

GUARANTEED ISSUE



COLUMBIAN MUTUAL LIFE INSURANCE COMPANY

HOME OFFICE: 4704 VESTAL PARKWAY EAST
 PO BOX 1381, BINGHAMTON, NY 13902-1381
 TELEPHONE: (800) 423-9765 / www.cfglife.com

APPLICATION FOR INDIVIDUAL GRADED BENEFIT WHOLE LIFE INSURANCE

MAIL POLICY TO: General Agent/Agent Owner

FGN: _____

SINCE THIS POLICY IS ISSUED WITH MINIMAL OR NO MEDICAL UNDERWRITING, THE PREMIUM RATE CHARGED INCLUDES AN EXTRA MORTALITY RISK CHARGE. IF YOU ARE HEALTHY ENOUGH TO QUALIFY AS A "STANDARD" RISK, PREMIUMS WOULD LIKELY HAVE BEEN LOWER IF YOU HAD APPLIED FOR A FULLY UNDERWRITTEN POLICY.

1. PROPOSED INSURED: First Name		Middle Initial	Last Name	
Citizen of What Country	Social Security No. / Green Card No.		Sex	Date of Birth
Residence Address (Street, City, State, Zip Code)			Contact Information	
Mailing Address; If Different From Street Address			Home:	
			Cell:	
			Email:	
2. OWNER Name & Address		Relationship	Social Security No. / Green Card No.	Telephone
				Email
3. BENEFICIARY Name & Address		Relationship	Social Security No. / Green Card No.	Telephone No.
Primary				
Contingent				
4. POLICY INFORMATION				
Send Premium Notices to: <input type="checkbox"/> Insured <input type="checkbox"/> Owner <input type="checkbox"/> Other				
If Other, Name & Address:				
Payment Mode			Face Amount \$ _____	
<input type="checkbox"/> Annual \$ _____ <input type="checkbox"/> Semi-Annual \$ _____ <input type="checkbox"/> Quarterly \$ _____				
<input type="checkbox"/> Monthly EFT \$ _____ <input type="checkbox"/> Monthly (Debit Collection) \$ _____				
<input type="checkbox"/> Draft 1 st Premium? (Specify draft date, must be within 30 days of application date.) Draft Date _____			Premium Paid \$ _____	
Dividend Options: <input type="checkbox"/> Cash <input type="checkbox"/> Premium Reduction <input type="checkbox"/> Dividend Accumulations <input type="checkbox"/> Paid-Up Additions (Default if no option elected.)				
5. REPLACEMENT:				
Do you have any existing life insurance or annuities? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is this application for insurance intended to replace any life insurance or annuities now in force? <input type="checkbox"/> Yes <input type="checkbox"/> No				
(If "Yes", Submit any special forms required by the state in which the application is signed)				
6. REMARKS: (Attach a separate sheet if more space is needed.)				
<p>CONDITIONS RELATING TO THE APPLICATION: I have read the questions and answers in all parts of this application and agree that they are complete and true to the best of my knowledge and belief. I agree that this application shall form a part of any policy issued. I understand and agree that no agent has the authority to waive a complete answer to any question in the application, make or alter any contract, or waive any of Columbian Mutual Life Insurance Company's ("the Company") other rights or requirements. Any policy applied for shall not take effect (except as provided in the Conditional Receipt) unless and until the policy has been issued and delivered and the first full premium, according to the mode of payment selected by me (as permitted by the Company) and stipulated in the policy, has been paid and accepted by the Company during the lifetime of the Proposed Insured.</p>				
Date of Application		X _____ Proposed Insured		
Dated At (City & State)		X _____ Applicant/Owner (If Other than Proposed Insured)		
REPORT OF LICENSED AGENT:				
Does the proposed insured have any existing life insurance or annuities? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is this application for insurance intended to replace, in whole or part, any life insurance or annuities? <input type="checkbox"/> Yes <input type="checkbox"/> No				
(If "YES", submit any special forms required by the state in which the application is signed.)				
I hereby affirm that I have physically seen the Proposed Insured, and: (1) the Proposed Insured is not confined at home, or to a hospital, hospice, clinic, assisted living facility, nursing home or convalescent home; (2) I have no knowledge of any terminal illness of the Proposed Insured; and (3) I have no knowledge of intravenous drug abuse (IVDA) of the Proposed Insured.				
Date		X _____ Signature of Licensed Agent		
Name of GA (Print)		Name of Licensed Agent (Print)		Agent #
GA #		Agent's State License ID Number (in jurisdictions where required)		

SECONDARY ADDRESSEE / THIRD PARTY DESIGNEE

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

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

Name & Address:

Secondary Addressee / Third Party Authorization

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

X _____
Signature of Secondary Addressee/Third Party (If Required)

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

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

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

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

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

Financial Institution _____ Name of Bank Account Holder: _____

Account Type Checking or Savings

Transit / Routing #

--	--	--	--	--	--	--	--	--	--

 Must have 9 digits in routing #

Account Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

 Can have up to 17 positions in account #

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

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

REQUEST FOR ELECTRONIC FUNDS TRANSFER PLAN

- DRAFT FIRST
- ONGOING EFT DRAFT

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

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

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

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

Transit / Routing #

--	--	--	--	--	--	--	--	--	--

 Must have 9 digits in routing #

Account #

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

 Can have up to 17 positions in account #

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

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

CONDITIONAL RECEIPT

Complete Only When Full Modal Premium Is Received With Application

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

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

EFFECTIVE DATE OF COVERAGE: Provided that each of the conditions below is satisfied, coverage under this Conditional Receipt will begin on the date the application is signed.

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

- (1) You had paid the full first modal premium on the policy applied for; and
(2) The Company is able to issue the policy as applied for; and
(3) The amount of insurance applied for, with respect to any Proposed Insured, is not in excess of the Company's maximum issue limit.

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

Date

X _____
Signature of Licensed Agent

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