

## Telephone Application with Voice Signature Oregon

Dear Insured/Applicant:

Thank you for your application for Dignified Choice® Final Expense life insurance. Your verbal answers were obtained by phone and used to complete the questions on the life insurance application, and your voice signature was secured by digital recording. The completed application and your voice signature have been submitted to the Company's administrative service office for processing.

To protect the privacy of information collected and transmitted during the application process, the data is encrypted and stored in secured databases. All of the Company's data and systems are secured using current technology standards and procedures that undergo a variety of internal and external audits and reviews of the process and systems to ensure they are kept current.

I am providing you with printed versions of the following documents, which were read to you during the application process. Please keep these documents with your important insurance papers.

- Application Authorization & Acknowledgment
- Information Practices Relating to Underwriting Your Application
- Conditional Receipt (applicable if initial premium is to be paid by immediate bank draft)
- Accelerated Benefit Rider Disclosures, Form No. 6180-CL (IC)  
(applicable if applying for the Accelerated Benefit Rider in states where the disclosure is required)
- Important Notice: Replacement of Life Insurance or Annuities, Form No. 4551CFG  
(applicable if a replacement is occurring)

Thank you for giving us the opportunity to serve you and your insurance needs. We appreciate your business and are dedicated to providing you with the highest level of service.

Form No. 5376CFG-OR-FE

**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 |
|--------------------|-------------------------------------------------|------------------|-----------------------|
|                    |                                                 |                  |                       |

**6. REPLACEMENT:**

|                                                                                                           | YES                      | NO                       |
|-----------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| Does any Proposed Insured have any existing life insurance or annuities? .....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Is this application for insurance intended to replace any life insurance or annuities now in force? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>(If "YES," submit any special forms required by the state in which the application is signed.)</i>     |                          |                          |

**7. SPECIAL REQUESTS / REMARKS / CONTINGENT OWNER DESIGNATION / ADDITIONAL BENEFICIARY INFORMATION****8. 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, pass on insurability, make or alter any contract, or waive any of the Company's other rights or requirements; that any policy applied for shall not take effect (except as provided in the Conditional Receipt bearing the same number as this application) unless and until the policy has been issued and delivered and the full first premium, according to the mode of payment selected by the applicant (as permitted by the Company) and stipulated in the policy, has been paid and accepted by the Company during the lifetime and condition of health of the Proposed Insured as stated in the application.

**9. 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 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 5 of this application.**

|                         |          |                                            |        |
|-------------------------|----------|--------------------------------------------|--------|
| _____                   | <b>X</b> | _____                                      | (Date) |
| Date of Application     |          | Signature of Proposed Insured              |        |
| _____                   | <b>X</b> | _____                                      | (Date) |
| Signed At (City, State) |          | Signature of Owner (If other than Insured) |        |

**10. REPORT OF LICENSED AGENT:**

|                                                                                                       |                              |                             |
|-------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| Does any Proposed Insured have any existing life insurance or annuities?.....                         | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Is this insurance intended to replace, in whole or part, any life insurance or annuities?.....        | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| <i>(If "YES," submit any special forms required by the state in which the application is signed.)</i> |                              |                             |
| Is the agent related to the Proposed Insured or Owner? If "YES," please provide relationship _____    | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

**I hereby affirm that I personally solicited and completed this application and all answers given above are true and correct to the best of my knowledge. The application was signed in my presence.**

|                                |              |                                                                                       |        |
|--------------------------------|--------------|---------------------------------------------------------------------------------------|--------|
| _____                          | <b>X</b>     | _____                                                                                 | (Date) |
| Name of Licensed Agent (Print) |              | Signature of Licensed Agent (required)                                                |        |
| Primary Agent Name             | Agent Number | % of Commission (Enter 100% if you are NOT splitting commission)                      |        |
| Secondary Agent Name           | Agent Number | % of Commission (Amount of 1 <sup>st</sup> and 2 <sup>nd</sup> Agent must equal 100%) |        |

## INFORMATION PRACTICES RELATING TO UNDERWRITING YOUR APPLICATION

Thank you for choosing insurance from Columbian Life Insurance Company. This Notice is given to you at the time you apply for life or health 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 my 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 13902-1381.

### 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](http://www.mib.com).

### CONDITIONAL RECEIPT

Complete Only When Payment Received

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 (Print) \_\_\_\_\_, the sum of \_\_\_\_\_ on the life of  
(Proposed Insured) \_\_\_\_\_. Columbian 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  
later of the Underwriting Date (as defined below) or the specific policy date requested on the application. The Underwriting Date is the later of (1) the  
date of the application; or (2) the date all underwriting requirements, as required by the Company's underwriting rules, are completed.

**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) All Proposed Insureds were insurable at standard rates on the date of the application; and
- (3) The Company is able to issue the policy as applied for; and
- (4) The amount of insurance applied for, with respect to any Proposed Insured, is not in excess of \$50,000.

**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; or (3) Ninety (90) days  
after the date of the application.

\_\_\_\_\_  
Date

X

\_\_\_\_\_  
Signature of Licensed Agent

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

## **Important Disclosures**

### **Accelerated Benefit Rider**

This briefly describes the provisions of the Accelerated Benefit Rider. Consult your rider for specific information. Please read your policy and rider carefully.

The Accelerated Benefit Rider allows you to elect to receive an advance on the death benefit of the policy when the Insured is diagnosed as having a non-correctable terminal illness which, in the best medical judgment of a physician, will result in the death of the insured within twelve (12) months from the date of the diagnosis. Diagnosis must be made during the time the rider and the policy are in force.

The Accelerated Benefit is equal to fifty percent (50%) of the insured's base policy death benefit. We will pay this amount less any loan (and unpaid loan interest) on the policy, any due and unpaid premium, and an Administrative Service Fee of \$250.00. The policy loan and unpaid loan interest will be repaid. There will be no change in premiums. Regular premium payments as specified in the policy will be required in order to keep the policy in force. We will establish a lien against the death benefit of the policy equal to the amount of the Accelerated Benefit, plus accrued interest at the Accelerated Benefit interest rates. At the death of the insured, we will deduct the lien from the death benefit of the policy. If the Policy has a Surrender Value, the total amount of the lien and any policy loans and loan or lien interest will be deducted from the Surrender Value of the policy. If the total of all liens, loans and loan interest equals or exceeds the death benefit of the Policy, the Policy will terminate.

IF AN ACCELERATED BENEFIT IS PAID THE POLICY DEATH BENEFIT AND SURRENDER VALUE WILL BE REDUCED. RECEIPT OF ACCELERATED BENEFITS MAY BE TAXABLE. YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR TO DETERMINE THE CURRENT TAX CONSEQUENCES PRIOR TO MAKING ANY ELECTION.

The rider may affect your ability to receive certain government benefits or entitlements. The Accelerated Benefit may be considered an asset in determining eligibility. You should contact your local Medicaid Unit and the Social Security Administration for more information.

The Accelerated Benefit Rider is not long-term care insurance and does not provide long-term care benefits.

There is no premium charge for the rider; however, there is a \$250 Administrative Service Fee for processing an Accelerated Benefit payment.

I hereby acknowledge that I have received a copy of this statement. I understand that there is no premium charge for the rider, but there will be a \$250 Administrative Service Fee for processing an Accelerated Benefit payment. I understand that the rider may affect my ability to receive certain government benefits or entitlements and that receipt of an Accelerated Benefit may be taxable.

\_\_\_\_\_  
Signature of Applicant/Owner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Applicant/Owner

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Signature of Licensed Agent

\_\_\_\_\_  
License No.

\_\_\_\_\_  
Date

# IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

COLUMBIAN MUTUAL LIFE INSURANCE COMPANY • HOME OFFICE:  
BINGHAMTON, NY  
COLUMBIAN LIFE INSURANCE COMPANY • HOME OFFICE: CHICAGO, IL  
ADMINISTRATIVE SERVICE OFFICES:  
VESTAL PARKWAY EAST • PO BOX 1381 • BINGHAMTON, NY 13902-1381  
507 PLUM STREET • PO BOX 1056 • SYRACUSE, NY 13201-1056

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? \_\_\_ YES \_\_\_ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? \_\_\_ YES \_\_\_ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

| INSURER NAME | CONTRACT OR POLICY # | INSURED OR ANNUITANT | REPLACED (R) OR FINANCING (F) |
|--------------|----------------------|----------------------|-------------------------------|
| 1. _____     |                      |                      |                               |
| 2. _____     |                      |                      |                               |
| 3. _____     |                      |                      |                               |

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because \_\_\_\_\_  
\_\_\_\_\_.

I certify that the responses herein are, to the best of my knowledge, accurate:

\_\_\_\_\_  
Applicant's Signature and Printed Name

\_\_\_\_\_  
Date

**Producer Statement:** I represent that this transaction follows Columbian's Replacement Policy, that I have used only insurer-approved sales material in connection with this sale and that copies of all sales materials were left with the applicant.

\_\_\_\_\_  
Producer's Signature and Printed Name

\_\_\_\_\_  
Date

I do not want this notice read aloud to me. \_\_\_\_\_ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

**PREMIUMS:**

- Are they affordable?
- Could they change?
- You're older -- are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

**POLICY VALUES:**

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

**INSURABILITY:**

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

**IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:**

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

**IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:**

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

**OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:**

- What are the tax consequences of buying the new policy?
- Is this a tax free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

**If a replacement is involved in the purchase of the new policy or contract, you may return it within thirty (30) days of receipt for a full refund of all premiums or considerations paid on it, including any policy fees or charges. For a variable or market value adjustment policy or contract, the amount paid will be the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations or imposed under the policy or contract. If the policy or contract is returned, the coverage will be considered void from the beginning.**