proposed Insured

_____ _____

Witness (Agent, if present) Date

_____

Printed Name of Witness (Agent, if present)

Full Names of Children Proposed for Insurance:

_____ _____

_____ _____

_____ _____

_____ _____

Not valid without both pages.

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AUTHORIZATION FOR APPLICATION AND POLICY ISSUE

The Columbus Life Insurance Company requires the natural or adoptive parent of a minor to complete this form prior to issuing a contract not owned by a natural or adoptive parent.

Proposed Minor Insured: _____ Date of Birth _____

Applicant and Owner: _____

I, the undersigned and natural (or adoptive) parent of the minor child listed above, hereby authorize and request The Columbus Life Insurance Company to accept an application and to issue a policy insuring the life of the minor child above, as nearly in accordance with the application signed by the Applicant as the practice of The Columbus Life Insurance Company will permit.

I further authorize and request the designation of the Applicant as Owner of this policy of life insurance and acknowledge that the Applicant may designate any Beneficiary and/or Successor Owner of his/her choosing.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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

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

The signature on page 2 acknowledges that any agreements I have made to restrict the named child's protected health information do not apply to this Authorization and I instruct any Providers and other entities or persons referred to above to release and disclose the named child's health information without restriction.

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

Not valid without both pages.

I also authorize the Company or its reinsurers to release any information collected about the named child to MIB, Inc. and to other insurance companies with whom I may apply for insurance on behalf of the named child.

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

_____

Printed name of person whose signature appears below

_____ _____

Signature of ☐ Father or ☐ Mother of the Proposed Insured Date

Not valid without both pages.

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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:** Must Complete: Sections A, C, G, H, I, J, K, L, N. (Completion of Section N is optional if a Paramedic or MD exam is required.) Complete if Applicable: B – Survivorship or Other Insured only. D – For any optional benefits/riders. E – Proposed Insured under 18. F – Owner other than Proposed Insured. M – Additional remarks. Attach a separate page if more space is needed. **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. **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.** 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. • The applicant is employed, has a business address or regular business dealings in that state. • 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. • The applicant is different than the insured/annuitant and the insured/annuitant's primary residence is in that state. • The applicant is a trust and the trustee's primary residence is in that state. • 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. • 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. • The applicant was shopping or vacationing in that state. • The applicant is visiting a relative or friend who is not the agent in that state. • 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.