Filing at a Glance

Company: Columbus Life Insurance Company

Product Name: CLIC/2009 Application/rp
SERFF Tr Num: WSST-126376987
State: Arkansas

TOI: L08 Life - Other
SERFF Status: Closed-Approved-Closed
State Tr Num: 44202

Sub-TOI: L08.000 Life - Other
Co Tr Num: CL 45.300 (6/09)
State Status: Approved-Closed

Filing Type: Form
Reviewer(s): Linda Bird

Authors: Megan Thomas, Nikki Lape, Ramona Piercefield
Disposition Date: 12/03/2009

Date Submitted: 11/30/2009
Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
Implementation Date:

State Filing Description:

General Information

Project Name: CLIC/2009 Application/rp
Project Number: CLIC/2009 Application/rp
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 12/03/2009

Deemer Date:
Submitted By: Ramona Piercefield
Filing Description:
RE: CL 45.300-A (6/09) Application for Life Insurance
CL 30.1 (8/09) Certification – Medical History
CL 30.7 (6/09) Part 2 - Medical Exam
CL 45.458 (6/09) Children Term Rider Supplement
CL 45.461 (6/09) Supplement to Application
CL 45.452 (6/09) Premium Allocation Change

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: These forms have been filed concurrently in our state of domicile, Ohio, and are pending.
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 12/03/2009
Created By: Ramona Piercefield
Corresponding Filing Tracking Number:

CL 70.255 (6/09) Confidential Financial Statement
CL 45.14 (6/09) Temporary Insurance Agreement
Columbus Life Insurance Company – NAIC Code # 99937

The above referenced forms are being submitted in “John Doe” fashion for review and approval as an application package. These forms are intended to replace previously state approved form CL 45.300 (10/05), approved August 7, 2006, state filing #33324.

These forms are intended to be marketed on an individual basis by licensed insurance producers. Currently the form for approval is being used in traditional paper formatting. We reserve the right to develop and utilize electronic and/or telephonic uses in the future. Should we decide to pursue alternative methods, we certify we will amend the filing with our procedures, John Doe information and any additional processes as required by state law.

Previously Approved Forms to be Used With Application
This application will be used with the following previously approved policy forms and its related riders and other policies or riders that may be approved by the state departments.

Form No. Form Description Approval Date State Filing No.
CL 79 0203 AR Individual Joint Last to Die Survivorship Flexible Premium Variable Life February 21, 2002
CL 83 0405 AR Individual Term Life February 18, 2004
CL 83-U 0405 AR Unisex Individual Term Life February 12, 2004
CL 84 0503 AR Individual Flexible Premium Variable Adjustable Life January 14, 2005 28352
CL 85 0707 AR Individual Flexible Premium Adjustable Life April 3, 2007 35498
CL 86 0707 AR Individual Flexible Premium Adjustable Life April 3, 2007 35499
CL 87 0707 AR Individual Flexible Premium Adjustable Life April 3, 2007 35500
CL 88 0707 AR Individual Flexible Premium Adjustable Life April 3, 2007 35501
CL 89 0806 AR Individual Joint Last to Die Survivorship Flexible Premium Life April 2,2008 38272
CL 90 0806 AR Individual Joint Last to Die Survivorship Flexible Premium Life April 2,2008 38273

Statement of Variability
The forms include variability where noted with hypothetical information. Please refer to the attached Statement(s) of Variability.

Format
These forms are submitted in final printed format and are subject to only minor modification in paper size and stock, ink, border, typographical errors, printing in the form of a booklet and formatting pages to conform to our printer requirements. No change in language will occur.

We look forward to your review and approval.

Company and Contact

Filing Contact Information

Ramona Piercefield, Product & State Filing Analyst
400 Broadway
Cincinnati, OH 45202

Ramona.Piercefield@wslife.com
800-446-0795 [Phone] 1873 [Ext]
513-357-4123 [FAX]

Filing Company Information

Columbus Life Insurance Company	CoCode: 99937	State of Domicile: Ohio
400 East Fourth Street	Group Code: 836	Company Type: Life
Cincinnati, OH 45202	Group Name: West-Southern Group	State ID Number:
(800) 446-0795 ext. [Phone]	FEIN Number: 31-1191427	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	$50 per submission
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Columbus Life Insurance Company	$50.00	11/30/2009	32352786

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/03/2009	12/03/2009

Disposition

Disposition Date: 12/03/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*WSST-126376987*	*State:*	*Arkansas*
Filing Company:	*Columbus Life Insurance Company*	*State Tracking Number:*	*44202*
Company Tracking Number:	*CL 45.300 (6/09)*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CLIC/2009 Application/rp*		
Project Name/Number:	*CLIC/2009 Application/rp/CLIC/2009 Application/rp*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Statements of Variability		Yes
Supporting Document	CL 45.265 - Variable UL Supplement		Yes
Supporting Document	CL 45.456 Disclosure (MIB, Consumer Reporting and HIPAA)		Yes
Form	Application for Life Insurance		Yes
Form	Certification - Medical History		Yes
Form	Part 2 - Medical Exam		Yes
Form	Children Term Rider Supplement		Yes
Form	Supplement to Application		Yes
Form	Premium Allocation Change		Yes
Form	Confidential Financial Statement		Yes
Form	Temporary Insurance Agreement		Yes

Form Schedule

Lead Form Number: CL 45.300 (6/09)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	CL 45.300-A (6/09)	Application/Enrollment Form	Application for Life Insurance	Initial		50.000	CL 45.300-A (6-09) John Doe-bracket.pdf
	CL 30.1 (8/09)	Other	Certification - Medical History	Initial		52.000	CL 30.1 (8-09).pdf
	CL 30.7 (6/09)	Other	Part 2 - Medical Exam	Initial		52.000	CL 30.7 (6-09).pdf
	CL 45.458 (6/09)	Other	Children Term Rider Supplement	Initial		53.000	45-458-0906.pdf
	CL 45.461 (6/09)	Other	Supplement to Application	Initial		53.000	CL 45.461 (6-09).pdf
	CL 45.452 (6/09)	Other	Premium Allocation Change	Initial		52.000	CL 45.452 (6-09).pdf
	CL 70.255 (6/09)	Other	Confidential Financial Statement	Initial		50.000	CL 70.255 (6-09).pdf
	CL 45.14 (6/09)	Other	Temporary Insurance Agreement	Initial		52.000	CL 45.14 (6-09).pdf

Columbus Life Insurance Company

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☐ New Business ☐ Reinstatement of Policy #_____

APPLICATION FOR LIFE INSURANCE – PART 1

For reinstatement, complete Sections A, B, I, J, K, L, M. N

A. Proposed Insured 1

1. Name of Proposed Insured Male ☑ Female ☐
   John E. Doe
   First Middle Last
2. Date of Birth 06/01/1974 (mm/dd/yyyy) Age 35
3. Place of Birth (state/country) ST, USA
4. Social Security No. or Tax I.D. 123-45-6789
5. Drivers License No. and State ST 123456
6. Marital Status M
7. Employer ABC Company
   Length Of Employment At This Business 5 years
   Occupation Analyst
   Duties _____
   Earned Income $45,000 Net Worth $100,000
8. U.S. Citizen ☑ Yes ☐ No
   If No, complete the Citizenship Supplement CL 45.461.
9. Home Address: Years at Address 5 E-mail john.doe@dmail.com
   123 Main Street
   Street/Apt No.
   City, ST 45678
   City State Zip Code
10. Home Phone (513) 555-6789 Alternate Phone _____

B. Proposed Insured 2 (For Survivorship or Other Insured Rider)

1. Name of Proposed Insured Male ☐ Female ☐
   First Middle Last
2. Date of Birth _____ (mm/dd/yyyy) Age _____
3. Place of Birth (state/country) _____
4. Social Security No. or Tax I.D. _____
5. Drivers License No. and State _____
6. Marital Status _____
7. Employer _____
   Length Of Employment At This Business _____
   Occupation _____
   Duties _____
   Earned Income _____ Net Worth _____
8. U.S. Citizen ☐ Yes ☐ No
   If No, complete the Citizenship Supplement CL 45.461.
9. Home Address and Phone Information: E-mail _____
   ☐ Same as Proposed Insured 1
   ☐ Different; Provide information below:

C. Coverage Applied For. (If VUL, complete Supplement CL 45.265; If Indexed UL, complete Supplement CL 45.452.)

Plan of Insurance Term

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

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

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

$ 100,000 Base Amount

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

$ _____ Total Base Plus SCR Amount

D. Optional Benefits and Riders.

Universal Life Only:
- ☐ No-Lapse Guarantee: ☐ Intermediate ☐ Lifetime
- ☐ Capital Transfer
- ☐ Disability Credit: indicate Monthly Credit Amount $ _____
- ☐ Term Rider:
  Check one: ☐ 20 Years ☐ 30 Years $_____
- ☐ Extended Maturity Plus: ☐ Pay at Issue, or ☐ Pay at Age 80
- ☐ Change of Insured
- ☐ Enhanced Cash Value
- ☐ Estate Protection Rider

Term Plans Only:
- ☑ Return of Premium ☐ Waiver of Premium
- ☐ Accidental Death/Specific Loss

Universal Life and Term:
- ☐ Accidental Death $_____
- ☐ Insured Insurability $_____
- ☐ Other Insured $_____
- ☐ Children's Term **(complete supplement form CL 45.458)**

For Voyager only, you may select a shorter No-Lapse Guarantee than the Lifetime No-Lapse:
☐ To age 90 ☐ To age 95 ☐ To age 100

E. Child as Primary Proposed Insured

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

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

F. Owner of Policy. Complete only if Owner is other than Proposed Insured 1.

If Trust Owner, complete questions 1 A), D) and E) and attach declarations and signature pages of Trust Agreement.

1. A) Name _____
   First Middle Last
   B) Date of Birth (mm/dd/yyyy)_____ C) Relationship to Proposed Insured 1 _____
   D) Social Security/Tax ID Number _____ E-mail address _____
   E) Place of Birth (State/Country)_____
   F) Address _____
   Street No. and Name Apt. No. City State Zip Code
2. Multiple Owners: provide all details as above for other Owner in Additional Remarks section. E-mail _____
   Type of Ownership: ☐ Joint with right of survivorship ☐ Tenants in common

G. Beneficiaries

	Name	Relationship	%
Primary:	Jane Doe	Wife	100
Primary ☐ Secondary ☐			
Primary ☐ Secondary ☐			

H. Premium Amount, Mode of Premium Payment, Payer Information.

Modal Premium Amount $ 1000 Mode A (Note: 2 months premium required for monthly PAT mode)

Total Amount Paid at time of Application. If none, indicate zero or leave blank $_____

Payer Name and Address if other than Owner (if not the same as home address in section A) – please print.

First Name M.I. Last Name Street Address or P.O. Box Number

City State Zip Code

Relationship to Proposed Insured _____

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

	Proposed Owner	Proposed Insured 1 If other than Owner	Proposed Insured 2 If other than Owner
1. Have you been involved in any discussion about the possible sale or assignment of this policy to a life, settlement, viatical or other secondary market provider?	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you ever sold a policy to a life, settlement, viatical or other secondary market provider?	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No

3. Will any portion of the premiums for this policy be financed? ..... ☐ Yes ☑ No
4. Will any insured or policy owner receive any payment in connection with insurance issued on the basis of this application? ..... ☐ Yes ☑ No
   For **Yes** answers to questions 1, 2, 3 or 4, please give details:

J. Life Insurance In Force, Pending or Replacement.

	Proposed Insured 1	Proposed Insured 2
1. Has anyone proposed for insurance ever applied for life, health or disability insurance; or a reinstatement for life, health or disability insurance and been declined, postponed or charged an increased premium?	☐ Yes ☑ No	☐ Yes ☐ No
2. Does any Proposed Insured/Other Insured have any applications or preliminary or informal quote requests currently pending with any other life, settlement, viatical or secondary market provider or company?	☐ Yes ☑ No	☐ Yes ☐ No

If answered **Yes**, give details below for each Proposed Insured, including owner, beneficiary, carrier name and purpose of each policy.

3. a) Does anyone proposed for insurance now have life insurance policies or annuity contracts with any company (excluding group coverage?) ..... ☐ Yes ☑ No
   b) Will this insurance replace, or will it cause a change in, or involve a loan under, any insurance policy or annuity contract on anyone proposed for insurance, or in any insurance policy or annuity contract owned by the Owner? ..... ☐ Yes ☑ No

4. List all insurance in force for any Proposed or Other Insured. **If none, check here or leave blank** ☐ **Note below if it is a replacement.**

Proposed Insured Name	Company	Check If Repl	Check If 1035	B – Bus. P – Pers.	Face Amount	Policy Number	Issue Year	Purpose

K. Lifestyle Information on Proposed Insured 1 and Proposed Insured 2.

For **Yes** answers, complete Details section below.	Proposed Insured 1 Yes	Proposed Insured 1 No	Proposed Insured 2 Yes	Proposed Insured 2 No
1. In the past year has anyone proposed for insurance used tobacco or any other product containing nicotine? If **No,** select the answer that best describes tobacco/nicotine product history. **Proposed Insured 1:** Quit: Over ☐ 5, ☐ 2, ☐ 1 year(s) ago ☑ Never Used **Proposed Insured 2:** Quit: Over ☐ 5, ☐ 2, ☐ 1 year(s) ago ☐ Never Used	☐	☑	☐	☐
2. Ever used illegal drugs or controlled substances except as legally prescribed by a licensed member of the medical profession?	☐	☑	☐	☐
3. Do you consume alcoholic beverages? If Yes: Type _____ Frequency _____ Amount _____	☐	☑	☐	☐
4. Received or been advised to seek treatment for, attended a program for or been counseled for alcohol or drug abuse, or been advised by a health professional to reduce the use of alcohol?	☐	☑	☐	☐
5. Ever had a drivers license suspended or revoked, or within the last 5 years, been convicted of reckless or negligent driving or driving under the influence of alcohol or drugs?	☐	☑	☐	☐
6. Are you currently receiving, or within the past 3 years have you received or applied for, any disability benefits, including Workers Compensation, Social Security Disability Insurance, or any other form of Disability insurance?	☐	☑	☐	☐
7. In the past 2 years have you been unable to work, attend school or been disabled for one month or more?	☐	☑	☐	☐
8. Does anyone proposed for this insurance intend to travel or reside outside the U.S. or Canada within the next two years? If **Yes**, list where, when, purpose and duration in the Details section.	☐	☑	☐	☐
9. In the past 2 years, flown as a pilot, crew member, or with any duties aboard an aircraft, or is there any intention of doing so within the next two years? **If Yes, complete a Supplemental Questionnaire.**	☐	☑	☐	☐
10. In the past 2 years, engaged in any motor racing on land or water, parachuting, skydiving, ballooning, gliding (kite or other), flying ultra-light aircraft, underwater or scuba diving, mountain climbing, or other hazardous sports or hobbies, or is there any intention of doing so within the next two years? **If Yes, complete a Supplemental Questionnaire.**	☐	☑	☐	☐
11. Have you ever been convicted of, are you awaiting trial for, or have you pled no contest to a felony? If **Yes,** indicate in Details section type, date and city/state of felony and if currently on probation or parole.	☐	☑	☐	☐
12. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? If **Yes**, please list branch of service, rank, duties, and current duty station.	☐	☑	☐	☐

Details: List details to question above, listing question number and the Proposed Insured details apply to.

Question No. and Proposed Insured	Details

L. Personal Physician Information

	Proposed Insured 1	Proposed Insured 2
Name of personal physician:	Dr. Adam Smith	
Address:	456 Elm Street; City, ST 12345	
Telephone number:	(513) 555-0000	
Date last consulted:	06/09	
Reason last consulted:	routine check	
Treatment or medication prescribed:	N/A	

M. Additional Remarks

Completion of this section is optional if Proposed Insured(s) is/are being examined.
DO NOT remove this page from the application.

N. Medical Information on Proposed Insured 1, Proposed Insured 2.

For YES answers, complete Details section below.	**Proposed Insured 1** Yes	No	**Proposed Insured 2** Yes	No
1. Has any person proposed for insurance ever been diagnosed with, treated for, hospitalized for or been advised to seek treatment by a member of the medical profession for any of the following:				
a) High blood pressure, high cholesterol or high triglycerides?	☐	☑	☐	☐
b) Heart disease or disorder, heart attack, heart murmur, angina or chest pain, palpitations, irregular heart beat or coronary artery disease?	☐	☑	☐	☐
c) Circulatory system disorder, thrombophlebitis, aneurysm, embolism, peripheral vascular disease or edema?	☐	☑	☐	☐
d) Chronic headaches, carotid artery blockage, seizures, fainting, dizziness, epilepsy, stroke or mini stroke (TIA – transient ischemic attack), paralysis or other nervous system or brain disorder?	☐	☑	☐	☐
e) Any tumor, masses, cysts, cancer, melanoma, pre-cancerous lesion, lymphoma, or disorder of the lymph nodes?	☐	☑	☐	☐
f) Anemia, leukemia, clotting disorder, or any other blood disorder?	☐	☑	☐	☐
g) Diabetes, elevated blood sugar, a disorder of the urinary tract or findings of sugar, protein or blood in the urine?	☐	☑	☐	☐
h) Asthma, emphysema, chronic obstructive pulmonary disease (COPD), shortness of breath, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or bronchitis, spitting up blood or any other disorder of the lungs or respiratory system?	☐	☑	☐	☐
i) Arthritis, gout, fibromyalgia or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	☐	☑	☐	☐
j) Ulcers, colitis, Crohn's disease, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder or pancreas?	☐	☑	☐	☐
k) Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	☐	☑	☐	☐
l) Thyroid, pituitary or other endocrine or glandular disorder?	☐	☑	☐	☐
m) Any nervous, mental, emotional, mood, anxiety or eating disorders, or received counseling for anxiety, depression, stress or any other emotional condition?	☐	☑	☐	☐
n) Any disorder of the eyes, ears, nose or throat?	☐	☑	☐	☐
2. Ever tested positive for exposure to the HIV (Human Immunodeficiency Virus) or been diagnosed as having or been treated for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS-Related Complex) or any other immune deficiency disorder?	☐	☑	☐	☐
3. In the past 12 months have you been prescribed any medications other than contraceptives?	☐	☑	☐	☐
4. Are you planning to seek medical advice or treatment for any reason; are you scheduled for a medical test or appointment or have you been advised to schedule a follow up medical appointment or test?	☐	☑	☐	☐
5. Has any immediate family member (parents, sisters or brothers) died as a result of, or been diagnosed with, heart disease prior to age 60?	☐	☑	☐	☐
6. What is your height and weight? If weight changed in the past 12 months, indicate pounds lost or gained.	Ht 6'0"		Ht	
	Wt 185		Wt	
	Loss 0		Loss	
	Gain 0		Gain	

Medical Information Details
Details of **Yes** answers to the above questions 1-5.

Question No. and name of proposed insured.	Physicians, hospitals, illness, treatment, medical information, reason for checkup.	Dates and duration of illness.	Name, address, phone number of medical professionals, hospitals.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (Complies with the HIPAA Privacy Rule): The undersigned, individually (and/or on behalf of any children named in the application, individually), hereby consent and authorize any health plan, physician, medical practitioner, health care professional, hospital, clinic, pharmacy or pharmacy benefit manager, other medical or medically related facility, other health-care provider, MIB, Inc., consumer reporting agency, my employer, or other companies or institutions that has provided payment, treatment or services, or who has information about me, to disclose to Columbus Life Insurance Company or their authorized representatives any information from health care or medical records. This includes information relating to diagnosis, prognosis, or treatment relative to any physical, or mental condition, or treatment relative 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; investigative consumer reports, other insurance coverage and details of employment.

The signature(s) below acknowledge that any agreements made to restrict my/our health information do not apply to this authorization and instruct any physician, medical practitioner, other health care professional, hospital, clinic, pharmacy or pharmacy benefit manager, other medical or medically related facility, or other health-care provider to release and disclose my/our health information without restriction. This authorization for disclosure of information is effective for 30 months following the date of signature(s) below. A copy of this authorization is as valid as the original.

The purpose for this disclosure is for Columbus Life Insurance Company to 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 that relate to any coverage I/we have or have applied for with Columbus Life Insurance Company.

I, each Proposed Insured, Named Child or Legal Representative, understand that: a) I have the right to obtain a copy of and revoke this authorization at any time by notifying Columbus Life Insurance Company (hereafter, 'the Company') in writing at 400 East Fourth Street, P.O. Box 5737, Cincinnati, Ohio, 45201-5737, Attention: Privacy Officer; b) the revocation is only effective after it is received by the Company; c) any use or disclosure prior to the revocation will not be affected by a revocation d) a revocation is not effective to the extent that the Company has a legal right to contest a claim under a policy or to contest the policy itself; e) after health information is disclosed, federal law might not protect it, and the recipient might redisclose it; f) health care and payment for health care will not be affected by refusal to sign this authorization; g) on refusal to sign this authorization, the Company may not be able to process an application, or if coverage has been issued, may not be able to make any benefit determinations or payments.

AGREEMENT AND ACKNOWLEDGEMENT

Each of the Undersigned declares that: This Application consists of: a) Part I Application; b) Part II Medical Application, if required; c) any amendments to the application(s) attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. Except as provided in any Temporary Insurance Agreement, any policy issued on this application shall take effect on the date it is delivered to the owner and the first premium is paid during the lifetime of each and every person proposed for insurance under such policy and then only if the health and other conditions affecting insurability remain as described in this application.

Any and all statements and answers provided anywhere in this application, together with those in any Part II and in any supplemental application made in connection herewith are full, complete and true to the best of my knowledge and belief and are made to the Company to induce it to issue the policy or policies applied for and will be attached to and made a part of any policy issued.

No agent is authorized to make or alter contracts, to extend the time for payment of premiums, or to waive any of the Company's rights or requirements. Corrections, additions or amendments to this application may be made by the Company. Acceptance of a policy issued with such changes will constitute acceptance of the changes. No changes, corrections or additions will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

The undersigned each represent that the applicant and proposed insured(s) each has read, or had read to each of them, the completed application and that they each realize that any false statement or misrepresentation which is material to the risk therein may result in loss of coverage under any policy issued hereunder, or if this is an application for reinstatement, the Company shall be under no liability except to return premiums paid in connection with such reinstatement.

I have read and understand 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.

Under penalties of perjury, I certify that (1) the number shown on this form is my correct Taxpayer Identification Number, and (2) I am not currently subject to backup withholding as a result of Internal Revenue Service notification. **The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

Signed at City, ST (City and State) Date 1/4/2010 John Doe /s/ Signature of Proposed Insured 1 (if age 15 or older)

Signature of Applicant/Owner if other than Proposed Insured

Signature of Proposed Insured 2

Agent/Producer's Certification - To the best of my knowledge, a replacement ☐ is ☑ is not involved in this transaction. I also certify that only Company approved sales material was used, and copies of all sales material and any disclosures or illustrations required by law have been given to the Applicant.

Ima Agent
Agent's Name (Please Print)

98765
License No.

Signature of Agent Ima Agent /s/ Date 1/4/2010

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CERTIFICATION – MEDICAL HISTORY

Proposed Insured John E. Doe S.S.N. 123-45-6789 Birth Date 06/01/1974
First Middle Last Month Day Year

Policy Number _____
(for policy change or reinstatement of existing insurance)

1. a) Name & address of your personal physician (if none, so state). _____
b) Date & reason last consulted. _____
c) What treatment was given or medication prescribed? _____

2. 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:	**Yes**	**No**
a) High blood pressure, high cholesterol or high triglycerides?	☐	☐
b) Heart disease or disorder, heart attack, heart murmur, angina or chest pain, palpitations, irregular heart beat or coronary artery disease?	☐	☐
c) Circulatory system disorder, thrombophlebitis, aneurysm, embolism, peripheral vascular disease or edema?	☐	☐
d) Chronic headaches, carotid artery blockage, seizures, fainting, dizziness, epilepsy, stroke or mini stroke (TIA – transient ischemic attack), paralysis or other nervous system or brain disorder?	☐	☐
e) Any tumor, masses, cysts, cancer, melanoma, pre-cancerous lesion, lymphoma, or disorder of the lymph nodes?	☐	☐
f) Anemia, leukemia, clotting disorder, or any other blood disorder?	☐	☐
g) Diabetes, elevated blood sugar, a disorder of the urinary tract or findings of sugar, protein or blood in the urine?	☐	☐
h) Asthma, emphysema, chronic obstructive pulmonary disease (COPD), shortness of breath, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or bronchitis, spitting up blood or any other disorder of the lungs or respiratory system?	☐	☐
i) Arthritis, gout, fibromyalgia or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	☐	☐
j) Ulcers, colitis, Crohn's disease, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder or pancreas?	☐	☐
k) Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	☐	☐
l) Thyroid, pituitary or other endocrine or glandular disorder?	☐	☐
m) Any nervous, mental, emotional, mood, anxiety or eating disorders, or received counseling for anxiety, depression, stress or any other emotional condition?	☐	☐
n) Any disorder of the eyes, ears, nose or throat?	☐	☐
3. Ever tested positive for exposure to HIV (Human Immunodeficiency Virus) or been diagnosed as having or been treated for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS-Related Complex) or any other immune deficiency disorder?	☐	☐
4. In the past 12 months have you been prescribed any medications other than contraceptives?	☐	☐
5. Are you planning to seek medical advice or treatment for any reason; are you scheduled for a medical test or appointment or have you been advised to schedule a follow up medical appointment or test?	☐	☐
6. Has any immediate family member (parents, sisters or brothers) died as a result of, or been diagnosed with, heart disease prior to age 60?	☐	☐
7. In the past year have you used tobacco or any other product containing nicotine? If **No,** select the answer that best describes tobacco/nicotine product history. ☐ Never Used ☐ Quit: Date (Month/Year) _____	☐	☐

8. Height (in shoes): Ft._____ In. _____ Weight (clothed): Lbs _____ Weight change last 12 months: Loss _____ Gain _____

DETAILS of **Yes** answers. Identify question number:

I have read, or had read to me, the answers in this certification before signing below. I declare that the answers are true and complete to my best knowledge and belief, and that there are no exceptions to any answers other than as written.

Signed at (City, State) _____ Date _____

_____ Witness (agent)

_____ (Signature of Insured/Proposed Insured)

_____ (Signature of Applicant/Owner if other than Proposed Insured)

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APPLICATION FOR LIFE INSURANCE – PART 2 – Medical Exam

Proposed Insured John E. Doe S.S.N. 123-45-6789 Birth Date 06/01/1974
First Middle Last Month Day Year

1. a) Name & address of your personal physician (if none, so state). _____
b) Date & reason last consulted. _____
c) What treatment was given or medication prescribed? _____

	Yes	No
2. 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?	☐	☐
b) Heart disease or disorder, heart attack, heart murmur, angina or chest pain, palpitations, irregular heart beat or coronary artery disease?	☐	☐
c) Circulatory system disorder, thrombophlebitis, aneurysm, embolism, peripheral vascular disease or edema?	☐	☐
d) Chronic headaches, carotid artery blockage, seizures, fainting, dizziness, epilepsy, stroke or mini stroke (TIA – transient ischemic attack), paralysis or other nervous system or brain disorder?	☐	☐
e) Any tumor, masses, cysts, cancer, melanoma, pre-cancerous lesion, lymphoma, or disorder of the lymph nodes?	☐	☐
f) Anemia, leukemia, clotting disorder, or any other blood disorder?	☐	☐
g) Diabetes, elevated blood sugar, a disorder of the urinary tract or findings of sugar, protein or blood in the urine?	☐	☐
h) Asthma, emphysema, chronic obstructive pulmonary disease (COPD), shortness of breath, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or bronchitis, spitting up blood or any other disorder of the lungs or respiratory system?	☐	☐
i) Arthritis, gout, fibromyalgia or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	☐	☐
j) Ulcers, colitis, Crohn's disease, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder or pancreas?	☐	☐
k) Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	☐	☐
l) Thyroid, pituitary or other endocrine or glandular disorder?	☐	☐
m) Any nervous, mental, emotional, mood, anxiety or eating disorders, or received counseling for anxiety, depression, stress or any other emotional condition?	☐	☐
n) Any disorder of the eyes, ears, nose or throat?	☐	☐
3. Ever tested positive for exposure to HIV (Human Immunodeficiency Virus) or been diagnosed as having or been treated for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS-Related Complex) or any other immune deficiency disorder?	☐	☐
4. In the past 12 months have you been prescribed any medications other than contraceptives?	☐	☐
5. Are you planning to seek medical advice or treatment for any reason; are you scheduled for a medical test or appointment or have you been advised to schedule a follow up medical appointment or test?	☐	☐
6. Has any immediate family member (parents, sisters or brothers) died as a result of, or been diagnosed with, heart disease prior to age 60?	☐	☐
7. In the past year have you used tobacco or any other product containing nicotine? If **No,** select the answer that best describes tobacco/nicotine product history. ☐ Never Used ☐ Quit: Date (Month/Year) _____	☐	☐

8. Height (in shoes): Ft._____ In. _____ Weight (clothed): Lbs _____ Weight change last 12 months: Loss _____ Gain _____

DETAILS of **Yes** answers. Identify question number:

I have read, or had read to me, the answers in this application before signing below. I declare that the answers are true and complete to my best knowledge and belief, and that there are no exceptions to any answers other than as written.

Signed at (City, State) _____ Date _____

Witness _____ (Examiner)

Proposed Insured _____ (Signature in full of Person Examined)

PART 3 — EXAMINER'S REPORT

Examiners are requested to make a very careful examination of heart and lungs with stethoscope against bared skin.

9. a) Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

b) Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

c) Males Only: Measure Abdomen at Umbilicus _____ in

10. Blood Pressure (Record ALL readings.)

Systolic			
Diastolic { 4th phase			
Diastolic { 5th phase			

11. Pulse:

	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

12. Heart: Is there any:

Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No

Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No

(Describe below; if more than one, describe separately.)

Location		
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐
After exercise:	☐	☐
Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

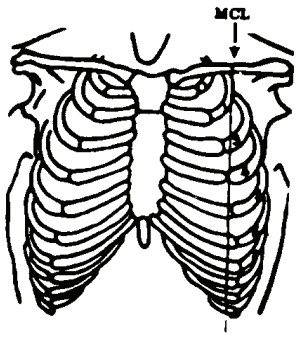
Indicate:

Apex by X

Murmur area by

Point of greatest Intensity by 0

Transmission by ➔



For comments and your impression?

13. Is there on examination any abnormality of the following:
(Circle applicable items and give details.)

	YES	NO
a) Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
b) Skin (include scars); lymph nodes; varicose veins or	☐	☐
c) Nervous system (include reflexes, gait, paralysis)?	☐	☐
d) Respiratory system?	☐	☐
e) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
14. Are you aware of additional medical history? (A confidential report may be sent to the Medical Director.)	☐	☐
15. Are you aware of any other abnormalities not otherwise noted?	☐	☐

Details of "Yes" answers. (Identify item.)

Urinalysis: Specific Gravity _____

Albumin _____ Sugar _____

	Yes	No
Is specimen being sent to lab?	☐	☐
Is blood being drawn?	☐	☐
Is EKG being performed?	☐	☐

SPECIMEN OF URINE REQUIRED WITH ALL EXAMS

Mail urine specimen directly to laboratory as addressed on specimen container.

I certify that I have carefully examined _____ at _____
(city and street address)

on (Date) _____ at _____ a.m. / p.m. that the statement of Proposed Insured on other side of this sheet is in
month day year

my handwriting, and is exactly as made by the Proposed Insured to me, and that it was signed by said Proposed Insured in my presence.

_____ _____
(Signature of Examiner) (Address)

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Children Term Rider Supplement

Proposed Insured 1 Name John E. Doe Date of Birth 06/01/1974 Soc Sec# 123-45-6789

Amount Applied For _____

Child Name	Date of Birth (mm/dd/yyyy)	SSN	Sex	Age	Height	Weight	Place of Birth (State, Country)	Amount of Life Insurance Inforce

Has any child proposed for coverage received or been advised to receive any medical or surgical treatment or test; or had, or been treated for, any abnormality, illness or disease? ☐ Yes ☐ No

Has any child proposed for coverage had unexplained weight loss or gain? ☐ Yes ☐ No

If Yes to either question, indicate which child or children, provide details, amount of weight lost or gained, dates of treatment, medications and names and addresses of attending physicians below in Additional Information.

Additional Information:

Signed at _____ Date _____ _____
(City and State) (Signature of Parent or Legal Guardian)

Signature of Agent _____ Date _____

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SUPPLEMENT TO APPLICATION

This supplement is to be completed when a Proposed Insured is not a U.S. citizen.

Name of Proposed Insured John E. Doe
First Middle Last

1. What countries and cities will you visit within the next 12 months?

_____

2. What is the purpose of each trip (business, personal, etc.)?

_____

3. What will be the length of each stay? _____

4. What mode of transportation will be used while in foreign countries? _____

_____

5. What type of housing accommodations will be used (hotel, personal home, missionary facility, etc.)?

_____

Signed At _____ Date _____
City and State

_____ _____
Signature of Proposed Insured Signature of Owner, if other than Proposed Insured

Signature of Agent _____ Date _____

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INDEXED EXPLORER PLUS
PREMIUM ALLOCATION ELECTION

Please indicate below the percentage of premium that you would like allocated to each Indexed Account and the Fixed Account. Percentages must be in whole numbers and total 100%. If this is a change to a current election, we suggest allocating sufficient premium to the Fixed Account to cover your Monthly Policy Charges for the current Policy Year. The allocation change will be effective when we receive it and record it.

S&P 500 Capped Index Option: _____%

S&P 500 Uncapped Index Option: _____%

Fixed Account: _____%

Total: 100 %

Please read and check (applicable only when applying for a new policy):

☐ I understand, and acknowledge by my signature below, that I am applying for an Indexed product, and that while the values of the Policy may be affected by an external Index, the Policy does not directly participate in any stock, bond or equity investments. Further, that any values shown, other than guaranteed minimum values, are not guarantees, promises or warranties.

"Standard & Poor's®", "S&P®", "S&P 500®", "Standard & Poor's 500" and "500" are trademarks of The McGraw-Hill Companies, Inc. and have been licensed for use by Columbus Life Insurance Company. The policy is not sponsored, endorsed, sold or promoted by Standard & Poor's and Standard & Poor's makes no representation regarding the advisability of purchasing the policy. If the S&P 500 is discontinued or if we are unable to use it for reasons beyond our control, we will substitute a successor index of our choosing (subject to the approval of the state insurance authorities).

TELEPHONE TRANSACTION AUTHORIZATION

I (or we, if Joint Owners), hereby authorize Columbus Life to act on telephone instructions to 1) transfer values from the Fixed Account to the Indexed Accounts; 2) to change allocations for future purchase payments; or 3) to complete other financial transactions as may be allowed by Columbus Life at the time of request given by:
(Initial Appropriate boxes below):

☐ ☐ Policy Owner(s) --- If Joint Owners, either of us acting independently.

☐ Producer

☐ Other _____ _____ _____
Name Address SS#

Columbus Life will not be liable for following instructions communicated by telephone that it reasonably believes to be genuine. Columbus Life will employ reasonable procedures, including requiring the policy number to be stated and tape recording all instructions.

This authorization will remain in effect until Columbus Life receives written notification of cancellation from the policy owner, or in the event a Producer has been authorized, until the named Producer is no longer contracted and appointed with Columbus Life.

_____ _____
Signature of Owner/Proposed Owner **Signature of Producer**

_____ _____
Signed at (City) (State) **Date**

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SUPPLEMENTAL APPLICATION
CONFIDENTIAL FINANCIAL STATEMENT

Complete for all risk amounts $500,000 and greater, and for all amounts on Proposed Insured's age 65.

Financial Information **Name of Proposed Insured(s)** John E. Doe
(For Joint Sales Indicate Both Insureds)

1. Purpose of Insurance?
   - ☐ Estate Planning
   - ☐ Family Income Replacement
   - ☐ Final Expenses
   - ☐ Mortgage Coverage
   - ☐ Buy/Sell
   - ☐ Deferred Comp.
   - ☐ Employee Bonus
   - ☐ Key Person
   - ☐ Retirement Plan
   - ☐ Split-Dollar
   - ☐ Stock Redemption
   - ☐ Charitable Giving
   - ☐ Required by Creditor (debt protection)
   - ☐ Other (Specify) _____

For Business related sales complete Question 2.

2. Is Proposed Insured owner in business? ☐ Yes ☐ No % of Ownership? _____ %

   Are other partners, corporate officers or key persons insured or being insured with similar amounts? ☐ Yes ☐ No

   If **"No"** why not? _____

   For other owners, list:

Name	Title	% Ownership	Amount of Business Insurance in Force

   Net worth of business: Book Value $ _____ Fair Market Value $ _____

   How was the value of the business determined? _____

   Gross Annual Sales $_____ Net Annual Income of business (before taxes) $_____

3. Is Insurance required by creditor? ☐ Yes ☐ No Amount of Loan? $ _____ Term of Loan _____

4. Earned Income:

	Last Year	Previous Year
Salary	$_____	$_____
Bonus	$_____	$_____
Other	$_____	$_____
Unearned Income (interest, rentals, etc.)	$_____	$_____
Total	$_____	$_____

5. Current personal financial status:

Assets at current market value	$_____
Liabilities	$_____
NET WORTH	$_____

6. Filed for bankruptcy in the past seven years? ☐ Yes ☐ No (If **"Yes,"** indicate chapter filed, date, reason, and if discharged.)

7. Provide additional details, formulas, plans or documentation, if any, to substantiate amount of coverage applied for.

I represent that these statements are true and complete to the best of my knowledge and belief. They are a part of my insurance application.

_____ _____ _____
Date Signature of Proposed Insured 1 Signature of Proposed Insured 2

If required by Company guideline, Print Accountant's Name: _____

_____ _____
Date Signature of Accountant

Accountant's Business Address: _____
Street City State Zip Code

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TEMPORARY INSURANCE AGREEMENT

The life insurance policy you have applied for will not become effective unless and until a policy is delivered to you and you accept it. However, if you have paid our agent at least one-twelfth of the annual premium for the policy you applied for, we will provide temporary insurance on the lives of the proposed insureds listed below. The amount, duration and conditions of this temporary insurance are described below.

Amount of Coverage - $500,000 Maximum for All Applications or Agreements

If money has been accepted by the Company as advance payment with an application for Life Insurance and any Person proposed for coverage listed below dies while this temporary insurance is in effect, the Company will pay to the designated beneficiary the lesser of (a) the amount of all death benefits applied for in the Application, including any accidental or supplemental death benefits, if applicable, or (b) $500,000. This total benefit limit applies to all insurance applied for under this and any other current applications to the Company and any other Temporary Insurance Agreements.

Insurability Preserved If Change In Health While Covered

If any person listed below suffers a change in health after the effective date of this Agreement, but before coverage terminates as set forth below, and if the person is determined to have been insurable as of the date of the application, the Company will offer the insurance applied for on such person at the appropriate rate on the basis of such person's insurability as of the effective date of the insurance applied for if such person is living after the termination date of this Agreement.

Date Coverage Begins

Temporary Life Insurance under this Agreement will begin on the date of this Agreement, but only if the Application for insurance and the Health Questions listed below have been completed on the same date or prior to the date of this Agreement.

Date Coverage Terminates - 90-Day Maximum

Temporary Life Insurance under this Agreement will terminate automatically on the earliest of

a. 90 days from the date of this Agreement, or
b. the date that insurance takes effect under the policy applied for, or
c. the date a policy, other than as applied for, is offered to the Applicant, or
d. the date the Company mails notice of termination of coverage to the premium notice address designated in the Application for insurance. The Company may terminate coverage at any time.

Special Limitations

- This Agreement does not provide benefits for disability.
- Fraud or material misrepresentations in the Application or in the answers to the Health questions of this Agreement will invalidate this Agreement and the Company's only liability is for refund of any payment made.
- No one is authorized to accept money on Persons proposed for coverage under 15 days of age or over age 70 (last birthday) on the date of this Agreement, nor will any coverage take effect.
- If any Person proposed for coverage dies by suicide, the Company's liability under this Agreement is limited to a refund of the payment made.
- There is no coverage under this Agreement if the check or draft submitted as payment is not honored by the bank.
- The minimum advance payment acceptable for this Agreement is 1/12 the minimum annual premium for the insurance applied for.
- No one is authorized to waive or modify any of the provisions of this Agreement.
- Do not collect any premium if total death benefit applied for exceeds $1,000,000.

All Checks Must Be Made **Payable To Columbus Life. Do Not Make Check Payable To The Agent** Or Leave The Payee Blank.

Names of Persons Proposed for Coverage _____

Date of Birth: _____ Payment Amount _____

HEALTH QUESTIONS - Has any Person listed above:

	YES	NO
a. within the past 6 months, been admitted to a hospital or other medical facility, or been advised to be admitted?	☐	☐
b. within the past 3 years, been treated for chest pain, heart disease or disorder, cancer, drug or alcohol use, or any disorder of the liver, or had such treatment recommended by a physician or other medical practitioner?	☐	☐

If either of these questions is answered "YES" or left blank, no representative of the Columbus Life Insurance Company is authorized to accept money, and NO COVERAGE will take effect under this agreement.

This agreement provides a limited amount of life insurance protection, for a limited period of time, subject to the terms of this Agreement. I have received a copy of, and have read the above terms and conditions of this Temporary Insurance Agreement and declare that the answers are true to the best of my knowledge and belief. I understand and agree to all the terms and conditions of this Agreement.

_____ _____ _____

Signature of Agent | Date | Signature of Applicant (if other than Proposed Insured)

Signature(s) of Proposed Insured(s) _____

HOME OFFICE COPY

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TEMPORARY INSURANCE AGREEMENT

The life insurance policy you have applied for will not become effective unless and until a policy is delivered to you and you accept it. However, if you have paid our agent at least one-twelfth of the annual premium for the policy you applied for, we will provide temporary insurance on the lives of the proposed insureds listed below. The amount, duration and conditions of this temporary insurance are described below.

Amount of Coverage - $500,000 Maximum for All Applications or Agreements

If money has been accepted by the Company as advance payment with an application for Life Insurance and any Person proposed for coverage listed below dies while this temporary insurance is in effect, the Company will pay to the designated beneficiary the lesser of (a) the amount of all death benefits applied for in the Application, including any accidental or supplemental death benefits, if applicable, or (b) $500,000. This total benefit limit applies to all insurance applied for under this and any other current applications to the Company and any other Temporary Insurance Agreements.

Insurability Preserved If Change In Health While Covered

If any person listed below suffers a change in health after the effective date of this Agreement, but before coverage terminates as set forth below, and if the person is determined to have been insurable as of the date of the application, the Company will offer the insurance applied for on such person at the appropriate rate on the basis of such person's insurability as of the effective date of the insurance applied for if such person is living after the termination date of this Agreement.

Date Coverage Begins

Temporary Life Insurance under this Agreement will begin on the date of this Agreement, but only if the Application for insurance and the Health Questions listed below have been completed on the same date or prior to the date of this Agreement.

Date Coverage Terminates - 90-Day Maximum

Temporary Life Insurance under this Agreement will terminate automatically on the earliest of

a. 90 days from the date of this Agreement, or
b. the date that insurance takes effect under the policy applied for, or
c. the date a policy, other than as applied for, is offered to the Applicant, or
d. the date the Company mails notice of termination of coverage to the premium notice address designated in the Application for insurance. The Company may terminate coverage at any time.

Special Limitations

- This Agreement does not provide benefits for disability.
- Fraud or material misrepresentations in the Application or in the answers to the Health questions of this Agreement will invalidate this Agreement and the Company's only liability is for refund of any payment made.
- No one is authorized to accept money on Persons proposed for coverage under 15 days of age or over age 70 (last birthday) on the date of this Agreement, nor will any coverage take effect.
- If any Person proposed for coverage dies by suicide, the Company's liability under this Agreement is limited to a refund of the payment made.
- There is no coverage under this Agreement if the check or draft submitted as payment is not honored by the bank.
- The minimum advance payment acceptable for this Agreement is 1/12 the minimum annual premium for the insurance applied for.
- No one is authorized to waive or modify any of the provisions of this Agreement.
- Do not collect any premium if total death benefit applied for exceeds $1,000,000.

All Checks Must Be Made **Payable To Columbus Life. Do Not Make Check Payable To The Agent** Or Leave The Payee Blank.

Names of Persons Proposed for Coverage _____

Date of Birth: _____ Payment Amount _____

HEALTH QUESTIONS - Has any Person listed above:

	YES	NO
a. within the past 6 months, been admitted to a hospital or other medical facility, or been advised to be admitted?	☐	☐
b. within the past 3 years, been treated for chest pain, heart disease or disorder, cancer, drug or alcohol use, or any disorder of the liver, or had such treatment recommended by a physician or other medical practitioner?	☐	☐

If either of these questions is answered "YES" or left blank, no representative of the Columbus Life Insurance Company is authorized to accept money, and NO COVERAGE will take effect under this agreement.

This agreement provides a limited amount of life insurance protection, for a limited period of time, subject to the terms of this Agreement. I have received a copy of, and have read the above terms and conditions of this Temporary Insurance Agreement and declare that the answers are true to the best of my knowledge and belief. I understand and agree to all the terms and conditions of this Agreement.

Signature of Agent _____ Date _____ Signature of Applicant (if other than Proposed Insured) _____

Signature(s) of Proposed Insured(s) _____

APPLICANT COPY

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

FleschCert.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

The application is attached to the Forms Schedule tab.

Item Status: **Status Date:**

Satisfied - Item: Statements of Variability

Comments:

Attachments:

CL 45.300 (standard, A, B, AZ, CA, DE, ND) Statement of Variability.pdf

Statement of Variability other forms.pdf

Item Status: **Status Date:**

Satisfied - Item: CL 45.265 - Variable UL Supplement

Comments:

Informational only Supporting Documentation

Attachment:

CL 45.265 (1-05) updated 12-08.pdf

Item Status: **Status Date:**

SERFF Tracking Number:	*WSST-126376987*	*State:*	*Arkansas*
Filing Company:	*Columbus Life Insurance Company*	*State Tracking Number:*	*44202*
Company Tracking Number:	*CL 45.300 (6/09)*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CLIC/2009 Application/rp*		
Project Name/Number:	*CLIC/2009 Application/rp/CLIC/2009 Application/rp*		

Satisfied - Item: CL 45.456 Disclosure (MIB, Consumer Reporting and HIPAA)

Comments:

Informational only Supporting Documentation

Attachment:

CL 45.456 (8-08).pdf

Columbus Life Insurance Company

NAIC CODE #99937

C E R T I F I C A T I O N

I, Denise Sparks, an officer of Columbus Life Insurance Company hereby certify that the following forms have the following readability scores as calculated by the Flesch Reading Ease Test and that these forms meet the reading ease requirements of your state Statutes and Regulations.

Form Numbers	Readability Score
CL 45.300 (6/09)*	50
CL 30.1 (8/09)*	52
CL 30.7 (6/09)*	52
CL 45.458 (6/09)*	53
CL 45.461 (6/09)*	53
CL 45.452 (6/09)*	52
CL 70.255 (6/09)	50
CL 45.14 (6/09)*	52

*combined with CL 89 0806

Denise Sparks

Denise Sparks
Vice President

Date: 11/10/2009

Statement of Variability

CL 45.300 (09/06) Application for Life Insurance

Columbus Life Insurance Company – NAIC 99937

This document defines the range of variation for items identified by brackets and found on the form(s) for approval. Any use of variability shall be administered in a uniform and non-discriminatory manner and shall not result in unfair discrimination.

1. **Company Logo**

   Description of Variability: We reserve the right to change our company logo if such item should change in the future. The flexibility of our logo does not include the Company name.

2. **Administrative Address**

   Description of Variability: We reserve the right to change our administrative address if it should change in the future.

3. **Marketing Names and Administrative Forms**

   Description of Variability: We reserve the right to update our Marketing names or administrative forms and/or instructions from time to time consistent with our current administrative procedures.

4. **Part A. Proposed Insured 1**

   Description of Variability: We reserve the right to change the information collected and the text to coincide with current or future product offerings.

5. **Part B. Proposed Insured 2 (For Survivorship or Other Insured Rider)**

   Description of Variability: We reserve the right to change the information collected and the text to coincide with current or future product offerings.

6. **Part C. Coverage Applied For**

   Description of Variability: We reserve the right to change the information collected and the text to coincide with current or future product offerings.

7. **Part D. Optional Benefits and Riders**

   Description of Variability: We reserve the right to change the information collected and the text to coincide with current or future product offerings.

8. **Page Numbers**

   Description of Variability: A page number is included in the bottom right hand corner and may change due to formatting.

9. Part E. Child as Primary Proposed Insured

Description of Variability: We reserve the right to change the information collected and the text to coincide with current or future product offerings.

10. Part F. Owner of Policy

Description of Variability: We reserve the right to change the information collected and the text to coincide with current or future product offerings.

11. Part G. Beneficiaries

Description of Variability: We reserve the right to change the information collected and the text to coincide with current or future product offerings.

12. Part H. Premium Amount, Mode of Premium Payment, Payer Information

Description of Variability: We reserve the right to change the information collected and the text in accordance with our current or future administrative procedures.

13. Part I. Premium Financing

Description of Variability: We reserve the right to change the information collected and the text in accordance with our current or future administrative procedures.

14. Authorization to Obtain Information

Description of Variability: The Company may change or delete the IRS information if the current tax laws, rules and procedures are amended in the future. Further, information contained in this section may change from time to time, and we will update the information accordingly to meet our administrative needs.

15. Agent/Producer's Certification

Description of Variability: Some of the certified information within this section if state-required, such as that a replacement is/not involved with this transaction, only Company approved sales material was provided and any buyer's guide, comparison and/or disclosure statement(s) were provided where required by state or federal law where the application was signed.

We reserve the right to add, delete or change the text of the certification statement with the exception of the phrases required by regulation noted above to meet our administrative procedures.

Statement of Variability

Columbus Life Insurance Company – NAIC 99937

CL 30.1 (8/09)	Certification – Medical History
CL 30.7 (6/09)	Medical Exam form
CL 45.458 (6/09)	Child Life Rider supplement
CL 45.461 (6/09)	Supplement to Application
CL 45.452 (6/09)	Premium Allocation Change
CL 70.255 (6/09)	Confidential Financial Statement
CL 45.14 (6/09)	Temporary Insurance Agreement

This document defines the range of variation for items identified by brackets and found on the form(s) for approval. Any use of variability shall be administered in a uniform and non-discriminatory manner and shall not result in unfair discrimination.

We certify that any change or modification to a variable item shall be administered in accordance with the requirements in this Statement of Variability, including any requirements for prior approval of a change or modification.

1. **Company Logo**

   Description of Variability: We reserve the right to change our company logo if such item should change in the future. The flexibility of our logo does not include the Company name.

2. **Administrative Address**

   Description of Variability: We reserve the right to change our administrative address if it should change in the future.

3. **Marketing Names**

   Description of Variability: We reserve the right to update our Marketing names and/or instructions from time to time consistent with our current administrative procedures.

4. **Page Numbers**

   Description of Variability: A page number is included in the bottom right hand corner and may change due to formatting.

Columbus Life Insurance Company

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Supplement to Application

To be completed when applying for Flexible Premium Variable Universal Life or Joint Survivorship Variable Universal Life.

I. NET PREMIUM ALLOCATION (Must be completed)

Allocations must be in whole percentages. There is no limit on the number of allocations, but the total allocations must equal 100%. This allocation will apply until changed by the policy owner.

Your net premium will be allocated as described in the policy to the Sub-Accounts you select.

Allocate my purchase payment(s) among the following investment options:

II. DOLLAR COST AVERAGING (Optional)

Please transfer $ _____ ($100 minimum) from the

(check one) ☐ Touchstone Money Market ☐ Fixed Account

Frequency ☐ Monthly

☐ Quarterly

☐ Until Source Fund is Depleted

Transfer to the following investment options:

Net Prem Alloc	Dollar Cost Avg	Deduct Charges		Net Prem Alloc	Dollar Cost Avg	Deduct Charges	
_____ %	_____ %	☐	AIM V.I. Basic Value	_____ %	_____ %	☐	PIMCO VIT CommodityRealReturn Strategies
_____ %	_____ %	☐	AIM V.I. Capital Appreciation	_____ %	_____ %	☐	PIMCO VIT Total Return
_____ %	_____ %	☐	AIM V.I. Core Equity	_____ %	_____ %	☐	Putnam VT Growth and Income
_____ %	_____ %	☐	DWS Equity 500 Index VIP	_____ %	_____ %	☐	Putnam VT International Equity
_____ %	_____ %	☐	DWS Small Cap Index VIP	_____ %	_____ %	☐	Putnam VT Small Cap Value
_____ %	_____ %	☐	Fidelity VIP Asset Manager	_____ %	_____ %	☐	Rydex Alternative Strategies
_____ %	_____ %	☐	Fidelity VIP Balanced	_____ %	_____ %	☐	Rydex Hedged Equity
_____ %	_____ %	☐	Fidelity VIP Contrafund	_____ %	_____ %	☐	Templeton Foreign Securities
_____ %	_____ %	☐	Fidelity VIP Equity-Income	_____ %	_____ %	☐	Templeton Growth Securities
_____ %	_____ %	☐	Fidelity VIP Freedom 2010	_____ %	_____ %	☐	Touchstone Aggressive ETF
_____ %	_____ %	☐	Fidelity VIP Freedom 2015	_____ %	_____ %	☐	Touchstone Baron Small Cap Growth
_____ %	_____ %	☐	Fidelity VIP Freedom 2020	_____ %	_____ %	☐	Touchstone Conservative ETF
_____ %	_____ %	☐	Fidelity VIP Freedom 2025	_____ %	_____ %	☐	Touchstone Core Bond
_____ %	_____ %	☐	Fidelity VIP Freedom 2030	_____ %	_____ %	☐	Touchstone Enhanced ETF
_____ %	_____ %	☐	Fidelity VIP Growth	_____ %	_____ %	☐	Touchstone High Yield
_____ %	_____ %	☐	Fidelity VIP Growth & Income	_____ %	_____ %	☐	Touchstone Large Cap Core Equity
_____ %	_____ %	☐	Fidelity VIP Mid Cap	_____ %	_____ %	☐	Touchstone Mid Cap Growth
_____ %	_____ %	☐	Fidelity VIP Money Market	_____ %	_____ %	☐	Touchstone Moderate ETF
_____ %	_____ %	☐	Franklin Growth and Income Securities	_____ %	_____ %	☐	Touchstone Money Market
_____ %	_____ %	☐	Franklin Income Securities	_____ %	_____ %	☐	Touchstone Third Avenue Value
_____ %	_____ %	☐	Franklin Large Cap Growth Securities	_____ %	_____ %	☐	Van Kampen LIT Capital Growth
_____ %	_____ %	☐	Franklin U.S. Government	_____ %	_____ %	☐	Van Kampen LIT Comstock
_____ %	_____ %	☐	Janus Aspen Forty	_____ %	_____ %	☐	Van Kampen UIF Emerging Markets Debt
_____ %	_____ %	☐	Janus Aspen Mid Cap Growth	_____ %	_____ %	☐	Van Kampen UIF Emerging Markets Equity
_____ %	_____ %	☐	Janus Aspen Worldwide Growth	_____ %	_____ %	☐	Van Kampen UIF Global Real Estate
_____ %	_____ %	☐	Mutual Shares Securities	_____ %	_____ %	☐	Van Kampen UIF Mid Cap Value
_____ %	_____ %	☐	Oppenheimer International Growth	_____ %	_____ %	☐	Columbus Life Fixed Account
_____ %	_____ %	☐	Oppenheimer MidCap	_____ %	_____ %	☐	Total
_____ %	_____ %	☐	Oppenheimer Strategic Bond				

III. AUTOMATIC REBALANCING (Optional)	IV. DEDUCTIONS FROM SELECTED ACCOUNT (Must be completed)
Do you wish to employ the automatic rebalancing feature? ☐ NO ☐ YES Frequency: ☐ Quarterly ☐ Semi-Annually ☐ Annually Note: If frequency is not selected, quarterly rebalancing will apply. Automatic Rebalancing is not available if Dollar Cost Averaging is from Touchstone Money Market.	Do you wish to deduct monthly expense charges and cost of insurance from all accounts? ☐ NO ☐ YES If No, then select funds on page 1. Note: If Yes, or if accounts selected are insufficient to cover the monthly charges, the monthly charges will be taken prorata out of the Fixed Account and the Sub-Accounts based on their respective values on the Monthly Anniversary.

V. TELEPHONE ACCESS AUTHORIZATION (Must be completed)

I (or we, if Joint Owners), hereby authorize Columbus Life to act on telephone instructions to transfer values among the variable Sub-Accounts and the Columbus Life Fixed Account, to change allocations for future purchase payments and monthly deductions or to complete other financial transactions as may be allowed by Columbus Life at the time of request, given by:

(Initial Appropriate boxes below):

☐☐ Policy Owner(s) --- If Joint Owners, either of us acting independently.

☐ Agent/Registered Representative.

☐ Other _____ _____ _____

Name Address Social Security Number

Columbus Life will not be liable for following instructions communicated by telephone that it reasonably believes to be genuine. Columbus Life will employ reasonable procedures, including requiring the policy number to be stated, tape recording all instructions, and mailing written confirmations. If Columbus Life does not employ reasonable procedures to confirm that instructions communicated by telephone are genuine, Columbus Life may be liable for any losses due to unauthorized or fraudulent instructions.

☐☐ INITIAL HERE TO DECLINE THE ABOVE TELEPHONE AUTHORIZATION.

VI. SUITABILITY (All questions must be answered.)

	YES	NO
A. Do you understand that the Death Benefit and Account Value may increase or decrease on the investment experience of the Sub-Accounts?	☐	☐
B. Do you believe that this policy will meet your insurance needs and financial objectives?	☐	☐
C. Have you received a copy of current prospectus?	☐	☐

You understand that the Death Benefit under a Variable Life Insurance Policy may increase or decrease, depending on the investment return of the Sub-Account(s) you select. Regardless of investment return, the Death Benefit can never be less than the Specified Amount, as long as the Policy is in force. The Account Value may increase or decrease on any day, depending on the investment return for the Policy. No minimum Account Value is guaranteed. On request, we will furnish illustrations of benefits, including Death Benefits and Account Value for a Variable Life Insurance Policy and a Fixed Life Insurance Policy.

Signed at: _____ Date: _____

CITY STATE

X _____ X _____

SIGNATURE OF PROPOSED INSURED (REQUIRED) SIGNATURE OF REGISTERED REPRESENTATIVE

X _____ X _____

SIGNATURE OF OTHER PROPOSED INSURED (REQUIRED) **PRINCIPAL'S SIGNATURE (REQUIRED)**

X _____ X _____

SIGNATURE OF OWNER (IF DIFFERENT FROM PROPOSED INSURED) PRINT NAME OF BROKER/DEALER

X _____

SIGNATURE OF ADDITIONAL OWNER (IF DIFFERENT FROM PROPOSED INSUREDS)

Columbus Life
Insurance Company

A member of Western & Southern Financial Group

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Disclosures Regarding Insurance Information Practices

MIB, Inc. Pre-Notice

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

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642 for hearing impaired). 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 its file 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