APPLICATION FOR INDIVIDUAL REINSTATEMENT

COLUMBIAN LIFE INSURANCE COMPANY
HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: PO Box 1381, Binghamton, NY 13902-1381

NAME OF INSURED	POLICY NUMBER	AMOUNT RECEIVED
		$

CURRENT ADDRESS: STREET/RD: APT #

CITY: STATE: ZIP CODE: PHONE NUMBER:
EMAIL:

I hereby apply for reinstatement of the above numbered policy, subject to its provisions and terms. This application is made on the basis of, and is subject to, the following answers:

1. What is your current height and weight? **HEIGHT _____Ft. _____In.** **WEIGHT _____lbs.**

1. HEALTH HISTORY

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

TOBACCO USE

1. Have you used any form of tobacco or nicotine products including cigarettes, cigars, pipes, e-cigarettes, chewing tobacco, snuff, nicotine patches, or nicotine gum in the past twelve (12) months? ☐ YES ☐ NO
2. Have you smoked marijuana in the past twelve (12) months? ☐ YES ☐ NO

PART 1 (If any question in this section is answered "YES," DO NOT SUBMIT THE APPLICATION)	**YES**	**NO**
1. Are you currently hospitalized, confined to a nursing home, hospice, bed, assisted living facility, convalescent home, institutionalized, receiving home health care, or confined to a wheelchair due to illness or disease?	☐	☐
2. Have you ever been diagnosed by a member of the medical profession as having or tested positive for Human Immunodeficiency Virus (HIV), or having an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or have you been diagnosed by a member of the medical profession as having a terminal medical condition that is expected to result in death within the next twelve (12) months?	☐	☐
3. Have you ever been recommended by a member of the medical profession for an organ or bone marrow transplant, or ever had a heart, lung, liver or bone marrow transplant, or ever had an amputation due to disease or, within the last twelve (12) months, received kidney dialysis?	☐	☐
4. Are you awaiting a diagnosis or test result, or been advised by a member of the medical profession to have a surgical operation, a diagnostic test (except for HIV) other than for routine screening, that has not been completed?	☐	☐
5. Have you ever been diagnosed by a member of the medical profession with, or received treatment for: mental retardation, Down's Syndrome, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, sickle cell anemia, or Huntington's Disease?	☐	☐
6. Have you ever been diagnosed or treated (including taking medication) by a member of the medical profession with congestive heart failure, Alzheimer's disease, dementia or Lou Gehrig's disease (ALS), or received a cardiac defibrillator implant (except pacemaker implant)?	☐	☐
7. During the last twenty-four (24) months, have you been diagnosed or treated (including taking medication) by a member of the medical profession for any form of cancer, including, leukemia, melanoma or any other internal cancer (other than basal cell skin cancer)?	☐	☐
8. During the last six (6) months have you been diagnosed by a member of the medical profession as having a heart attack?	☐	☐

PART 2 (If any question in this section is answered "YES," the Proposed Insured will be considered for the Classic Advantage Graded Benefit plan. If two or more questions are answered "YES," DO NOT SUBMIT THE APPLICATION.)	**YES**	**NO**
1. Have you ever been diagnosed, treated (including taking medication), tested positive for, or been advised by a member of the medical profession to seek treatment for chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, black lung disease, chronic respiratory disorder (excluding asthma or sleep apnea), or used oxygen to assist with breathing (except for sleep apnea)?	☐	☐
2. During the last thirty-six (36) months, have you been diagnosed or received treatment (including taking medication) by a member of the medical profession for:		
a. Kidney disease, kidney failure, liver disease, chronic hepatitis, drug or alcohol abuse or dependency, sarcoidosis or Systemic Lupus?	☐	☐
b. Multiple Sclerosis, Parkinson's Disease, schizophrenia, or brain tumor?	☐	☐
3. In the past twenty-four (24) months, have you been hospitalized or institutionalized for a mental or nervous disorder?	☐	☐
4. In the past thirty-six (36) months, have you:		
a. Been on probation, parole, been convicted of, or pled guilty to, any crime or to possession or distribution of drugs or any other illegal substance?	☐	☐
b. Been convicted of three (3) or more moving violations, or been convicted of driving under the influence of alcohol or drugs?	☐	☐
5. During the last twenty-four (24) months, have you been diagnosed by a member of the medical profession as having: A stroke (including TIA), aneurysm, enlarged heart, angina, peripheral vascular disease, pacemaker implant, stent, angioplasty, bypass surgery, or any procedure to improve the circulation to the brain?	☐	☐
6. During the last thirty-six (36) months, have you:		
a. been diagnosed by a member of the medical profession as having complications of diabetes, including insulin shock, or diabetic coma, or diabetes not under control with current treatment?	☐	☐
b. been diagnosed by a member of the medical profession as having complications of diabetes, including Retinopathy (eye), Nephropathy (kidney), or Neuropathy (nerve, circulatory), or have you used insulin for the treatment of diabetes prior to age 50?	☐	☐
7. During the last seven to twenty-four (7–24) months have you been diagnosed by a member of the medical profession as having a heart attack?	☐	☐

PART 3 (If any question in this section is answered "YES," the Proposed Insured will be considered for the Classic Select Full Benefit Plan. If two or more questions are answered "YES," the Proposed Insured will be considered for the Classic Advantage Graded Benefit plan.) If all questions in all sections are answered "NO," the Proposed Insured will be considered for the Classic Elite Full Benefit plan.	**YES**	**NO**
1. In the past five (5) years, have you been diagnosed, treated (including taking medication), tested positive for, or been advised by a member of the medical profession to seek treatment for cancer, leukemia, melanoma, or any other internal cancer (except basal cell carcinoma)?.....	☐	☐
2. Have you ever been diagnosed, treated (including taking medication), tested positive for, or been advised by a member of the medical profession to seek treatment for atrial fibrillation?.....	☐	☐
3. Are you currently requiring the assistance of another person in performing any ADL's (Activities of Daily Living) including eating, bathing, dressing, toileting, continence, transferring in and out of a bed or chair, or taking medications?.....	☐	☐

PART 4 Please provide the following details for your most recent consultation with a physician or medical facility.

Date of last visit	Name & Address of Physician or Medical Facility	Reason Consulted	Treatment / Diagnosis

2. REPLACEMENT:	**YES**	**NO**
Does any Proposed Insured have any existing life insurance or annuities? ……	☐	☐
Is this application for insurance intended to replace or change any life insurance or annuities now in force? ……	☐	☐
(If "YES," submit any special forms required by the state in which the application is signed.)		

3. SPECIAL REQUESTS / REMARKS / CONTINGENT OWNER DESIGNATION / ADDITIONAL BENEFICIARY INFORMATION

4. CONDITIONS RELATING TO THE APPLICATION:

It is understood and agreed that reinstatement shall not be effective unless and until this application is approved by the Company, nor shall it be effective unless all payments required for reinstatement have been paid with the application. The temporary retention of the amount tendered herewith shall not be deemed to effect reinstatement. If reinstatement of the above policy number cannot be approved, any premium remitted with this application will be refunded. I have read the answers and statements in this application and agree:

(1) they are complete and correctly recorded to the best of my knowledge and belief and
(2) they shall be the basis upon which the reinstatement will be considered.

To the extent permitted by law, the provisions contained in the policy which relate to incontestability shall run anew from the date of such reinstatement, but only with respect to the statements and answers contained in this application.

5. AUTHORIZATION & ACKNOWLEDGMENT:

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance company, MIB, Inc., consumer reporting agency, or other organization, institution or person that has any records or knowledge of me or any proposed insured, to give any such information to Columbian Life Insurance Company ("the Company") or its reinsurers for underwriting or claims purposes. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization also includes information about drugs, alcoholism, prescription drug records, or any other medical history information. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. **I understand** my information may be subject to redisclosure to a third party and may no longer be protected by federal privacy laws. **I authorize** Columbian Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. **I understand** a telephone interview may be necessary to verify or supplement information given to the Company on this application. This interview may be made from the Administrative Service Office or from a consumer-reporting agency by a trained interviewer acting on the Company's behalf. A photocopy of this form will be as valid as the original; this authorization will be valid for two (2) years from the date shown below, or the time limit permitted by applicable law in the state where the policy is delivered or issued for delivery. You may revoke this authorization by contacting us at PO Box 1381 Binghamton, NY 13902-1381 however, we retain the right to use any information obtained under your authorization prior to your revocation. **I have read and understand** the Conditions Relating to the Application and the Authorization & Acknowledgment. **I acknowledge** receipt and review of the Information Practices Relating to Underwriting Your Application. **I have read and understand the fraud warning in Section 1 of this application.**

_____ **X** _____

Date of Application — Signature of Proposed Insured — (Date)

_____ **X** _____

Signed At (City, State) — Signature of Owner (If other than Insured) — (Date)

PAYMENT FREQUENCY: ☐ Monthly (not available for direct bill) ☐ Quarterly ☐ Semi-Annual ☐ Annual

REINSTATEMENT PREMIUM PAYMENT:

Amount of Reinstatement Premium: $ _____

☐ Draft initial premium from the account below at a future date. (The first draft must be within 35 days of the application date). **If you select an initial premium draft date in the future, you will not have potential coverage until that date under the Conditional Receipt.**

☐ Immediate Draft - Draft initial premium **upon receipt** of the application at Columbian's office, from the account below. **Please note that your bank account may be debited the same day your agent submits this authorization.**

☐ Check, cashier's check or money order. By signing below, you authorize the Company to initiate an electronic funds transfer from your bank account if payment is made by check. **Please note that your bank account may be debited the same day your agent submits this authorization.**

Agent, complete the Conditional Receipt only if premium is paid by immediate draft or by check, cashier's check, or money order

SUBSEQUENT PREMIUM PAYMENTS MADE BY:

☐ Direct Bill (Not available for monthly payment mode) ☐ Electronic Funds Transfer (Select option below)

☐ **Choose a specific day (1st -28th)** ***OR*** ☐ **Choose a specific week and day of the month**

_____
Ongoing Premium Draft Day

Select Week: ☐1st Week ☐2nd Week ☐3rd Week ☐4th Week

Select Day: ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday

beginning in the month of _____ .

BANK ACCOUNT AUTHORIZATION (Complete if initial premium or ongoing premiums will be drafted from an account)

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

☐ **SOCIAL SECURITY BENEFIT AUTHORIZATION:** If checked, I authorize the Company to adjust the date of withdrawal from my bank account to match my Social Security Benefit deposit.

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.

Financial Institution _____ ☐ Checking (*Attach Voided check if available*) ☐ Savings

Transit / Routing Number (must have 9 digits)

Account Number (may have up to 17 digits)

I have read and understand the above statements in bold regarding the timing for the initial premium to be drawn from my account. I hereby acknowledge that the Company is not responsible to reimburse me if my account has insufficient funds and overdraft fees are charged by the bank.

_____ _____ _____
Name of Bank Account Holder Date Authorized Signature as it appears on Bank Records

REINSTATEMENT DEPOSIT RECEIPT COLUMBIAN LIFE INSURANCE COMPANY

NO INSURANCE COVERAGE IS CREATED BY THIS RECEIPT

All premium checks must be made payable to Columbian Life Insurance Company.
Do not make checks payable to the agent or leave the payee blank.

Received from _____ the sum of $ _____ to be retained by the Company while the Reinstatement Application bearing the above number is processed. This is not a conditional receipt and shall have no binding effect on the Company. The Company will refund any money remitted herewith for a policy that is not approved for reinstatement. The Reinstatement Application applies to the policy number: _____.

It is understood and agreed that reinstatement shall be effective on the date this application is approved by the Company and all payments required for reinstatement have been paid with the application. The temporary retention of the amount tendered herewith shall not be deemed to effect reinstatement. If reinstatement cannot be approved, any premium remitted with this application will be refunded.

To the extent permitted by law, the provisions contained in the policy which relate to incontestability shall run anew from the date of such reinstatement, but only with respect to the statements and answers contained in this application.

Date _____ Agent's Signature _____ Agent Number _____

INFORMATION PRACTICES RELATING TO UNDERWRITING YOUR APPLICATION FOR REINSTATEMENT

This Notice is given to you at the time you apply for life insurance to tell you about the kinds of information we may obtain in connection with your application. **We will treat all personal information about you as confidential**.

INVESTIGATIVE CONSUMER REPORT
We may obtain an investigative consumer report and may tell the consumer reporting agency the amount and type of your coverage. The report may contain data about your identity, age, residence, past and present job (including work duties), economic conditions, driving record, personal and business reputation in the community and mode of living, but will not include any information relating directly or indirectly to sexual orientation.

IDENTIFICATION
To obtain the data described above, the insurer may give your name, address and date and place of birth to the above persons or organizations.

ACCESS TO INFORMATION
You may request, in writing, to receive information from Columbian Life Insurance Company about the nature and scope of an investigative consumer report. Within five (5) business days of receipt of a written request, we will provide you with the name, address and phone number of any agency we ask to prepare such a report. By contacting the investigative agency, you may inspect or receive a copy of such report.

WHERE TO WRITE US
You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please send your written request to Underwriting Department, Columbian Life Insurance Company, PO Box 1381, Binghamton, NY 13905.

MIB, INC. PRE-NOTICE
MIB, Inc. is a not-for-profit membership organization of life insurance companies. The MIB provides an information exchange for its members. It maintains information of underwriting significance on policyholders and applicants as furnished to it by member companies. Such information is available only to member companies and only when such company has an authorization signed by you to request such information.

We use the MIB to check information of underwriting significance, but only as a guide to identify areas about which we might need additional information before reaching a final underwriting decision. Columbian Life does not rely, in whole or in part, on an MIB report in making a final underwriting decision.

We make a brief report to the MIB on those individuals about whom we have information about underwriting significance. We will not report what action we have taken on your application. The MIB, on request, supplies other member companies with information in its files if an application for life or health insurance, or a claim for benefits, is submitted to such company. MIB rules require that a member company have our authorization before requesting information about you.

If you question the accuracy of information in the MIB file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone Number (866) 692-6901. MIB's website is www.mib.com.