Columbus Life Insurance Company

A member of Western & Southern Financial Group

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

The following checklist can assist you in fulfilling all form requirements.
Forms can be found in iPipeline through the Columbus Life extranet at www.columbuslife.com.

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

Essential Forms

☐ Life Insurance Application	CL 45.300-CA	**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.
☐ Authorization for Release of Health Information	CL 45.406-CA	Always required for insureds 18 years or older.
☐ 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.
☐ Conditional Receipt for Life Insurance Application	CL 45.14	Money will be accepted on an eligible Proposed Insured only if the face amount applied for, plus the amount already in force with Columbus Life, does not exceed $1,000,000.
☐ 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 5.720 to the Applicant.
☐ Term Accelerated Death Benefit Disclosure	CL 45.267	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.
☐ Indexed Explorer Plus UL Disclosure	CL 45.450	Provide a copy to Applicant, and a signed copy to the Home Office with application.
☐ 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).

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400 East Fourth Street
Cincinnati, OH 45202-3302
Toll Free: 1.800.677.9696
www.ColumbusLife.com

Application for Individual Life Insurance

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

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

PROPOSED INSURED INFORMATION

Proposed Insured 1

NAME (First, Middle, Last, Suffix) | **SOCIAL SECURITY NUMBER**

DATE OF BIRTH (MM/DD/YYYY) | **BIRTHPLACE (State/Country)** | **AGE** | **SEX** ☐ Male ☐ Female

DRIVER'S LICENSE NUMBER | **DRIVER'S LICENSE STATE OF ISSUE** | **MARITAL STATUS**

EMPLOYER | **OCCUPATION**

DUTIES | **YEARS EMPLOYED** | **EARNED INCOME** $ | **NET WORTH** $

U.S. CITIZEN?
☐ Yes ☐ No *If No, complete the Citizenship Supplement*

ADDRESS Line 1 | **Line 2**

CITY | **STATE** | **ZIP**

YEARS AT ADDRESS | **EMAIL ADDRESS**

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

PROPOSED INSURED INFORMATION

Proposed Insured 2 (for Survivorship or Other Insured Rider)

NAME (First, Middle, Last, Suffix)

SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM/DD/YYYY)

BIRTHPLACE (State/Country)

AGE

SEX
☐ Male ☐ Female

DRIVER'S LICENSE NUMBER

DRIVER'S LICENSE STATE OF ISSUE

MARITAL STATUS

EMPLOYER

OCCUPATION

DUTIES

YEARS EMPLOYED

EARNED INCOME
$

NET WORTH
$

U.S. CITIZEN?
☐ Yes ☐ No *If No, complete the Citizenship Supplement*

ADDRESS Line 1

Line 2

CITY

STATE

ZIP

YEARS AT ADDRESS

EMAIL ADDRESS

PRIMARY PHONE NUMBER (include area code)

ALTERNATE PHONE NUMBER (include area code)

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

PLAN OF INSURANCE

BASE AMOUNT
$

SUPPLEMENTAL COVERAGE RIDER (SCR) AMOUNT
$

TOTAL AMOUNT
$

Universal Life Only

DEATH BENEFIT OPTION
☐ 1. Level Death Benefit

☐ 2. Specified Amount plus Cash Value

LIFE INSURANCE QUALIFICATION TEST
☐ Guideline Premium (default for all plans besides Voyager, if none selected)

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

Term Plans Only

TERM PERIOD
☐ Ten Year

☐ Fifteen Year

☐ Twenty Year

☐ Thirty Year

OPTIONAL BENEFITS AND RIDERS

Universal Life Only

☐ No Lapse Guarantee: ☐ Intermediate ☐ Lifetime

MONTHLY CREDIT AMOUNT

☐ Disability Credit: $

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

☐ Change of Insured ☐ Estate Protection Rider

Term Plans Only

☐ Waiver of Premium ☐ Accidental Death/Specific Loss

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

☐ To age 90 ☐ To age 95 ☐ Lifetime

Universal Life and Term

AMOUNT

☐ Accidental Death $

AMOUNT

☐ Insured Insurability $

AMOUNT

☐ Other Insured $

☐ Children's Term **(complete Child Term Rider Supplement)**

CHILD AS PRIMARY PROPOSED INSURED

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

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

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

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

OWNERSHIP TYPE

☐ Joint with right of survivorship (fill out both Owner sections below) ☐ Trust (fill out form CL 45.959)

☐ Tenants in common (fill out both Owner sections below) ☐ Qualified Plan (fill out form CL 45.959)

☐ Other Legal Entity (fill out form CL 45.959)

Owner Information

NAME (First, Middle, Last, Suffix)

ADDRESS Line 1 **Line 2**

CITY **STATE** **ZIP**

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

Owner Information - Continued

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

BIRTHPLACE (State/Country)

SOCIAL SECURITY NUMBER/TIN

EMAIL ADDRESS

RELATIONSHIP TO PROPOSED INSURED

PRIMARY PHONE NUMBER (include area code)

ALTERNATE PHONE NUMBER (include area code)

Additional Owner Information

NAME (First, Middle, Last, Suffix)

ADDITIONAL OWNER TYPE

☐ Contingent ☐ Joint

ADDRESS Line 1

Line 2

CITY

STATE

ZIP

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

BIRTHPLACE (State/Country)

SOCIAL SECURITY NUMBER/TIN

EMAIL ADDRESS

RELATIONSHIP TO PROPOSED INSURED

PRIMARY PHONE NUMBER (include area code)

ALTERNATE PHONE NUMBER (include area code)

BENEFICIARIES

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

NAME (First, Middle, Last, Suffix)

TELEPHONE NUMBER (include area code)

ADDRESS

CITY

STATE

ZIP

EMAIL ADDRESS

RELATIONSHIP

BENEFICIARIES - Continued

SOCIAL SECURITY NUMBER / TIN Check if TIN ☐ **DATE OF BIRTH / TRUST (MM/DD/YYYY)**

BENEFICIARY TYPE ☐ Primary ☐ Contingent **PERCENTAGE** %

NAME (First, Middle, Last, Suffix) **TELEPHONE NUMBER (include area code)**

ADDRESS **CITY** **STATE** **ZIP**

EMAIL ADDRESS **RELATIONSHIP**

SOCIAL SECURITY NUMBER / TIN Check if TIN ☐ **DATE OF BIRTH / TRUST (MM/DD/YYYY)**

BENEFICIARY TYPE ☐ Primary ☐ Contingent **PERCENTAGE** %

NAME (First, Middle, Last, Suffix) **TELEPHONE NUMBER (include area code)**

ADDRESS **CITY** **STATE** **ZIP**

EMAIL ADDRESS **RELATIONSHIP**

SOCIAL SECURITY NUMBER / TIN Check if TIN ☐ **DATE OF BIRTH / TRUST (MM/DD/YYYY)**

BENEFICIARY TYPE ☐ Primary ☐ Contingent **PERCENTAGE** %

PREMIUM INFORMATION

MODAL PREMIUM AMOUNT $ **MODE** **TOTAL AMOUNT PAID** (If none, indicate zero or leave blank) $

PAYER INFORMATION (if other than Owner)

NAME (First, Middle, Last, Suffix)

RELATIONSHIP TO PROPOSED INSURED

ADDRESS

CITY

STATE

ZIP

SOCIAL SECURITY NUMBER / TIN

Check if TIN ☐

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

SEX ☐ Male ☐ Female

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

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

CONTRACT QUESTIONS

Complete each question for the Proposed Owner and Proposed Insured(s) (if other than Owner).	**Proposed Owner**	**Proposed Insured 1**	**Proposed Insured 2**
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.

DETAILS

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.

DETAILS

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

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

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

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

PROPOSED INSURED NAME

NAME OF COMPANY | **POLICY NUMBER**

TYPE (check one if applicable)
☐ Replacement ☐ 1035 Exchange

ACCOUNT TYPE
☐ Business ☐ Personal

AMOUNT | **ISSUE YEAR** | **PURPOSE**
$

PROPOSED INSURED NAME

NAME OF COMPANY | **POLICY NUMBER**

TYPE (check one if applicable)
☐ Replacement ☐ 1035 Exchange

ACCOUNT TYPE
☐ Business ☐ Personal

AMOUNT | **ISSUE YEAR** | **PURPOSE**
$

LIFE INSURANCE IN FORCE, PENDING OR REPLACEMENT - Continued

PROPOSED INSURED NAME

NAME OF COMPANY

POLICY NUMBER

TYPE (check one if applicable)
☐ Replacement ☐ 1035 Exchange

ACCOUNT TYPE
☐ Business ☐ Personal

AMOUNT
$

ISSUE YEAR

PURPOSE

LIFESTYLE INFORMATION

For "**Yes**" answers, complete Details section below.

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

LIFESTYLE INFORMATION - Continued

For "**Yes**" answers, complete Details section below.

	Proposed Insured 1	Proposed Insured 2
8. Within the next year, do you intend to travel or live outside of the U.S. or Canada? If "**Yes**," list where, when, purpose and duration in the Details section. **If "Yes," complete a Foreign Travel Supplement.**	☐ Yes ☐ No	☐ Yes ☐ No
9. Within the past 2 years, did you fly as a pilot, crew member, or with any duties aboard an aircraft, or is there any intention of doing so within the next 2 years? **If "Yes," complete an Aviation Questionnaire.**	☐ Yes ☐ No	☐ Yes ☐ No
10. Within the past 2 years, did you engage in racing, parachuting, or scuba diving, or is there any intention of doing so within the next 2 years? **If "Yes," complete a Scuba Diving Questionnaire.**	☐ Yes ☐ No	☐ Yes ☐ No
11. Have you ever been convicted of, pled no contest to, or are you currently awaiting trial for, a felony or misdemeanor? If "**Yes**," indicate in Details section type, date and city/state of felony and if currently on probation or parole.	☐ Yes ☐ No	☐ Yes ☐ No
12. Are you a member of, or applied to be a member of, or received a notice of required service in, the military, reserves or National Guard? If "**Yes**," please list branch of service, rank, duties, and current duty station.	☐ Yes ☐ No	☐ Yes ☐ No
13. Have you used, in either synthetic or natural form, marijuana (cannabis) or marijuana products in the past 12 months? If "**No**," select the answer that best describes your marijuana or marijuana product history.	☐ Yes ☐ No	☐ Yes ☐ No

Proposed Insured 1 ☐ Never Used ☐ Quit over 5 years ago ☐ Quit over 2 years ago ☐ Quit over 1 year ago

Proposed Insured 2 ☐ Never Used ☐ Quit over 5 years ago ☐ Quit over 2 years ago ☐ Quit over 1 year ago

	Proposed Insured 1	Proposed Insured 2
14. Within the past 5 years, have you been declined, withdrawn, or postponed for insurance or had a policy issued other than as applied for?	☐ Yes ☐ No	☐ Yes ☐ No

15. What is your height and weight? If weight changed in the past 12 months, indicate pounds lost or gained.

	HEIGHT (feet, inches)	WEIGHT (pounds)	CHANGES IN WEIGHT	AMOUNT OF CHANGE
Proposed Insured 1			☐ Gain ☐ Loss	
Proposed Insured 2			☐ Gain ☐ Loss	

DETAILS

PHYSICIAN INFORMATION

PHYSICIAN NAME (for Proposed Insured 1)

TELEPHONE NUMBER (include area code)

ADDRESS

CITY

STATE

ZIP

DATE LAST SEEN (MM/DD/YYYY)

REASON FOR VISIT

TREATMENT / MEDICATION

PHYSICIAN NAME (for Proposed Insured 2)

TELEPHONE NUMBER (include area code)

ADDRESS

CITY

STATE

ZIP

DATE LAST SEEN (MM/DD/YYYY)

REASON FOR VISIT

TREATMENT / MEDICATION

ADDITIONAL REMARKS

MEDICAL INFORMATION

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

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

MEDICAL INFORMATION - Continued

	Proposed Insured 1	Proposed Insured 2
c. Circulatory system disorder, including, but not limited to, thrombophlebitis, aneurysm, embolism, peripheral vascular disease or edema?	☐ Yes ☐ No	☐ Yes ☐ No
d. Chronic headaches, seizures, fainting, dizziness, epilepsy, paralysis, dementia, Alzheimer's Disease, cognitive impairment, or other nervous system or brain disorder?	☐ Yes ☐ No	☐ Yes ☐ No
e. Any tumor, masses, cysts, cancer, melanoma, pre-cancerous lesion, lymphoma, or disorder of the lymph nodes?	☐ Yes ☐ No	☐ Yes ☐ No
f. Anemia, leukemia, clotting disorder, or any other blood disorder?	☐ Yes ☐ No	☐ Yes ☐ No
g. Diabetes or any complications of diabetes, elevated blood sugar, a disorder of the urinary tract or findings of sugar, protein or blood in the urine?	☐ Yes ☐ No	☐ Yes ☐ No
h. Asthma, emphysema, chronic obstructive pulmonary disease (COPD), shortness of breath, sleep apnea, tuberculosis, sarcoidosis, persistent bronchitis, spitting up blood or any other disorder of the lungs or respiratory system?	☐ Yes ☐ No	☐ Yes ☐ No
i. Arthritis, gout, fibromyalgia, any disorder of the back, spine, muscles, nerves, bones, joints or skin or a neuromuscular disorder?	☐ Yes ☐ No	☐ Yes ☐ No
j. Disorder of the stomach, esophagus, liver, intestines, gallbladder or pancreas, including, but not limited to, ulcers, colitis (including Ulcerative Colitis), Crohn's disease, jaundice, hepatitis, cirrhosis, or gastrointestinal bleeding?	☐ Yes ☐ No	☐ Yes ☐ No
k. Disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, reproductive organs, kidney, or urinary bladder, including, but not limited to, kidney failure, or any complication of pregnancy?	☐ Yes ☐ No	☐ Yes ☐ No
l. Disease or disorder of the endocrine system, including, but not limited to, thyroiditis, Cushing's syndrome, or Graves' disease?	☐ Yes ☐ No	☐ Yes ☐ No
m. Any nervous, mental, emotional, mood, anxiety, depression, PTSD, BiPolar, Schizophrenia, or a psychiatric disorder, or eating disorders?	☐ Yes ☐ No	☐ Yes ☐ No
n. Lupus, Scleroderma, Multiple Sclerosis (MS), Rheumatoid Arthritis, autoimmune disease, or connective tissue disease?	☐ Yes ☐ No	☐ Yes ☐ No
o. Carotid artery disease, stroke, mini-stroke, or Transient Ischemic Attack (TIA)?	☐ Yes ☐ No	☐ Yes ☐ No

MEDICAL INFORMATION - Continued

For "**Yes**" answers, complete Details section below.

	Proposed Insured 1	Proposed Insured 2
2. Have you ever been told by a health care professional that you had AIDS (Acquired Immune Deficiency Syndrome), or any other immune deficiency disorder, excluding HIV, or has any HIV test done in the connection with a previous insurance application indicated a positive result for exposure to HIV?	☐ Yes ☐ No	☐ Yes ☐ No
3. In the past 12 months have you been prescribed any medications other than contraceptives?	☐ Yes ☐ No	☐ Yes ☐ No
4. Within the past five years, have you been treated or examined by a member of the medical profession or been advised by a member of the medical profession to get specified medical care which was not completed, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)?	☐ Yes ☐ No	☐ Yes ☐ No
5. Has any immediate family member (parents, sisters or brothers) died as a result of, or been diagnosed with, heart disease or cancer prior to age 60?	☐ Yes ☐ No	☐ Yes ☐ No

ADDITIONAL DETAILS AND EXPLANATIONS

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

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

AUTHORIZATION AND SIGNATURES

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

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

Print Name _____

OWNER'S SPOUSE (if applicable)

Sign Here _____ Date _____

SIGNATURE OF OWNER'S SPOUSE (if applicable)

MIB Authorization and Disclosure: We treat all information about your insurability as confidential. However, we or our reinsurer(s) may make a brief report to MIB, Inc. The undersigned, individually and on behalf of any children named in the application, authorize MIB, Inc. to give to the Company any information it has on me or named children. If you ask MIB, Inc., it will arrange to disclose any information it has in your file. If you think any of this information is not correct, contact MIB, Inc. The federal Fair Credit Reporting Act tells you how to seek a correction. MIB, Inc.'s address is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone: 866-692-6901.

I (We) also authorize CLIC 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, or to third parties retained by CLIC to conduct or assist in conducting mortality, morbidity, actuarial, research, or underwriting studies.

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 CLIC 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 CLIC 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, CLIC 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.

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.

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

AUTHORIZATION AND SIGNATURES - Continued

Signed in the State of: _____

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

Sign Here _____ Date _____
SIGNATURE OF PROPOSED INSURED (if age 15 or older)

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

Sign Here _____ Date _____
SIGNATURE OF APPLICANT / OWNER (if other than Proposed Insured)

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

Sign Here _____ Date _____
SIGNATURE OF PROPOSED INSURED 2 (if age 15 or older)

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

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

AGENT INFORMATION AND SIGNATURE

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.

Primary Representative

NAME (First, Middle, Last)

AGENT STATE LICENSE NUMBER

Sign Here _____ Date _____
SIGNATURE OF SALES REPRESENTATIVE/LICENSED AGENT

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

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

AGENT CERTIFICATION

☐ **NO ILLUSTRATION USED**

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

Agent's Printed Name	Agent's Signature	Date

☐ **POLICY APPLIED FOR OTHER THAN AS ILLUSTRATED**

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

Agent's Printed Name	Agent's Signature	Date

APPLICANT/OWNER ACKNOWLEDGEMENT

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

Applicant/Owner's Printed Name	Applicant/Owner's Signature	Date

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

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STATE OF 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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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.

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Date: _____ State of Residence _____

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

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

_____

_____ Signature of Agent _____

_____

HIV Antibody Test
Information Form For Insurance Applicant

AIDS

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

The HIV antibody test:

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

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

Listing of California AIDS Counseling Resources

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

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

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

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

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

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

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

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

HIV AND AIDS

American Red Cross

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

FACT: AIDS is caused by a virus called HIV.

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

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

ANYONE CAN GET HIV

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

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

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

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

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

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

The most common ways in which HIV is spread are –

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

YOU CANNOT GET HIV FROM GIVING BLOOD

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

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

You cannot get HIV from –

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

Or from using –

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

HIV IS NOT SPREAD THROUGH EVERYDAY CASUAL CONTACT

FACT: You can protect yourself and others from HIV.

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

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

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

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

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

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

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

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

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

YOU CAN PROTECT YOURSELF AND OTHERS FROM HIV.

FACT: There are tests for HIV.

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

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

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

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

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

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

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

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

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

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

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

Set an example for others.

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

Become a volunteer.

Sponsor an AIDS fund-raising event or donate money.

Become a Red Cross HIV/AIDS instructor.

For more information, contact –

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

Red Cross HIV / AIDS programs

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

How to use a condom ("rubber")

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

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

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

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

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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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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

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

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

Disclosures Regarding Insurance Information Practices

MIB, Inc. Pre-Notice

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

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

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

Consumer Reports Notification

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

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

Notice Of Insurance Information Practices

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

Applicant Copy

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

California Senior Home Visit

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

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

Name: _____

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

Mailing Address: _____

_____

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

☐ **Life insurance, including annuities.**

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

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

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

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

The following individuals will be coming to your home:

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

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

Certification of Notification Per California Insurance Code, Section 789.10b

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

Name of Applicant

Date

Agent's Signature

Agent's Printed Name

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

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

IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

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

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

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

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

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

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

ACCELERATING CONDITIONS

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

"Chronic Illness" means the insured has been unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity. Also, a Licensed Health Care Practitioner has determined that the insured's loss of ability to perform those Activities of Daily Living is expected to be permanent or the insured requires Substantial Supervision to protect himself or herself from threats to health and safety due to Severe Cognitive Impairment

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

RIDER CHARGES

There is no charge for this rider, but interest will be charged on the amount of the advance. Also, we reserve the right to assess an administrative fee of not more than $250 to process claims under this rider.

IMPACT ON POLICY VALUES

When an advance is paid, a lien is created against the policy. We will increase the lien, if necessary, to keep the policy in force. If a premium remains unpaid at the end of the grace period, we will increase the lien by the amount of the premium with lien interest to the next policy anniversary. If you do not pay lien interest when it is due, it will be added to the amount of the lien.

For the portion of the outstanding lien that is less than or equal to the Net Cash Surrender Value of the policy, the lien interest rate will be the lesser of (a) the fixed loan interest rate then in effect under the policy or (b) 8% per year. The lien interest rate on the amount of the outstanding lien in excess of the net cash surrender value will be 8%. The lien will continue to exist against the policy until it is repaid or the policy terminates. In addition, while a lien is outstanding, the lien will be increased each month to pay the monthly policy charges. The loan amount available under the policy will be reduced by the amount of any outstanding lien. The net cash surrender value available upon surrender of the policy will be reduced by the amount of any outstanding lien.

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

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

TAX CONSEQUENCES

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

ACKNOWLEDGEMENTS

A. Complete this section at time of application.

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

Signature of Applicant/Proposed Owner	Date
Applicant/Proposed Owner Printed Name	
Signature of Agent	Date

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

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

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

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

Columbus Life Insurance Company

A member of Western & Southern Financial Group

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. 10/01/2020

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 history
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 or service your account.
How does Western & Southern Financial Group collect my personal information?	We collect your personal information, for example, when you • Give us your contact information • Open an account • Provide account information • Purchase products or services from us • Seek advice about your investments 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. See below for more on your rights under state law.
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*. Visit our website at https://www.westernsouthern.com/about/family-of-companies for a list of affiliated companies.
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 as permitted by California law. This may include: for our everyday business purposes, for marketing our products and services to you, and as permitted by law or otherwise authorized by you, including, for example, to service your account. We limit sharing among our affiliates to the extent required by California law. Types of information we collect, in addition to what is described in this notice, may include, but is not limited to: financial information, demographic information, medical information, and employment information. We do not sell your information, nor do we share information with nonaffiliate companies. Per the California Consumer Privacy Act, you have the right to: access your personal information that is collected, request that we delete your personal information pursuant to this Act, request information about how your information is shared and what it is used for, know with what third parties your information is shared, and opt-out of the sharing of your personal information. To exercise any of these rights, you may visit our website or call customer service to submit a request. For additional information regarding our privacy policies, visit our website or call (800) 926-1993.
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. For additional information concerning our privacy policies, visit our website 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.

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

Who is providing this notice?

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

Columbus Life Insurance Company

A member of Western & Southern Financial Group

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

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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

Name of Proposed Insured (Please print) _____

I (We), individually (and/or on behalf of any named children listed on page 2, individually), hereby consent and authorize any health plan, physician, medical practitioner, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, other medical or medically related facility, treatment facility related to drug, alcohol or substance abuse or use (including treatment provided by a federally assisted alcohol, drug or substance abuse program),or other health care provider that has provided payment, treatment or services to me(us) or on my(our) behalf (hereafter, My(Our) Providers) to disclose my(our) entire medical record, (including diagnosis, prognosis 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.

Columbus Life Insurance Company
A member of Western & Southern Financial Group

400 Broadway
Cincinnati, OH 45202
Fax: 888-436-6591
Email: clcaseanalysts@columbuslife.com

Preauthorized Transfer (PAT)

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

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

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

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

To Bank Name _____

Bank Address (number and street) _____

City _____ State _____ Zip _____ Phone # _____

Bank Routing # _____ Bank Account # _____

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

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

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

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

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

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

Set up the PAT account based on the selection below:

☐ Monthly* ☐ Quarterly ☐ Semi-Annually ☐ Annually

*Frequency will be monthly if none selected.

☐ Establish a **New** PAT account ☐ Use **Existing** PAT account – Policy No. _____

☐ Use existing PAT account – Change Bank Information Withdrawals to begin: ____/____/_____ Amount: $ _____

☐ Use existing PAT account – Change Account Number Withdrawals to begin: ____/____/_____ Amount: $ _____

☐ Please draft for back due premiums

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

_____ _____

Signature of Premium Payer/Account Holder | Print Name of Premium Payer/Account Holder

_____ _____

Signature of Joint Account Holder | Print Name of Joint Account Holder

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

Columbus Life Insurance Company

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

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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OVERFLOW PAGE

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

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

Insured _____ Date _____

Owner _____ Date _____

Life Insurance Buyer's Guide

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers.

This guide does not endorse any company or policy.
Reprinted by Western & Southern Financial Group

Before You Buy Life Insurance

Understand What Life Insurance Is

Life insurance pays a death benefit if you die while the policy is in effect, in exchange for premiums you pay before your death. You can use the death benefit to protect against financial hardships such as loss of your in- come, funeral expenses, medical or nursing care expenses, debt repayments, and child care costs after your death. You can get information from the NAIC InsureU Life Insurance website -- www.insureuonline.org/insureu_type_life.htm

If You Need Life Insurance, Decide How Much Coverage to Buy

How much life insurance to buy depends on the financial needs that will continue after your death. Examples include supporting your family, paying for child(ren)'s education, and paying off a mortgage. Some questions you may want to ask about your own needs include:

- Does anyone depend on me financially?
- How much of the family income do I provide?
- How will my family pay my final expenses and repay debts after my death?
- Do I want to leave money to charity or family?
- If I have life insurance through my employer, is it enough to meet my financial obligations?

The answers to these questions can help you decide how much coverage you need. An insurance agent, financial advisor, or insurance company representative can help you evaluate your insurance needs and give you information about available policies.

If You Already Have Life Insurance, Assess Your Current Life Insurance Policy

It's important to compare your current policy with any new policy you might buy. Keep in mind that you may be able to change your current policy to get benefits you want. Also, know that any changes in your health may impact your ability to get a new policy or the premium you'll pay. Don't cancel your current policy until you get the new one.

Also, while you may have free or low-cost life insurance through your employer, the death benefit usually is less than you need. And if you leave the employer, you may not be able to take this coverage with you.

Compare the Different Types of Insurance Policies

There are many types of life insurance policies. You should choose a policy with features that fit your individual needs. Some things to consider are:

- ***Term Insurance vs. Cash Value Insurance.*** Term insurance is intended to provide lower-cost coverage for a specific period of time ("a term"). If you want coverage for a longer period of time, such as for your lifetime, cash value insurance may be more cost effective. Most term policies don't build up cash values that you can use in the future.

- ***Renewable Term vs. Non-renewable Term.*** Most term life insurance coverage can be continued ("renewed") at the end of the term, even if your health has changed. If you renew a term policy, the new premiums are higher. Ask what the premiums will be before you renew the policy. Also ask if you'll lose the right to renew the policy at a certain age. A Non-renewable term policy can't be continued. You'll have to apply for a new policy if you still want coverage.

- ***Whole Life vs. Universal Life.*** Whole life and universal life insurance are two types of cash value insurance. A key difference between the two is how you pay for the coverage. You typically pay premiums for whole life insurance according to a set schedule. In a universal life policy, you can choose a flexible premium payment pattern as long as you pay enough to keep your policy in force.

- ***Variable Life vs. Non-variable Life.*** The investments you will choose (such as stock and bond funds) in a variable life policy directly impact your cash value. These policies have the greatest potential to build cash value but also the greatest risk of losing cash value. Non-variable life policies often have guaranteed minimums for some features (interest or cash value, for example) but not all. Non-variable life policies also have less potential to build cash value than variable life policies.

Be Sure You Can Afford the Premium

Before you buy a life insurance policy, be sure you can pay the premiums. Can you afford the initial premium? If the premium increases later, will you still be able to afford it? The premiums for many life insurance policies are sensitive to changes in the company's investment earnings, claims costs, and other expenses. If those are worse than expected, you may have to pay a much higher premium. Ask what might be the highest premium you'd have to pay to keep your coverage.

Understand the Application Process

You can apply for life insurance through life insurance agents, the mail, and online. In addition to basic information, such as your name, address, employer, job title, and date of birth, you'll be asked for more personal information. Depending on the type of policy, the insurer may require you to see a doctor, answer health-related questions, or have a medical professional come to your home or office to assess your health. Usually a policy that doesn't require detailed health information will cost more and provide less coverage than one that does.

It's important to tell the truth on the application. The insurance company will check your answers so review the application before you sign. If the insurance company discovers false statements on your application after it issues your policy, it could reduce or cancel your coverage.

Choose a Beneficiary

A beneficiary is the person(s) or organization(s) you name to receive your life insurance policy's death benefit. You'll need to know the Social Security or tax identification number for all beneficiaries. Experts advise you not to name a minor child as a beneficiary. Insurance companies won't pay a minor. Instead, consider leaving the money to your estate or trust.

Evaluate the Future of Your Policy

Does your policy have a cash value? In some cash value policies, the values are low in the early years but build later on. In other policies the values build up gradually over the years. Most term policies have no cash value. Ask your insurance agent, financial advisor, or an insurance company representative for an illustration showing future values and benefits.

After You Buy Life Insurance

Read Your Policy Carefully

After you carefully read your policy, you should be able to answer the following important questions:

- Is your personal information correct?
- Do premiums or policy values vary from year to year?
- What part of the premium or policy value isn't guaranteed?
- How will the timing of money paid and received affect any interest the policy might earn?

Your insurance agent, financial advisor, or an insurance company representative can help you understand anything that isn't clear.

If you're not satisfied with your new policy, you can return it for a full refund within a certain period, usually 10 days after you receive it. The review period usually is stated on the first page of the policy.

Review Your Life Insurance Program Every Few Years

Review your policy with your insurance agent, financial advisor, or an insurance company representative every few years to keep up with changes in your policy and your needs.

- Have the premiums or benefits changed since your policy was issued?
- Do the death benefits still meet your needs?
- Do you need more or less coverage after life events, such as birth, adoption, marriage, job change, death, or divorce?

The insurance company can provide policy statements and illustrations to help with this review. As the policy owner, you can change beneficiaries at no cost. Be sure to review your beneficiaries every few years, especially after major life events that affect your life insurance needs.