

SERFF Tracking Number: FRCS-126924641 State: Arkansas
Filing Company: Columbian Life Insurance Company State Tracking Number: 47481
Company Tracking Number: 5431
TOI: L04I Individual Life - Term Sub-TOI: L04I.500 Other
Product Name: Mortgage Term Life
Project Name/Number: CML-2/61/61

Filing at a Glance

Company: Columbian Life Insurance Company

Product Name: Mortgage Term Life

TOI: L04I Individual Life - Term

Sub-TOI: L04I.500 Other

Filing Type: Form

SERFF Tr Num: FRCS-126924641 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 47481

Co Tr Num: 5431

State Status: Approved-Closed

Reviewer(s): Linda Bird

Authors: Jana Finlay, Kevin Wiggs Disposition Date: 12/10/2010

Date Submitted: 12/08/2010 Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: CML-2/61

Project Number: 61

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 12/10/2010

Deemer Date:

Submitted By: Jana Finlay

Filing Description:

We have been retained by Columbian Life Insurance Company to file the enclosed forms for approval in your state.

Our fee of \$400.00 has been sent by EFT on this same date.

The Company offers their assurances that the Guaranty Association notice required by Regulation 49 will be provided.

Accelerated Benefit letters used at the time a request to accelerate the benefit is received are included as supporting documentation.

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TOI: L041 Individual Life - Term Sub-TOI: L041.500 Other
Product Name: Mortgage Term Life
Project Name/Number: CML-2/61/61

The enclosed forms are submitted for approval.

These forms are new and do not replace any existing forms.

There are no unique or innovative features in these forms. The policy specification pages contain hypothetical John Doe data/information. All variable information is bracketed. The forms are written in readable language. Licensed agents will market these forms on an individual basis in the Ordinary Market.

The policy is individual, non-participating, renewable, and has a level death benefit to age 95. Premiums are level for the initial term and increase annually thereafter. The Death Benefit will be payable in one lump sum. This policy will not be illustrated.

Form Number / Initial Term Period / Issue Ages / Return of Premium Option
FORM NO. 1F580-CL / 15 years / 18-65 / None

The enclosed riders listed below will be used with the policy form.

Form No. 1H843-CL, is a Children's Term Insurance Rider providing term life insurance coverage on child(ren), subject to the conditions set out in the rider.

Form No. 1H844-CL, is an Accelerated Benefit Rider providing an advance on the death benefit when the Insured is diagnosed by a physician as having a Terminal Illness as defined in the rider.

FORM NO. 1H845-CL, is a Disability Income Rider providing a monthly income while the insured is totally disabled due to an accident or sickness after 90-day waiting period.

FORM NO. 1H846-CL, is a Disability Income Rider providing a monthly income while the insured is totally disabled due to an accident or sickness occurring off the job, after 90-day waiting period.

Application FORM NO. A430-CL will be used to apply for this policy.

Application FORM NO. A431-CL is a reinstatement application.

The Company intends to make secured electronic versions of the applications available to their agents for the purpose of printing and electronically completing applications in the field. The electronic process will include the use of appropriate industry recognized technology and security in order to capture data and signatures. The text of the

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electronic form will be identical to the form approved by the Department. While electronic forms may result in changes or variations in margins, formatting and pagination, the text will not be less than ten-point type and the form will meet the readability standards required under your law. Any electronic transmissions of the application and data will be secured via industry recognized methods.

In the future, the Company would like to include an option for the insured to complete their application on the internet in addition to continuing the option for a traditional paper application. The internet channel will use an electronic signature process and technology that will allow customers to review and sign their applications online electronically. The Company will ensure security and the privacy of the applicant will be protected. The online application, when printed, will have the exact text as the paper version of the application form filed and approved with your Department.

The following previously approved riders may also be used with the policy: Accidental Death Benefit Rider, FORM NO. 1H840F-CL and Waiver of Premium Rider, FORM NO. 1H841F-CL. Both of these riders were approved by your Department on 5/19/10, your state ID number 45692.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

Company and Contact

Filing Contact Information

Jana Finlay, Senior Compliance Specialist jana.finlay@firstconsulting.com
1020 Central 800-927-2730 [Phone] 2741 [Ext]
Suite 201 816-391-2755 [FAX]
Kansas City, MO 64105

Filing Company Information

(This filing was made by a third party - FC01)

Columbian Life Insurance Company	CoCode: 76023	State of Domicile: Illinois
4704 Vestal Parkway East	Group Code: 535	Company Type:
P.O. BOX 1381	Group Name:	State ID Number:
Binghamton, NY 13902-1381	FEIN Number: 16-1321681	
(800) 328-2739 ext. 203[Phone]		

Filing Fees

Fee Required? Yes
Fee Amount: \$400.00

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Product Name: Mortgage Term Life
Project Name/Number: CML-2/61/61
Retaliatory? No
Fee Explanation: 8 forms x \$50 per form = \$400.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Columbian Life Insurance Company	\$400.00	12/08/2010	42755566

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/10/2010	12/10/2010

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Disposition

Disposition Date: 12/10/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Actuarial Memo		No
Supporting Document	Accelerated benefit letters, for your information		Yes
Form	Individual Term Life Insurance Policy (15 year period)		Yes
Form	Children's Term Insurance Rider		Yes
Form	Accelerated Benefit Rider		Yes
Form	Disability Income Rider (Accident and Sickness)		Yes
Form	Disability Income Rider (Off-the-job Accident and Sickness)		Yes
Form	Application for Individual Term Life Insurance		Yes
Form	Application for Reinstatement		Yes
Form	Disclosure: Accelerated Death Benefit Terminal Condition Rider		Yes

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Form Schedule

Lead Form Number: FORM NO. 1F580-CL

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	FORM NO. 1F580-CL	Policy/Cont Individual Term Life Insurance Policy (15 year period) Certificate	Initial		54.000	Form No 1F580-CL_Final_DISTILLED.pdf
	FORM NO. 1H843-CL	Policy/Cont Children's Term Insurance Rider Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		58.600	FORM NO. 1H843-CL DISTILLED.pdf
	FORM NO. 1H844-CL	Policy/Cont Accelerated Benefit Rider Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		50.000	FORM NO. 1H844-CL DISTILLED.pdf
	FORM NO. 1H845-CL	Policy/Cont Disability Income Rider (Accident and Sickness) Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		50.100	FORM NO. 1H845-CL DISTILLED.pdf

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FORM NO. 1H846-CL	Policy/Cont ract/Fratern al Accident and Certificate: Sicknss) Amendmen t, Insert Page, Endorseme nt or Rider	Initial	55.800	FORM NO. 1H846-CL.DISTILLE D.pdf	
FORM NO. A430-CL	Application/ Enrollment Form	Application for Individual Term Life Insurance	Initial	50.000	FORM NO. A430-CL JOHN DOED DISTILLED.p df
FORM NO. A431-CL	Application/ Enrollment Form	Application for Reinstatement	Initial	50.000	FORM NO. A431-CL John Doed DISTILLED.p df
6141-CL	Other Disclosure: Accelerated Death Benefit Terminal Condition Rider	Initial	55.800	6141-CL DISTILLED.p df	



COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: VESTAL PARKWAY EAST
PO BOX 1381
BINGHAMTON, NY 13902-1381
TELEPHONE: (800) 423-9765
WEBSITE: www.cfglife.com

IT IS IMPORTANT THAT YOU READ YOUR POLICY CAREFULLY

This Policy is a legal contract between the Owner and the Columbian Life Insurance Company. This Policy sets forth, in detail, the rights and obligations of the Owner and Columbian Life Insurance Company.

NOTICE OF THIRTY DAY RIGHT TO EXAMINE POLICY

If this Policy is unsatisfactory, the Owner may return it within thirty (30) days after receiving it. The Policy should be returned to the Company, the Agent through whom it was purchased, or any Agent of the Company; then all premiums paid will be refunded and the Policy will be deemed void from the beginning.


DANIEL J. FISCHER
Secretary


THOMAS E. RATTMANN
Chairman, President
and Chief Executive Officer

**CONVERTIBLE TERM LIFE INSURANCE POLICY
RENEWABLE ANNUALLY AFTER FIRST TERM PERIOD
CONVERTIBLE TO DATE SHOWN ON PAGE 2
AMOUNT OF INSURANCE PAYABLE IN A LUMP SUM AT DEATH PRIOR TO EXPIRY DATE
PREMIUMS ARE PAYABLE AS SHOWN ON PAGE 3
PREMIUMS ARE LEVEL FOR FIRST TERM PERIOD AND INCREASE ANNUALLY THEREAFTER
NON-PARTICIPATING – NO DIVIDENDS PAID**

ALPHABETIC GUIDE TO POLICY PROVISIONS

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DEFINITIONS	5
ENTIRE CONTRACT	5
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REINSTATEMENT	7
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SUICIDE	6
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INSURED: [JOHN DOE]

SEX: [MALE]

INSURANCE AGE: [35]

POLICY CLASS: [STANDARD NON-TOBACCO]

AMOUNT OF INSURANCE: [\$50,000]

FIRST RENEWAL DATE: [JANUARY 1, 2025]

RENEWAL TERM PERIOD: 1 YEAR

CONVERSION PERIOD: [JANUARY 1, 2011 - JANUARY 1, 2020]

POLICY NUMBER: [SPECIMEN]

EFFECTIVE DATE: [JANUARY 1, 2010]

DATE OF ISSUE: [JANUARY 1, 2010]

REINSTATEMENT INT RATE: 6.00% ANNUALLY

FIRST TERM PERIOD: 15 YEARS

LAST RENEWAL DATE: [JANUARY 1, 2069]

POLICY EXPIRY DATE: [JANUARY 1, 2070]

**CONVERTIBLE TERM LIFE INSURANCE POLICY
RENEWABLE ANNUALLY AFTER FIRST TERM PERIOD
CONVERTIBLE TO DATE SHOWN ON PAGE 2
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SCHEDULE OF BENEFITS AND PREMIUMS FOR:

POLICY NUMBER: [SPECIMEN]

INSURANCE AGE: [35]

**** BENEFIT INFORMATION ****

BENEFIT DESCRIPTION	AMOUNT OF INSURANCE	PREMIUM CLASS	BENEFIT PERIOD ENDS	INITIAL ANNUAL PREMIUM	FORM NUMBER
TERM TO AGE 95 [ACCIDENTAL DEATH BENEFIT RIDER	[\$50,000]	[NON-TOBACCO]	[JAN 01, 2070]	[\$150.00]	1F580-CL
[WAIVER OF PREMIUM CHILDREN'S TERM INSURANCE RIDER	[\$50,000]	---	[JAN 01, 2045]	[\$51.00] ICC10 1H840-CL]	
[ACCELERATED BENEFIT RIDER	---	---	[JAN 01, 2040]	[\$38.52]*ICC10 1H841-CL]	
[DISABILITY INCOME RIDER	[5 UNITS]	---	[JAN 01, 2045]	[\$30.00]	1H843-CL]
	---	---	[JAN 01, 2065]	\$0.00	1H844-CL]
	[5 UNITS]	[NON-TOBACCO]	[JAN 01, 2035]	[\$90.00]*	1H845-CL]

INITIAL PREMIUM FOR THE POLICY IS GUARANTEED DURING THE FIRST TERM PERIOD BUT WILL INCREASE THEREAFTER AS SHOWN IN THE TABLE BELOW.

*PREMIUM SHOWN FOR THE WAIVER OF PREMIUM AND DISABILITY INCOME RIDERS ARE SUBJECT TO CHANGE, BUT WILL NOT EXCEED THE GUARANTEED PREMIUM SHOWN IN THE TABLE ON PAGE 3-4.

*****PREMIUM INFORMATION*****
FIRST TERM PERIOD ENDS: [JANUARY 01, 2025]

MODE OF PAYMENT ELECTED: [ANNUAL]

BEGINNING ON	AT AGE	-----CURRENT-----			-----GUARANTEED-----		
		ANNUAL	SEMI-ANNUAL	MONTHLY EFT	ANNUAL	SEMI-ANNUAL	MONTHLY EFT
[January 1, 2010	35	359.52	186.95	31.28	359.52	186.95	31.28
January 1, 2011	36	359.52	186.95	31.28	460.32	239.37	40.05
January 1, 2025	50	876.88	455.98	76.29	980.38	509.80	85.29
January 1, 2026	51	945.30	491.56	82.25	1,048.80	545.38	91.25
January 1, 2027	52	1,020.05	530.43	88.75	1,123.55	584.25	97.75
January 1, 2028	53	1,102.28	573.19	95.90	1,205.78	627.01	104.90
January 1, 2029	54	1,202.90	625.51	104.66	1,306.40	679.33	113.66
January 1, 2030	55	1,315.03	683.82	114.41	1,418.53	737.64	123.41
January 1, 2031	56	1,435.20	746.30	124.87	1,538.70	800.12	133.87
January 1, 2032	57	1,550.78	806.41	134.92	1,654.28	860.23	143.92
January 1, 2033	58	1,670.95	868.89	145.37	1,774.45	922.71	154.38
January 1, 2034	59	1,800.90	936.47	156.69	1,904.40	990.29	165.68
January 1, 2035	60	1,858.98	966.67	161.74	1,858.98	966.67	161.73
January 1, 2036	61	2,054.48	1,068.33	178.74	2,054.48	1,068.33	178.74
January 1, 2037	62	2,283.33	1,187.33	198.65	2,283.33	1,187.33	198.65]

(SCHEDULE CONTINUES)

SCHEDULE OF BENEFITS AND PREMIUMS FOR:

POLICY NUMBER: [SPECIMEN]

INSURANCE AGE: [35]

MODE OF PAYMENT ELECTED: [ANNUAL]

BEGINNING ON	AT AGE	-----C U R R E N T-----			-----G U A R A N T E E D-----		
		ANNUAL	SEMI-ANNUAL	MONTHLY EFT	ANNUAL	SEMI-ANNUAL	MONTHLY EFT
[January 1, 2038]	63	2,528.85	1,315.00	220.02	2,528.85	1,315.00	220.02
January 1, 2039	64	2,788.18	1,449.85	242.57	2,788.18	1,449.85	242.57
January 1, 2040	65	2,656.00	1,381.12	231.08	2,656.00	1,381.12	231.08
January 1, 2041	66	2,889.50	1,502.54	251.39	2,889.50	1,502.54	251.39
January 1, 2042	67	3,133.00	1,629.16	272.57	3,133.00	1,629.16	272.57
January 1, 2043	68	3,390.50	1,763.06	294.98	3,390.50	1,763.06	294.98
January 1, 2044	69	3,677.00	1,912.04	319.90	3,677.00	1,912.04	319.90
January 1, 2045	70	3,921.50	2,039.18	341.17	3,921.50	2,039.18	341.17
January 1, 2046	71	4,326.50	2,249.78	376.41	4,326.50	2,249.78	376.41
January 1, 2047	72	4,799.00	2,495.48	417.51	4,799.00	2,495.48	417.51
January 1, 2048	73	5,294.50	2,753.14	460.62	5,294.50	2,753.14	460.62
January 1, 2049	74	5,829.50	3,031.34	507.17	5,829.50	3,031.34	507.17
January 1, 2050	75	6,417.50	3,337.10	558.32	6,417.50	3,337.10	558.32
January 1, 2051	76	7,079.50	3,681.34	615.92	7,079.50	3,681.34	615.92
January 1, 2052	77	7,851.50	4,082.78	683.08	7,851.50	4,082.78	683.08
January 1, 2053	78	8,745.50	4,547.66	760.86	8,745.50	4,547.66	760.86
January 1, 2054	79	9,746.00	5,067.92	847.90	9,746.00	5,067.92	847.90
January 1, 2055	80	10,864.00	5,649.28	945.17	10,864.00	5,649.28	945.17
January 1, 2056	81	12,172.00	6,329.44	1,058.96	12,172.00	6,329.44	1,058.96
January 1, 2057	82	13,557.50	7,049.90	1,179.50	13,557.50	7,049.90	1,179.50
January 1, 2058	83	15,018.50	7,809.62	1,306.61	15,018.50	7,809.62	1,306.61
January 1, 2059	84	16,639.50	8,652.54	1,447.64	16,639.50	8,652.54	1,447.64
January 1, 2060	85	18,420.50	9,578.66	1,602.58	18,420.50	9,578.66	1,602.58
January 1, 2061	86	20,361.00	10,587.72	1,771.41	20,361.00	10,587.72	1,771.41
January 1, 2062	87	22,753.00	11,831.56	1,979.51	22,753.00	11,831.56	1,979.51
January 1, 2063	88	25,280.00	13,145.60	2,199.36	25,280.00	13,145.60	2,199.36
January 1, 2064	89	27,781.00	14,446.12	2,416.95	27,781.00	14,446.12	2,416.95
January 1, 2065	90	30,170.00	15,688.40	2,624.79	30,170.00	15,688.40	2,624.79
January 1, 2066	91	32,523.50	16,912.22	2,829.54	32,523.50	16,912.22	2,829.54
January 1, 2067	92	35,564.50	18,493.54	3,094.11	35,564.50	18,493.54	3,094.11
January 1, 2068	93	39,673.50	20,630.22	3,451.59	39,673.50	20,630.22	3,451.59
January 1, 2069	94	44,829.00	23,311.08	3,900.12	44,829.00	23,311.08	3,900.12
January 1, 2070	95	PREMIUMS	CEASE]				

ENDORSEMENTS:

POLICY NUMBER: [SPECIMEN]

INSURANCE AGE: [35]

FORM NO.	DESCRIPTION
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[]	[]
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THESE ENDORSEMENTS ARE A PART OF THE POLICY TO WHICH THEY ARE ATTACHED. THEY ARE SUBJECT TO ALL THE POLICY PROVISIONS WHICH ARE CONSISTENT WITH THESE ENDORSEMENTS; IF INCONSISTENCIES OCCUR, THE PROVISIONS OF THESE ENDORSEMENTS WILL APPLY.

TABLE OF GUARANTEED MAXIMUM PREMIUMS

POLICY NUMBER: [SPECIMEN]

INSURANCE AGE: [35]

MODE OF PAYMENT ELECTED: [ANNUAL]

~~----- [WAIVER OF PREMIUM] -----~~

~~----- [DISABILITY INCOME] -----~~

AGE	GUARANTEED MAXIMUM RATES	AGE	GUARANTEED MAXIMUM RATES
[35]	38.52	35	90.00
36	49.32	36	180.00
37	49.32	37	180.00
38	49.32	38	180.00
39	49.32	39	180.00
40	49.32	40	180.00
41	49.32	41	180.00
42	49.32	42	180.00
43	49.32	43	180.00
44	49.32	44	180.00
45	49.32	45	180.00
46	49.32	46	180.00
47	49.32	47	180.00
48	49.32	48	180.00
49	49.32	49	180.00
50	127.88	50	180.00
51	136.80	51	180.00
52	146.55	52	180.00
53	157.28	53	180.00
54	170.40	54	180.00
55	185.03	55	180.00
56	200.70	56	180.00
57	215.78	57	180.00
58	231.45	58	180.00
59	248.40	59	180.00
60	242.48	60	N/A
61	267.98	61	N/A
62	297.83	62	N/A
63	329.85	63	N/A
64	363.68	64	N/A]

DEFINITIONS

YOU and YOUR means the Owner of this Policy.

WE, OUR and US means Columbian Life Insurance Company.

The INSURED means the individual named as the Insured in this Policy. The Insured may or may not be the Owner.

POLICY ANNIVERSARY means the same date in each succeeding year as the Effective Date.

INSURANCE AGE, shown in the Policy Specifications Pages, means the age of the Insured on his or her last birthday.

IMPORTANT DATES

Effective Date – The Effective Date is shown on Page 2. Policy months, policy years, policy anniversaries and premium due dates are measured from the Effective Date.

Date of Issue - The Date of Issue is shown on Page 2.

Term Period – The length of time for which this Policy provides coverage is called the Term Period. The first Term Period begins on the Effective Date and ends on the date the basic term insurance benefit period ends. The date the benefit period ends is stated on Page 3-1.

Renewal Period – The period during which this Policy may be renewed for a new term is called the Renewal Period. The Last Renewal Date is stated on Page 2.

Conversion Period – The period during which this Policy may be converted to a new life policy is called the Conversion Period. The Conversion Period is stated on Page 2.

ENTIRE CONTRACT

This Policy, including any attached riders, endorsements and the application, including any supplemental applications, is the entire contract. All statements made in the application are assumed to be representations and not warranties, except in the case of fraud. No statement will be used to contest this Policy or defend against a claim unless it is contained in the application or a supplemental application.

This Policy may be subject to laws that will change its provisions. Any changes to this Policy must be in writing and agreed to by both the Owner and one of Our Officers. This Policy will be endorsed to reflect any change.

LIFE INSURANCE BENEFITS

The benefits payable at the death of the Insured will be the sum of:

- (A) The Amount of Insurance shown on Page 3; and
- (B) Any insurance on the life of the Insured provided by benefit riders; and
- (C) The portion of any premium actually paid, and that has not been waived under any waiver of premium rider, that applies to a period beyond the Policy month in which the Insured dies.

LESS:

- (A) The part of any unpaid premium that applies to the Grace Period provided the Insured dies within the Grace Period.

WAIVER OF PREMIUM FOR UNEMPLOYMENT

We will waive premiums for this Policy and all riders attached to it while the Insured remains unemployed for a maximum of six-months over the lifetime of the policy, if the Insured becomes unemployed while this Policy is in force. This is available beginning 24 months after the Date of Issue or beginning 24 months following a reinstatement.

To qualify, the Insured must:

- (A) Receive state or federal unemployment benefits for four consecutive weeks; and
- (B) Provide proof of receiving such benefits within 90 days after the end of this four-week period.

When we receive proof, we will waive premiums for up to six months. The waiver will begin on the premium due date following the date we approve this claim.

Premiums waived under this provision may result in tax consequences to you. Please consult a tax advisor.

OWNER. The Insured is the Owner of this Policy unless another person is named as Owner on the application. If the Owner is not the Insured, and dies before the Insured, all rights of ownership will belong to the Owner's estate unless otherwise provided.

The Owner may be changed by proper written notice sent to Us. When We record the change of ownership, it will be effective from the date the notice was signed. We are not responsible for any action We take before We receive the notice.

Unless the Policy states otherwise, the Owner can exercise all rights under it. These include the right to change the Beneficiary, assign the policy and change the Owner. All living Owners must act together with respect to this Policy.

BENEFICIARY. One or more persons may be named as Beneficiary on the application. Unless otherwise stated, all Beneficiaries will share equally in the amounts payable. The Life Insurance Benefits payable to any Beneficiary who dies before the Insured will be paid to any remaining Beneficiaries.

A Secondary Beneficiary may be named to take the place of a Beneficiary who dies while the Insured is living. If no Beneficiary is alive on the date the Insured dies, the Owner or the Owner's estate will be the Beneficiary, unless otherwise provided.

The Beneficiary may be changed by proper written notice to Us, unless the Beneficiary has been designated as irrevocable, in which case the written consent of the irrevocable beneficiary is also required. When We record the notice, the change of Beneficiary will be effective from the date the notice was signed, unless otherwise specified by the Owner. We are not responsible for any action We take before We receive the notice.

FILING OF A DEATH CLAIM. Claim to the Life Insurance Benefits is made by providing due proof of the Insured's death. Due proof of death shall consist of a certified copy of the death certificate of the Insured or other lawful evidence providing equivalent information, and proof of the claimant's interest in the proceeds. Upon receipt of such proof, the benefits will be paid to the Beneficiary as shown in the Policy Specification Pages.

We will pay interest from the date of death until the date of payment at a rate not less than required by state law.

INCONTESTABILITY

We may not contest this Policy after it has been in force during the Insured's lifetime for two (2) years after the Date of Issue except for nonpayment of premium. A reinstatement of coverage will be incontestable after it has been in force during the Insured's lifetime for two (2) years from the date of reinstatement. Any contest concerning reinstated coverage will be based on the answers in the written application for reinstatement.

MISSTATEMENT OF AGE

If the Insured's age has been misstated, We will adjust the amount payable. The adjustment will be based on the amount which the premiums would have purchased at the correct age.

SUICIDE

If the Insured commits suicide within two (2) years from the Date of Issue and while this Policy is in force, the amount We pay will be limited to a refund of all premiums paid that have not been waived under any waiver of premium rider.

PREMIUMS

Premiums are payable for the number of years shown on Page 3-1. The premium amount and payment frequencies are shown on Page 3. Payment is due in advance on the first day of each payment period, starting on the Effective Date.

RENEWAL

After the first Term Period, this Policy may be renewed annually. The Last Renewal Date is stated on Page 2. No evidence of insurability is required. Payment of the necessary renewal premium must be made while this Policy is in force or within the Grace Period.

The renewal premiums will be as listed under "Premium Information" on Page 3. These premiums include the premiums for any additional benefit included with this Policy.

GRACE PERIOD

We allow a Grace Period for paying each premium except the first. If a premium has not been paid by its due date, the Policy will stay in force for thirty-one (31) days. Any payment sent by U.S. mail must be postmarked within the Grace Period. If death occurs during the Grace Period, the premium due and unpaid will be deducted from the Life Insurance Benefits.

REINSTATEMENT

This Policy may be reinstated at any time within five (5) years after the premium default or the policy termination date whichever is earlier. To do so, You must:

- (A) Give proof of insurability satisfactory to Us; and
- (B) Pay all unpaid premiums with interest at the Reinstatement Interest Rate stated on Page 2.

CONVERSION BENEFIT

After the first Policy Anniversary, this Policy may be converted to a new policy on the Insured's life. No evidence of insurability is required.

CONDITIONS. Conversion is subject to these conditions:

- (A) The conversion must be applied for in writing within the Conversion Period shown on page 2 or before the Insured's sixty-fifth (65th) birthday whichever is earlier.
- (B) Any premiums due more than thirty-one (31) days before the date of the application must have been paid.
- (C) The first premium for the new policy must be paid to Us at our Administrative Service Office.
- (D) This Policy must be returned to Us.
- (E) The date of conversion must be the same day of the month as the Effective Date of this Policy as shown on page 2. The date of conversion will be the first such date after conditions (A) through (D) above, for conversion have been met.

NEW POLICY. The new policy will be issued as follows:

- (A) The Effective Date of the new policy will be the date to which premiums have been paid on this Policy. If premiums have been paid beyond the date of conversion, you may elect to have the Effective Date be the date of conversion. The portion of any premium paid beyond the Effective Date of the new policy will be credited toward the first premium for the new policy;
- (B) The Insurance Age will be based on the Insured's age on the Effective Date of the new policy as defined under the new policy;
- (C) The amount of insurance may not exceed the amount of insurance of this Policy on the date of conversion;
- (D) The plan may be any life plan (except term insurance) then issued by the Company for conversion purposes, subject to our rules as to amount, age and rating. At least one plan of insurance with a face amount to which the Insured may convert will always be available;
- (E) The premium will be based on rates in effect on the Effective Date of the new policy;
- (F) The underwriting rating will be the same as this Policy;
- (G) Any limitation of risk in this Policy will apply;

- (H) A Waiver of Premium Rider may be included only as stated later in this section. Other benefits may be included only with the consent of the Company;
- (I) The time period of the Incontestability and Suicide provisions will be computed from the Date of Issue of this Policy; and
- (J) The new policy will be subject to any assignment of this Policy.

WAIVER OF PREMIUM UNDER THE CONVERTED POLICY. The new policy may include a Waiver of Premium Rider provided:

- (A) This Policy includes a Waiver of Premium Rider which is in force on the date of conversion;
- (B) The Insured is not totally disabled, as defined in such Rider, on the date of conversion, except at the end of the Conversion Period. Please see information below under, "AUTOMATIC CONVERSION IN EVENT OF DISABILITY";
- (C) The new policy is issued on a whole life plan under which premiums are payable for at least twenty (20) years; and
- (D) The rider must be applied for.

Evidence of insurability is not required.

AUTOMATIC CONVERSION IN EVENT OF DISABILITY. This Policy will be automatically converted to a new policy if:

- (A) This Policy includes a Waiver of Premium Rider which is in force on the Last Conversion Date; and
- (B) We are then waiving the premiums under this Policy.

The conversion will be as of attained age. The new policy will be a whole life policy We make available for automatic conversion and will include a Waiver of Premium Rider. We will continue waiving premiums for the new policy under the terms of the new rider.

GENERAL PROVISIONS

ASSIGNMENT. You may assign the proceeds of this Policy. The rights of the Beneficiary become subject to that assignment. Unless specified by the Owner, an assignment shall take effect on the date it is signed, subject to any payments made or actions by the Company prior to receipt of the notice in written form at our Administrative Service Office. If there is already an assignment on record, We will require You to confirm the change in assignment. We assume no responsibility for the validity of any assignment.

NON-PARTICIPATING. This Policy is Non-Participating. No dividends will be paid.

TERMINATION. All privileges and rights of the Owner under this Policy and any accompanying riders terminate when any of the following events occur:

- (A) The date the Term Period ends;
- (B) The Policy lapses, after the end of the Grace Period, because of nonpayment of premium; or
- (C) The Insured dies.



COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: VESTAL PARKWAY EAST
PO BOX 1381
BINGHAMTON, NY 13902-1381
TELEPHONE: (800)423-9765
WEBSITE: www.cfglife.com

**CONVERTIBLE TERM LIFE INSURANCE POLICY
RENEWABLE ANNUALLY AFTER FIRST TERM PERIOD
CONVERTIBLE TO DATE SHOWN ON PAGE 2
AMOUNT OF INSURANCE PAYABLE IN A LUMP SUM AT DEATH PRIOR TO EXPIRY DATE
PREMIUMS ARE PAYABLE AS SHOWN ON PAGE 3
PREMIUMS ARE LEVEL FOR FIRST TERM PERIOD AND INCREASE ANNUALLY THEREAFTER
NON-PARTICIPATING – NO DIVIDENDS PAID**

COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: [BINGHAMTON, NY]

CHILDREN'S TERM INSURANCE RIDER

BENEFIT

If an Insured Child dies while covered under this Rider and while this Rider is in force, the death benefit of this Rider will be paid to the Beneficiary. Claim to the death benefit under this Rider is made by filing a claim form with Us at Our Administrative Service Office and giving Us satisfactory proof of the Insured Child's death. The payment is subject to all terms of this Rider and the Policy.

This Rider provides a death benefit of \$1,000 per unit on each Insured Child. The number of units is stated on the Policy Specifications Pages.

If the Insured dies while this Rider is in force, any insurance under this Rider will remain in force. Payment of premiums for this Rider will no longer be required. The other terms of this Rider will continue to apply. This benefit will not be provided if the Insured commits suicide within two (2) years after the Date of Issue of the Policy.

INSURED CHILDREN

Natural born children, stepchildren, and legally adopted children may become Insured Children under this Rider.

Each such child will be an Insured Child on the Date of Issue of this Rider if he or she is:

1. Named in the application for this Rider; and
2. More than 14 days old and less than 19 years old on the Date of Issue of this Rider.

Each such child acquired by the Insured after the date of application will automatically become an Insured Child if he or she is less than 19 years old when acquired. Coverage begins on the latest of:

- (1) The date the child is 15 days old; or
- (2) The date the child is acquired or legally adopted; or
- (3) The Date of Issue of this Rider.

Coverage of each Insured Child ends on the earlier of:

- (1) The policy date of the new policy for the Insured Child under the Conversion option; or
- (2) The Insured Child's 25th birthday; or
- (3) The first Policy Anniversary on or after the Insured's 70th birthday.

BENEFICIARY

The Beneficiary under this Rider will be as named in the application for this Rider. If no Beneficiary is named, the Insured will be the Beneficiary. If no Beneficiary is alive on the date an Insured Child dies, the Owner or the Owner's estate will be the Beneficiary, unless otherwise provided.

The Beneficiary of this Rider may be changed by a proper written notice to us. When We record the notice, the change of Beneficiary will be effective from the date the notice was signed. We are not responsible for any action We take before We record the notice on Company Records.

Neither a change of Owner nor a change of Beneficiary for the Policy will change the Beneficiary for this Rider.

MISSTATEMENT OF AGE OF AN INSURED CHILD

If the age of any Insured Child has been misstated, benefits will be based on the premiums actually paid and the correct age of the Insured Child.

DEATH OF OWNER

If the Policy Owner dies, the Insured, if living, will become Owner of this Rider. If the Insured is not living, the Owner's estate will be owner of the insurance on each Insured Child's life.

CASH SURRENDER OPTION AFTER DEATH OF INSURED

This Rider does not have a surrender value while the Insured is living.

If this Rider is being continued in force after the death of the Insured as stated in the "Benefit" section of this Rider, it has a value. Upon the written request of the Owner and the surrender of this Rider We will pay the Paid-Up Rider Value. This Rider will then terminate. We have six (6) months from the date We receive a written request in which to pay the Paid-Up Rider Value.

Paid-Up Rider Value. The Paid-Up Rider Value for each Insured Child is the net single premium for the future guaranteed Life Insurance Benefits on that Insured Child under this Rider. This net single premium is based on the following assumptions:

- (1) Mortality rates according to the Commissioners' 2001 Standard Ordinary Composite Ultimate Mortality Table, age last birthday; and
- (2) Interest at a rate shown in the Policy Specifications Pages; and
- (3) Immediate payment of death claims.

For thirty (30) days after each policy anniversary, this value will not be less than on the anniversary. The values of this Rider are not less than the minimum values required by the laws of the jurisdiction in which this Rider is delivered.

REINSTATEMENT

The Reinstatement Provision of the Policy also applies to this Rider. In addition to the requirements stated in the Policy, each Insured Child must be an acceptable insurance risk. If any Insured Child is not an acceptable insurance risk, this Rider may still be placed back in force. However, each Insured Child who is not an acceptable insurance risk will not be covered after reinstatement.

CONVERSION BENEFIT

Insurance on an Insured Child under this Rider may be converted to a new policy on the life of the Insured Child. Evidence that the Insured Child is a good insurance risk will not be required. Conversion may be made only at the following times (later called the date of conversion).

Up to 1 times the face amount of the rider if:

- (1) The Insured Child is not yet age 21;
- (2) The Rider terminates and the Insured Child is not yet age 21;
- (3) The base policy is converted to a permanent plan of insurance.

Up to 5 times the face amount of the rider, or \$50,000, whichever is less if:

- (1) The Insured Child is between the ages of 21 and 25.

CONDITIONS - Conversion is subject to these conditions:

1. Any premiums for this Rider and all the Policy premiums due more than thirty-one (31) days before the date of the application must have been paid; and
2. The first premium for the new policy must be paid to the Administrative Service Office.

NEW POLICY - The new policy will be issued as follows:

- (1) The Policy Date of the new policy will be the date of conversion; and
- (2) The Insurance Age will be based on the Insured Child's attained age on the Policy Date of the new policy as defined under the new policy; and
- (3) The plan may be any life plan (except term insurance) then issued by the Company, subject to our rules as to amount, age and rating. However, at least one plan will always be available for conversion; and
- (4) The premium will be based on the rates in effect on the Policy Date of the new policy; and
- (5) The time period of the Incontestability and Suicide provisions will be computed from the Date of Issue of this Rider; and
- (6) The new policy will not include any additional benefits for accidental death or disability or any other additional benefits provided by rider unless agreed to by Us.

INCONTESTABILITY

We may not contest a claim under this Rider after it has been in force during the Insured Child's lifetime for two (2) years after the Date of Issue.

A reinstatement of coverage under this Rider will be incontestable after it has been in force during the Insured Child's lifetime for two (2) years from the date of reinstatement. Any contest concerning reinstated coverage will be based on the answers written in the application for reinstatement.

TERMINATION

This Rider will terminate on the earliest of the following:

1. The date the Policy terminates for any reason other than the death of the Insured; or
2. The first Policy Anniversary on or after the Insured's 70th birthday; or
3. The date of the Policy Owner's written request to terminate this Rider is received at our Administrative Service Office; or
4. The date the Policy or this Rider lapse because of nonpayment of premium; or
5. The date the Policy is changed to any other plan of life insurance, except as stated below.

If the Policy is changed to any other plan of life insurance, this Rider may be continued under the new policy only if:

- (1) Premiums for the new policy are payable at least until the first Policy Anniversary on or after the Insured's 70th birthday; and
- (2) A written request for continuation is made at the same time the policy is changed; and
- (3) The premium for this Rider is paid along with the first premium for the new policy.

The Date of Issue of this Rider and the date the benefit ceases will not change.

GENERAL PROVISIONS

This Rider is attached to and is part of the Policy. This Rider is subject to all of the statements of the Policy that apply to and are not in conflict with the statements of this Rider. This Rider does not have loan values. The premium for this Rider is shown on the Policy Specifications Pages. The Date of Issue of this Rider is the Date of Issue of the Policy shown on Page 2 unless another Date of Issue is shown on Page 3-3.


DANIEL J. FISCHER
Secretary


THOMAS E. RATTMANN
Chairman, President
And Chief Executive Officer

COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: [BINGHAMTON, NY]

ACCELERATED BENEFIT RIDER

RECEIPT OF ACCELERATED BENEFITS FROM THIS RIDER MAY BE TAXABLE. THEREFORE, WE RECOMMEND THAT YOU CONTACT YOUR PERSONAL TAX ADVISOR WHEN MAKING DECISIONS ABOUT ELECTING TO RECEIVE AND USE BENEFITS FROM THIS RIDER.

DEFINITIONS

Life Insurance Benefits means the death benefit as stated in the provisions of the Policy, excluding additional death benefits added by Rider. If the coverage under the Policy includes term insurance under a Rider attached to the Policy, such term insurance is not included in the benefit calculations under this Rider.

Terminal Illness means a non-correctable medical condition 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 diagnosis.

Immediate Family means a spouse, children, parents, grandparents, grandchildren, brothers and sisters of the Insured and their spouses.

Physician means an individual, other than the Owner, the Insured or a member of the Insured's immediate family, who is licensed to practice medicine and/or treat illness in the state in which treatment is received.

BENEFIT

The Owner may elect to receive an advance on the death benefit as stated in the provisions of the Policy when the Insured is diagnosed by a physician as having a Terminal Illness as defined in this Rider. The Owner may request, and make proper claim for the Accelerated Benefit during the lifetime of the Insured. Such request is also subject to the consent of any Irrevocable Beneficiary or Assignee of record. The Accelerated Benefit is equal to fifty percent (50%) of the Insured's death benefit. We will pay this amount less:

1. Any loan (and unpaid loan interest) on the Policy;
2. Any additional minimum premium required to keep the Insured's coverage in force for the twelve (12) month period following the date the Accelerated Benefit is paid;
3. An Administrative Service Fee of \$250.00.

COST OF BENEFIT

There is no charge for this prior to the time the Owner requests payment of the Accelerated Benefit. At the time such payment is made, we will deduct a \$250 Administrative Service Fee from the amount of the payment. 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. The Owner may repay to us, all or any portion of the lien or lien interest at any time.

Each year as of the Policy Anniversary, the Accelerated Benefit interest rate will be determined by us. It will equal the greater of:

- The then current yield on the 90-day Treasury Bill on the date of application for an Accelerated Benefit payment;
or
- The then current maximum adjustable loan interest rate based on *Moody's Corporate Bond Yield Averages – Monthly Average Corporates*, as published by Moody's Investor's Service, Inc. or any successor to that service, for the calendar month ending two (2) months before the date of application for an Accelerated Benefit payment.

CONDITIONS

To qualify for this benefit, the Owner must provide evidence satisfactory to Us that the Insured has a Terminal Illness as defined in this Rider. Part of that evidence must be a certification by a licensed physician.

Such diagnosis must be made: 1) on or after the Rider effective date; and 2) while this Rider and the Policy are in force.

If the Insured dies after the Accelerated Benefit is elected, but before we pay the benefit, we will pay the death benefit as if the Accelerated Benefit had not been elected.

EFFECT ON POLICY BENEFITS

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.

No premiums will be payable for twelve (12) month period following the date an Accelerated Benefit is paid. If the Insured is still living at the end of this period, regular premium payments as specified in the Policy will be required in order to keep the Policy in force.

There will be no reduction in any accidental death benefit as long as the Policy remains in force.

CLAIMS

Notice of Claim – Written notice of a claim must be given to us any time after the date the Insured develops a Terminal Illness as defined in this Rider. This may be sent directly to the Company or to one of our authorized agents.

Claim Forms – Within fifteen (15) days of receiving notice, we will send claim forms to the Owner; otherwise his or her prior notice will be accepted as Proof of Loss.

Proof of Loss – Written proof of the Insured's Terminal Illness must be received by us Before we will advance the Accelerated Benefit. Proof will include a properly completed Claim Form and Physician Statement acceptable to us. We may request additional medical information from the physician submitting the statement. We may require, at our expense, an additional examination by a physician that we choose. We reserve the right to rely on our physician's opinion for claim purposes.

We must receive the release of any collateral assignees and the approval of any irrevocable beneficiaries. A spousal release may also be applicable in community property states.

Time Payment of Claims – All benefits described in this Rider will be available as soon as we receive satisfactory Proof of Loss.

Payment of Claims – Only the Owner has the right to the Accelerated Benefit payment under the Insured's coverage. Upon the death of the Owner, we will pay the benefit of this Rider, if the benefit is requested prior to the Owner's death, to his or her estate.

INCONTESTABILITY

We may not contest a claim under this Rider because of incorrect answers to questions in the application for this rider after it has been in force during the Insured's lifetime for two (2) years after the Date of Issue.

A reinstatement of coverage under this Rider will be incontestable after it has been in force during the Insured's lifetime for two (2) years from the date of reinstatement. Any contest concerning reinstated coverage will be based on the answers written in the application for reinstatement.

TERMINATION

This Rider will terminate:

1. If the Policy terminates for any reason; or
2. Upon written request by the Owner;
3. On the first Policy Anniversary on or after the Insured's ninetieth (90th) birthday.

GENERAL PROVISIONS

This Rider is attached to and is part of the Policy. This Rider is subject to all the statements of the Policy that apply to and are not in conflict with the statements of this Rider. The Date of Issue of this Rider is the Date of Issue of the Policy shown on Page 2 unless another Date of Issue is shown on Page 3-3.

DISCLOSURES

This Rider may affect the Owner's ability to receive certain government benefits or entitlement because the Accelerated Benefit may be considered an asset in determining eligibility.

The Accelerated Benefit may be taxable. As with all tax matters. The Owner should consult his or her personal tax advisor to determine the current tax consequences prior to making any election. This benefit is not available if either the Owner or the Insured is required by a government agency to use this benefit in order to apply for, obtain, or otherwise keep a government benefit or entitlement.

The Accelerated Benefit is an early payment of a portion of life insurance proceeds. Payment of the Accelerated Benefit will cause the Insured's coverage to have significant benefit changes.



DANIEL J. FISCHER
Secretary



THOMAS E. RATTMANN
Chairman, President
And Chief Executive Officer

COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: [BINGHAMTON, NY]

DISABILITY INCOME RIDER Accident and Sickness

Subject to the provisions of this Rider, this Rider provides a Monthly Disability Income Benefit. If the Insured has a Total Disability while this Rider is in force, the Monthly Disability Income Benefit will be paid according to the terms of this Rider.

DEFINITIONS

Accident - A sudden, unforeseen and unexpected event that occurs while this Rider is in force and without the Insured's intent and results in an Injury to the Insured that causes the Insured's Total Disability as defined herein.

Care - Treatment by a Health Care Provider whose specialty is appropriate for the Injury or Sickness causing the Total Disability. Such treatment must be at a frequency that is appropriate for the condition and in accordance with generally accepted medical standards.

Health Care Provider - A licensed health care practitioner working within the scope of his or her license. The Health Care Provider cannot be the Insured, Owner, or anyone to whom the Insured or Owner is related by blood or marriage, or anyone with whom the Insured or Owner shares a business interest.

Injury - Bodily injury sustained in an Accident which occurs while this Rider is in force.

Maximum Benefit Period - This is the longest period for which the Monthly Disability Income Benefit is payable for a Total Disability, whether from one or more causes. The Maximum Benefit Period has a twenty-four (24) month lifetime limit for all periods of Total Disability. The Maximum Benefit Period begins after the Waiting Period. The Monthly Disability Income Benefit is not payable after the end of the Maximum Benefit Period, even if the Insured has a Total Disability.

Monthly Disability Income Benefit - The amount that We will pay the Owner at the end of each month of Total Disability according to the terms of this Rider. The amount of Monthly Disability Income Benefit provided by this Rider is shown on the Policy Specifications page.

Occupation - The profession or professions in which the Insured was engaged immediately prior to the date on which the Total Disability began. If the Insured was not engaged in any profession when the Total Disability began, then Occupation means any profession or professions for which the Insured may qualify by training, education or experience.

Pre-existing Condition - Means an Injury or Sickness for which, in the first twelve (12) months prior to the Date of Issue of this Rider:

- (1). Medical advice or treatment was recommended by or received from a Health Care Provider; or
- (2). Symptoms existed that would cause an ordinarily prudent person to seek diagnosis, Care or treatment.

Sickness - A disease, illness or condition which is diagnosed, or for which medical advice or treatment is received from or recommended by a Health Care Provider while this Rider is in force.

Total Disability - Means that due to an Injury or Sickness:

1. The Insured is under the Care of a Health Care Provider; and
2. During the Waiting Period, the Insured is unable to perform all of the material and substantial duties of his or her Occupation and the Insured is not engaged in any other occupation for wage or profit; and
3. During the first twelve (12) months following the Waiting Period, the Insured is unable to perform all of the material and substantial duties of his or her Occupation and the Insured is not engaged in any other occupation for wage or profit; and
4. After twelve (12) months following the Waiting Period, the Insured is unable to perform all of the material and substantial duties of any Occupation for which the Insured may qualify by training, education or experience.

Waiting Period - The time period during which the Insured must have a continuous Total Disability from an Injury or Sickness before the Monthly Disability Income Benefit becomes payable. The Waiting Period is ninety (90) days. The Monthly Disability Income Benefit is not payable during the Waiting Period.

BENEFIT PROVISIONS

Total Disability Income Benefit - During the Total Disability of the Insured and subject to all of the provisions of this Rider, We will pay the Owner a Monthly Disability Income Benefit until the earlier of the end of the Maximum Benefit Period for such Total Disability or the date such Total Disability ceases provided:

1. Total Disability begins while this Rider is in force;
2. The Insured has a Total Disability as defined in this Rider;
3. Total Disability has been continuous during the Waiting Period;
4. The Insured is under the Care of a Health Care Provider; and
5. The Insured's Total Disability did not result from, or was contributed to by, the conditions outlined in the Exclusions & Limitations provision of this Rider.

The Monthly Disability Income Benefit will begin to accrue after the Insured has a Total Disability for the entire Waiting Period and the Insured has met all of the requirements to receive the Monthly Disability Income Benefit under this Rider. Benefits are paid monthly, in arrears. Benefits for less than one (1) calendar month are paid on a per day basis of 1/30 of the Monthly Disability Income Benefit.

Recurrent Disability - A recurrence of the Insured's Total Disability from the same or related causes will be considered a continuation of the prior Total Disability if the Recurrent Disability starts while this Rider is in force and before the expiration of six (6) months from the end of the prior Total Disability.

If the Insured's Total Disability is treated as a Recurrent Disability of the prior Total Disability, it will not be subject to a new Waiting Period.

This Recurrent Disability provision will not extend the Maximum Benefit Period beyond the stated lifetime maximum of twenty-four (24) months.

Concurrent Disability - We will consider a period of Total Disability due to more than one cause as a single period of Total Disability.

EXCLUSIONS & LIMITATIONS

Exclusions - This Rider does not provide benefits for Total Disability resulting from:

1. Attempted suicide, while sane or insane, or an intentional self-inflicted injury.
2. Committing or attempting to commit an assault or felony.
3. War or act of war, whether declared or undeclared.
4. Being under the influence of alcohol or drugs, excluding those drugs that were prescribed by a Health Care Provider and taken while under the Care of a Health Care Provider.
5. Normal pregnancy or childbirth.

Pre-existing Condition Limitation - We will not pay the Monthly Disability Income Benefit for a Total Disability that starts during the first twelve (12) months after the Date of Issue of this Rider if it was due to a Pre-existing Condition. This Pre-existing Condition Limitation does not apply to any condition that was disclosed and that was not misrepresented in the application or not excluded by name or specific description.

Premium - We reserve the right to change the premium for this Rider after the first Policy year. The premium will never be more than the Guaranteed Maximum Premium. The Guaranteed Maximum Premium for all Policy years is shown in the Rider information section of the Policy Specifications page.

The premium will be charged on the same basis for all riders of this type that are in effect for the same length of time, and that are issued to Insureds of the same rating class and issue age. No change in rating class or premium will occur because the Insured's health has worsened or occupation has changed. Each change will be based on Our expectations as to future morbidity, investment earnings, expenses, and persistency experience.

Notice of Claim - We require written Notice of Claim and Proof of Total Disability. Written Notice of Claim must be provided to Us:

1. Within thirty (30) days from the date the Total Disability began, or as soon thereafter as reasonably possible; and
2. While the Total Disability continues.

Claim Forms - Upon receipt of a notice of claim, We will furnish to the Owner a Claim Form. If a Claim Form is not furnished within fifteen (15) days after the giving of such notice, the Owner shall be deemed to have met the Proof of Total Disability requirements by giving Us a written statement of the nature and extent of the loss within the time stated in the Proof of Total Disability provision.

Proof of Total Disability - Proof of Total Disability includes:

1. An Attending Physician's Statement completed by the Health Care Provider;
2. Completed Claim Forms;
3. Proof of Occupation and duties; and
4. Upon Our request, release of medical records.

The Owner must furnish Us with Proof of Total Disability within ninety (90) days of the date the Total Disability began. However, failure to give such Proof of Total Disability within ninety (90) days will not reduce or nullify the claim if such written notice is sent as soon as reasonably possible within one (1) year. If the Owner is legally incapacitated as a result of an Injury or Sickness, the one (1) year limit does not apply.

Proof of continuing Total Disability must be furnished monthly or at intervals as We may require. At reasonable intervals, We at Our expense, have the right to require the Insured to be physically or mentally examined by a Health Care Provider of Our choice, or to be interviewed by Our representative.

Incontestability - We may not contest a claim under this Rider because of incorrect answers to questions in the application for this rider after it has been in force during the Insured's lifetime for two (2) years after the Date of Issue.

A reinstatement of coverage under this Rider will be incontestable after it has been in force during the Insured's lifetime for two (2) years from the date of reinstatement. Any contest concerning reinstated coverage will be based on the answers written in the application for reinstatement.

Rider Termination - This Rider will terminate at the earliest of:

1. When coverage terminates under the Policy to which this Rider is attached; or
2. When the Maximum Benefit Period is reached; or
3. When any premium for this Rider or Policy is not paid (subject to the Grace Period provision of the Policy); or
4. The Policy Anniversary following the Insured's 60th birthday; or
5. Written request to do so is received by Us.

Termination of this Rider will not affect an otherwise valid claim for Total Disability that began prior to termination.

Reinstatement - If the Policy terminates, this Rider ceases to be in force. However, if the Policy is reinstated, We may allow this Rider to be reinstated only if the reinstatement of this Rider is within six (6) months of the Rider's termination date. There is no coverage under this Rider between the date it lapses and the date it is reinstated. Upon reinstatement, the terms of this Rider, including the Monthly Disability Income Benefit, will be the same as before termination, except for any terms added or excluded at the time of reinstatement.

The reinstated rider will only cover Total Disability resulting from an Injury that occurs after the effective date of the reinstatement or caused by a Sickness that first presents itself more than ten (10) days after the effective date of the reinstatement.

Conversion Privilege - If the Owner converts the Policy to which this Rider is attached, the Owner may also convert this Rider prior to the Last Conversion Date provided: there is a Last Conversion Date shown on the Policy Specifications page, no premium is in default, and a similar rider is available on the new permanent policy. The amount of the Monthly Disability Income Benefit and class of risk must not be increased. The new rider will take effect as of the date of the conversion of the Policy. The Rider form and premium rate in use by Us on that date for the attained age of the Insured will be used.

Legal Actions - No legal action may be brought to recover on this Rider within sixty (60) days after written Proof of Total Disability has been given to Us as required by this Rider. No action may be brought after three (3) years from the time written Proof of Total Disability is required to be given.

GENERAL PROVISIONS

This Rider is attached to and is part of the Policy. This Rider is subject to all of the statements of the Policy that apply to and are not in conflict with the statements of this Rider. The premium for this Rider is shown on the Policy Specification Pages. The Date of Issue of this Rider is the Date of Issue of the Policy shown on Page 2 unless another Date of Issue is shown on Page 3-3.


DANIEL J. FISCHER
Secretary


THOMAS E. RATTMANN
Chairman, President
And Chief Executive Officer

COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: [BINGHAMTON, NY]

DISABILITY INCOME RIDER Off-the-job Accident and Sickness

Subject to the provisions of this Rider, this Rider provides a Monthly Disability Income Benefit. If the Insured has a Total Disability while this Rider is in force, the Monthly Disability Income Benefit will be paid according to the terms of this Rider.

DEFINITIONS

Accident - A sudden, unforeseen and unexpected event that occurs while this Rider is in force and without the Insured's intent and results in an Injury to the Insured that causes the Insured's Total Disability as defined herein.

Care - Treatment by a Health Care Provider whose specialty is appropriate for the Injury or Sickness causing the Total Disability. Such treatment must be at a frequency that is appropriate for the condition and in accordance with generally accepted medical standards.

Health Care Provider - A licensed health care practitioner working within the scope of his or her license. The Health Care Provider cannot be the Insured, Owner, or anyone to whom the Insured or Owner is related by blood or marriage, or anyone with whom the Insured or Owner shares a business interest.

Injury - Bodily injury sustained in an Accident which occurs while this Rider is in force.

Maximum Benefit Period - This is the longest period for which the Monthly Disability Income Benefit is payable for a Total Disability, whether from one or more causes. The Maximum Benefit Period has a twenty-four (24) month lifetime limit for all periods of Total Disability. The Maximum Benefit Period begins after the Waiting Period. The Monthly Disability Income Benefit is not payable after the end of the Maximum Benefit Period, even if the Insured has a Total Disability.

Monthly Disability Income Benefit - The amount that We will pay the Owner at the end of each month of Total Disability according to the terms of this Rider. The amount of Monthly Disability Income Benefit provided by this Rider is shown on the Policy Specifications page.

Occupation - The profession or professions in which the Insured was engaged immediately prior to the date on which the Total Disability began. If the Insured was not engaged in any profession when the Total Disability began, then Occupation means any profession or professions for which the Insured may qualify by training, education or experience.

Off-the-job Injury or Sickness - Means an Injury or Sickness which is not caused, or contributed to, by the Insured's Occupation.

Pre-existing Condition - Means an Injury or Sickness for which, in the first twelve (12) months prior to the Date of Issue of this Rider:

- (1). Medical advice or treatment was recommended by or received from a Health Care Provider; or
- (2). Symptoms existed that would cause an ordinarily prudent person to seek diagnosis, Care or treatment.

Sickness - A disease, illness or condition which is diagnosed, or for which medical advice or treatment is received from or recommended by a Health Care Provider while this Rider is in force.

Total Disability - Means that due to an Off-the-job Injury or Sickness:

1. The Insured is under the Care of a Health Care Provider; and
2. During the Waiting Period, the Insured is unable to perform all of the material and substantial duties of his or her Occupation and the Insured is not engaged in any other occupation for wage or profit; and
3. During the first twelve (12) months following the Waiting Period, the Insured is unable to perform all of the material and substantial duties of his or her Occupation and the Insured is not engaged in any other occupation for wage or profit; and
4. After twelve (12) months following the Waiting Period, the Insured is unable to perform all of the material and substantial duties of any Occupation for which the Insured may qualify by training, education or experience.

Waiting Period - The time period during which the Insured must have a continuous Total Disability from an Off-the-job Injury or Sickness before the Monthly Disability Income Benefit becomes payable. The Waiting Period is ninety (90) days. The Monthly Disability Income Benefit is not payable during the Waiting Period.

BENEFIT PROVISIONS

Total Disability Income Benefit - During the Total Disability of the Insured and subject to all of the provisions of this Rider, We will pay the Owner a Monthly Disability Income Benefit until the earlier of the end of the Maximum Benefit Period for such Total Disability or the date such Total Disability ceases provided:

1. Total Disability begins while this Rider is in force;
2. The Insured has a Total Disability as defined in this Rider;
3. Total Disability has been continuous during the Waiting Period;
4. The Insured is under the Care of a Health Care Provider; and
5. The Insured's Total Disability did not result from, or was contributed to by, the conditions outlined in the Exclusions & Limitations provision of this Rider.

The Monthly Disability Income Benefit will begin to accrue after the Insured has a Total Disability for the entire Waiting Period and the Insured has met all of the requirements to receive the Monthly Disability Income Benefit under this Rider. Benefits are paid monthly, in arrears. Benefits for less than one (1) calendar month are paid on a per day basis of 1/30 of the Monthly Disability Income Benefit.

Recurrent Disability - A recurrence of the Insured's Total Disability from the same or related causes will be considered a continuation of the prior Total Disability if the Recurrent Disability starts while this Rider is in force and before the expiration of six (6) months from the end of the prior Total Disability.

If the Insured's Total Disability is treated as a Recurrent Disability of the prior Total Disability, it will not be subject to a new Waiting Period.

This Recurrent Disability provision will not extend the Maximum Benefit Period beyond the stated lifetime maximum of twenty-four (24) months.

Concurrent Disability - We will consider a period of Total Disability due to more than one cause as a single period of Total Disability.

EXCLUSIONS & LIMITATIONS

Exclusions - This Rider does not provide benefits for Total Disability resulting from:

1. Attempted suicide, while sane or insane, or an intentional self-inflicted injury.
2. Committing or attempting to commit an assault or felony.
3. War or act of war, whether declared or undeclared.
4. Being under the influence of alcohol or drugs, excluding those drugs that were prescribed by a Health Care Provider and taken while under the Care of a Health Care Provider.
5. Normal pregnancy or childbirth.

Pre-existing Condition Limitation - We will not pay the Monthly Disability Income Benefit for a Total Disability that starts during the first twelve (12) months after the Date of Issue of this Rider if it was due to a Pre-existing Condition. This Pre-existing Condition Limitation does not apply to any condition that was disclosed and that was not misrepresented in the application or not excluded by name or specific description.

Premium - We reserve the right to change the premium for this Rider after the first Policy year. The premium will never be more than the Guaranteed Maximum Premium. The Guaranteed Maximum Premium for all Policy years is shown in the Rider information section of the Policy Specifications page.

The premium will be charged on the same basis for all riders of this type that are in effect for the same length of time, and that are issued to Insureds of the same rating class and issue age. No change in rating class or premium will occur because the Insured's health has worsened or occupation has changed. Each change will be based on Our expectations as to future morbidity, investment earnings, expenses, and persistency experience.

Notice of Claim - We require written Notice of Claim and Proof of Total Disability. Written Notice of Claim must be provided to Us:

1. Within thirty (30) days from the date the Total Disability began, or as soon thereafter as reasonably possible; and
2. While the Total Disability continues.

Claim Forms - Upon receipt of a notice of claim, We will furnish to the Owner a Claim Form. If a Claim Form is not furnished within fifteen (15) days after the giving of such notice, the Owner shall be deemed to have met the Proof of Total Disability requirements by giving Us a written statement of the nature and extent of the loss within the time stated in the Proof of Total Disability provision.

Proof of Total Disability- Proof of Total Disability includes:

1. An Attending Physician's Statement completed by the Health Care Provider;
2. Completed Claim Forms;
3. Proof of Occupation and duties; and
4. Upon Our request, release of medical records.

The Owner must furnish Us with Proof of Total Disability within ninety (90) days of the date the Total Disability began. However, failure to give such Proof of Total Disability within ninety (90) days will not reduce or nullify the claim if such written notice is sent as soon as reasonably possible within one (1) year. If the Owner is legally incapacitated as a result of an Injury or Sickness, the one (1) year limit does not apply.

Proof of continuing Total Disability must be furnished monthly or at intervals as We may require. At reasonable intervals, We at Our expense, have the right to require the Insured to be physically or mentally examined by a Health Care Provider of Our choice, or to be interviewed by Our representative.

Incontestability - We may not contest a claim under this Rider because of incorrect answers to questions in the application for this rider after it has been in force during the Insured's lifetime for two (2) years after the Date of Issue.

A reinstatement of coverage under this Rider will be incontestable after it has been in force during the Insured's lifetime for two (2) years from the date of reinstatement. Any contest concerning reinstated coverage will be based on the answers written in the application for reinstatement.

Rider Termination - This Rider will terminate at the earliest of:

1. When coverage terminates under the Policy to which this Rider is attached; or
2. When the Maximum Benefit Period is reached; or
3. When any premium for this Rider or Policy is not paid (subject to the Grace Period provision of the Policy); or
4. The Policy Anniversary following the Insured's 60th birthday; or
5. Written request to do so is received by Us.

Termination of this Rider will not affect an otherwise valid claim for Total Disability that began prior to termination.

Reinstatement - If the Policy terminates, this Rider ceases to be in force. However, if the Policy is reinstated, We may allow this Rider to be reinstated only if the reinstatement of this Rider is within six (6) months of the Rider's termination date. There is no coverage under this Rider between the date it lapses and the date it is reinstated. Upon reinstatement, the terms of this Rider, including the Monthly Disability Income Benefit, will be the same as before termination, except for any terms added or excluded at the time of reinstatement.

The reinstated rider will only cover Total Disability resulting from an Injury that occurs after the effective date of the reinstatement or caused by a Sickness that first presents itself more than ten (10) days after the effective date of the reinstatement.

Conversion Privilege - If the Owner converts the Policy to which this Rider is attached, the Owner may also convert this Rider prior to the Last Conversion Date provided: there is a Last Conversion Date shown on the Policy Specifications page, no premium is in default, and a similar rider is available on the new permanent policy. The amount of the Monthly Disability Income Benefit and class of risk must not be increased. The new rider will take effect as of the date of the conversion of the Policy. The rider form and premium rate in use by Us on that date for the attained age of the Insured will be used.

Legal Actions - No legal action may be brought to recover on this Rider within sixty (60) days after written Proof of Total Disability has been given to Us as required by this Rider. No action may be brought after three (3) years from the time written Proof of Total Disability is required to be given.

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DANIEL J. FISCHER
Secretary



THOMAS E. RATTMANN
Chairman, President
And Chief Executive Officer

COLUMBIAN LIFE INSURANCE COMPANY

APPLICATION FOR INDIVIDUAL TERM LIFE INSURANCE POLICY

HOME OFFICE: CHICAGO, IL
 ADMINISTRATIVE SERVICE OFFICE: [4704 VESTAL PARKWAY EAST
 PO Box 1381, Binghamton, NY 13902-1381
 (800) 423-9765 / www.cfglife.com]

MAIL POLICY TO: Agent Owner

1. PROPOSED INSURED

Name (Last, Middle Initial, First) <i>Doe M John</i>	Social Security Number <i>123-55-6717</i>	Sex <i>MA</i>	Age <i>35</i>	Date of Birth <i>11/16/75</i>	State of Birth <i>MO</i>
Home Address/Apt. No., City, State, Zip Code <i>1212st Kansas City, MO 64105</i>				Phone Number: <input checked="" type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <i>(555) 676-1234</i>	

2. OWNER (Complete only if Owner is other than Proposed Insured.)

Name of Owner	Social Security Number	Relationship to Proposed Insured
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Mailing Address/ (If different from Insured)

3. BENEFICIARY

Primary Beneficiary Designation: (Full Name & Relationship to Insured) <i>Same M. Doe, spouse</i>	Contingent Beneficiary Designation: (Full Name & Relationship to Insured) <i>Joe Doe son</i>
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4. POLICY INFORMATION

[Please select your preference for receiving correspondence from us: US Mail Email (If you choose Email please make sure you supply your email address.)] Email Address *JohnDoe@comcast.net*

PLAN OF INSURANCE: <input checked="" type="checkbox"/> 15 Year Term <input type="checkbox"/> 20 Year Term <input type="checkbox"/> 30 Year Term 50% Return of Premium Benefit <input checked="" type="checkbox"/> 20 Year Term <input type="checkbox"/> 30 Year Term 100% Return of Premium Benefit <input type="checkbox"/> 20 Year Term <input type="checkbox"/> 30 Year Term	RIDERS: <input type="checkbox"/> Accidental Death Benefit <input type="checkbox"/> Waiver of Premium - Disability <input type="checkbox"/> Children's Term Insurance Rider <input type="checkbox"/> Accelerated Death Benefit - Terminal Illness <input type="checkbox"/> Accelerated Death Benefit - Critical Illness <input type="checkbox"/> Disability Income Rider Monthly Benefit _____	AMOUNT OF INSURANCE (Face Amount): \$ <u>10,000</u>	AMOUNT PAID WITH APPLICATION: \$ <u>0.00</u>
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Payment Mode: Annual Semi-Annual
 EFT - Please specify Annual, Semi-Annual or Monthly _____
 Draft 1st Premium? (Draft date must be within 30 days of application date. Please see EFT options on Page 4.)

Requested Effective Date: *12/1/10*

Children's Rider Amount: _____ Units (Children are natural, step, and legally adopted children.)

Name	Sex	Date of Birth	Height / Weight	Beneficiary
			/	Applies to all Children, including Children added after Issue Date. NAME: RELATIONSHIP:
			/	
			/	
			/	
			/	

5. HEALTH HISTORY

SECTION A.

	YES	NO
1. Are all proposed insureds US citizens, permanent US residents or holding a permanent Visa?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Are you currently employed? If "NO," please explain _____ Occupation: <i>Manager</i> Annual Income: <u>80,000.00</u> Total Household Income: <u>100,000.00</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Have you applied for a home mortgage or refinanced an existing mortgage, been married and/or had or adopted a child in the last three (3) years? (If "NO," do not continue.)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Do you have a Driver's License? If "NO," please provide details: _____ If "YES," Driver's License No. and State: <u>31217 missouri</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. In the past three (3) years, have you: ■ Been on probation, parole, been arrested for, convicted or, or pled guilty to any crime or to possession or distribution of drugs or any other illegal substance? ■ Been convicted of three or more moving violations, been convicted of driving under the influence of alcohol or drugs, or had a driver's license suspended or revoked? If "YES" to above, please provide details: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Have you used tobacco or any nicotine products in the past twelve (12) months (to include cigarettes, cigars, snuff/chew/dip, pipes, nicotine patch and nicotine gum)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

SECTION B. YES NO

1. Have you been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infections (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or health care provider? YES NO

2. Have you ever received or been recommended for an organ or bone marrow transplant? YES NO

3. Are you currently:
 a. Bedridden or confined to any hospital, nursing home, or other medical facility? YES NO
 b. Using any of the following: walker, wheelchair, electric scooter, oxygen or catheter? YES NO

If "YES," please provide details: _____

4. Current Height: 6'1" Current Weight: 189
 Any unexplained history of weight loss or more than 10 lbs. in the last year? YES NO
 If "YES," please provide details: _____

5. In the past three (3) years have you:
 a. Engaged in: hang-gliding, cliff diving, scuba diving over 130 feet, parachuting, skydiving, rock or mountain climbing, speeds (in any vehicle) in excess of 100 mph (land or water) or plan such activity in the next 2 years? YES NO
 b. Flown as a student pilot, or private pilot with over 250 flight hours per year, used an ultra-light aircraft or plan such activity in the next 12 months? YES NO

SECTION C If "YES" to questions 1-6 in this section, please provide details in chart below. YES NO

1. In the past three (3) years, have you ever been declined, postponed, rated or denied reinstatement or asked to pay extra premium by any insurance company? YES NO

2. In the past five (5) years, have you:
 a. Used cocaine, narcotics, hallucinogens, barbiturates, amphetamines, marijuana or other drugs except as prescribed by a physician? YES NO
 b. Been advised by a healthcare professional to reduce or stop alcohol or drug use or received treatment for alcohol or drug abuse? YES NO

3. Do you have or had a diagnosis of diabetes prior to the age of 35 and/or experienced complications of diabetes, including insulin shock, diabetic coma, Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve, circulatory) disorder, leg ulcers, amputation or diabetes not under control with current treatments? YES NO

4. In the past ten (10) years, have you received a diagnosis of or required follow-up for:
 a. Cancer (other than basal cell or squamous cell carcinoma of the skin), leukemia, or lymphoma? YES NO
 b. Stroke (CVA), transient ischemic attack (TIA), paralysis? YES NO
 c. Systemic lupus, sarcoidosis, rheumatoid arthritis, Crohn's Disease or ulcerative colitis, degenerative muscle or nerve disease/disorder, immune system or connective tissue disease/disorder? YES NO
 d. Schizophrenia, bipolar disorder, major depression, mental retardation, Down's Syndrome, Alzheimer's disease, dementia, Parkinson's disease or Multiple Sclerosis? YES NO
 e. Coronary artery disease, heart attack, coronary bypass surgery (CABG), coronary angioplasty (PTCA), heart valve replacement, angina, heart arrhythmia, congenital heart disease, cardiomyopathy, congestive heart failure (CHF), pacemaker, defibrillator, aneurysm, disease or disorder of the brain, peripheral arteries, blood, liver, pancreas, or kidney (other than kidney stones)? YES NO
 f. Emphysema, COPD or asthma that has required one or more acute emergency care visits or an inpatient hospitalization? YES NO
 g. Epilepsy and recurring seizures with the last seizure occurring within the past year? YES NO

5. Are you awaiting a diagnosis or been advised to have a surgical operation, a diagnostic test or a medical or mental evaluation that has not been completed? YES NO

6. In the past five (5) years, have you been prescribed medication or taken any medication prescribed by a physician or been hospitalized or consulted a physician or medical facility for any reason? YES NO

TABLE FOR "YES" ANSWERS IN SECTION C QUESTIONS 1-6

Person Proposed for Insurance	Medication Name (Copy from Pharmacy Label)	Date last taken	Name & Address of Physician or Medical Facility	Treatment / Diagnosis	Dates & Durations

6. ANSWER ONLY IF APPLYING FOR THE DISABILITY INCOME RIDER YES NO

1. Are you currently covered by Workers Compensation? YES NO
(If yes, you are only eligible to apply for an Off-the-Job Disability Income Rider. If so, skip to question #3.)

2. Occupation Information:
 a. Description of duties _____
 b. Have you been working full time (at least 30 hours per week) for the past 12 months? YES NO
 c. If self-employed, % of time working at home? _____

3. What is the monthly amount of any individual disability insurance you have in force? _____

4. In the past ten (10) years, have you received care or treatment for, or been diagnosed by a member of the medical profession as having:
 a. Fibromyalgia, Chronic Fatigue Syndrome, Chronic Epstein-Barr, Rheumatoid Arthritis or other inflammatory arthritis? YES NO
 b. Inflammatory Bowel Disease including Crohn's Disease or Ulcerative Colitis, Diabetes, Skin or Connective Tissue Disorder? YES NO
 c. Disease or impairment of the spinal column, neck or back, including acute and Chronic neck or back strain; herniated disc syndrome, surgery of the spine or back, acute and chronic sciatica, or congenital disorders of the spinal column and back? YES NO
 d. Recurring disease or impairment of other bones or joints, e.g. wrist, knee, or shoulder? YES NO
 e. Any emotional or psychological disorder, including stress, anxiety, depression or nervous system disorder (including Grand mal Epilepsy)? YES NO

5. In the past five (5) years, have you filed for or received Disability, Worker's Compensation or State Disability benefits? YES NO
 If yes, please provide details _____

7. REPLACEMENT:

YES NO
[] [X]
[] [X]

Do you have any existing life insurance or annuities?
Is this application for insurance intended to replace any life insurance or annuities now in force?
(If "YES," submit any special forms required by the state in which the application is signed.)

8. SPECIAL REQUESTS / REMARKS:

9. 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.

10. AUTHORIZATION & ACKNOWLEDGMENT:

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance company, the Medical Information Bureau, consumer reporting agency, or other organization, institution or person that has any records or knowledge of me, 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 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, and will survive my death if it occurs during such two (2) year period. 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 acknowledge the applicable fraud notice required by state law.

[I wish to receive my policy electronically: [X] Yes [] No
(I understand I would receive a link via email to a secure location for my policy packet.)]

11/16/10 Date of Application
X John Doe Signature of Proposed Insured (Parent/Guardian if 15 or under) 11/16/10 (Date)
X Signature of Owner (If other than Insured) (Date)

11. REPORT OF LICENSED AGENT:

Does the applicant have any existing life insurance or annuities? [] YES [X] NO
Is this insurance intended to replace, in whole or part, any life insurance or annuities? [] YES [X] NO
(If "YES," submit any special forms required by the state in which the application is signed.)
HAS THE TELEPHONE INTERVIEW BEEN COMPLETED? [X] YES [] NO

I hereby affirm that I personally solicited, witnessed, and completed this application and all answers given above are true and correct to the best of my knowledge.

John Smith Name of Licensed Agent (Print)
X John Smith Signature of Licensed Agent (required) 11/16/10 (Date)
12 Agent Number % 1223 Second Agent Number % (If Splitting) Agent's State License ID No. (in jurisdictions where required)

SECONDARY ADDRESSEE / THIRD PARTY DESIGNEE Not Electing A Secondary Addressee/Third Party At this Time.
(The Applicant/Owner may designate a Secondary Addressee/Third Party to receive a copy of Important Notices.)

Name & Address: _____

Secondary Addressee / Third Party Authorization
I hereby give permission to accept any Important Notices on behalf of the named Proposed Insured.

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

REQUEST FOR ELECTRONIC FUNDS TRANSFER PLAN - (Must complete in full) DO NOT USE FOR DRAFT 1st PREMIUM

Amount Paid With Application: \$ 0.00

ONE TIME ELECTRONIC FUND TRANSFER

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

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

This will be a one time withdrawal from my account in the amount of \$ 250.00 from the account detailed below.

Financial Institution: BNA Name of Bank Account Holder: John Doe

Account Type: Checking or Savings

Routing Number:

1	1	1	2	2	3	4	5	6
---	---	---	---	---	---	---	---	---

 Must have 9 digits in routing no.

Account Number:

2	2	2	3	3	5	6	7	8	1	0	1	1	0	2	9	8
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

 Can have up to 17 positions in account no.

11/16/10 Date X John Doe Authorized Signature as it appears on Bank Records (one time withdrawal)

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

FIRST DRAFT AND ONGOING ELECTRONIC FUND TRANSFER

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

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

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

Bank Name _____ Checking (Attach voided check if available.) or Savings

Transit / Routing No.

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

 Must have 9 digits in routing no.

Account No.

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

 Can have up to 17 positions in account no.

[I request withdrawal of payments on: (CHOOSE ONE) Date (1st - 28th) _____ (OR) Week (1st - 4th) _____ /Day (Mon - Fri) _____ beginning in the month of _____.] X _____

Name of Bank Account Holder John Doe Date 11/16/10 Authorized Signature as it appears on Bank Records (ongoing withdrawals)

[Please charge \$ _____ to the following card: VISA® MasterCard® American Express® Discover® Debit

Card Number

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

 Security Code (on back of card, 3 digits)

--	--	--

 Card Expiration Date (M/M) - (Y/Y)

--	--	--	--

Date _____ Cardholder Name _____ X _____ Cardholder Signature]

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].

MEDICAL INFORMATION BUREAU (MIB), INC. PRE-NOTICE

The Medical Information Bureau is a nonprofit membership organization of life insurance companies. The Bureau 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 (TTY) (866) 346-3642]. MIB's website is www.mib.com].

CONDITIONAL RECEIPT

Complete Only When Full Modal Premium Is Received With Application

**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 \$500,000.

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.**

FRAUD WARNING STATEMENTS

If the application already includes a fraud warning, the state specific warnings listed below prevail over the standard warning in the application.

The law in **ARKANSAS, LOUISIANA, RHODE ISLAND and WEST VIRGINIA** states: "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."

The law in **COLORADO** states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

The law in **DISTRICT OF COLUMBIA** states: "WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

The law in **FLORIDA** states: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree."

The law in **KENTUCKY** states: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime."

The law in **MARYLAND** states: "ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

The law in **NEW JERSEY** states: "Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

The law in **NEW MEXICO** states: "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 CIVIL FINES AND CRIMINAL PENALTIES."

The law in **OHIO** states: "Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

The law in **OKLAHOMA** states: "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."

The law in **PENNSYLVANIA** states: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concealing any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

The law in **TENNESSEE, VIRGINIA and WASHINGTON** states: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

APPLICATION FOR REINSTATEMENT

COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: CHICAGO, IL

ADMINISTRATIVE SERVICE OFFICE: [P.O. Box 1381, Binghamton, NY 13902-1381]

NAME OF INSURED	POLICY NUMBER	AMOUNT RECEIVED	FOR THE OUTSTANDING PREMIUMS:	
			FROM	THROUGH
John Doe	121	\$ 200.00	9/10/10	10/10/10

CURRENT ADDRESS: STREET/RD:

Any Street

APT #

CITY:

City

STATE:

MO

ZIP CODE:

64133

PHONE NUMBER:

816-555-1234

[Please select your preference for receiving correspondence from us: US Mail Email
(If you choose Email please make sure you supply your email address.)]

Email Address

John@comcast

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

HEALTH HISTORY

SECTION A.

- | | YES | NO |
|--|-------------------------------------|-------------------------------------|
| 1. Are you currently employed? If "NO," please explain. _____
Occupation: <u>Manager</u> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. In the past three (3) years, have you:
<ul style="list-style-type: none"> ▪ Been on probation, parole, been arrested for, convicted or, or pled guilty to any crime or to possession or distribution of drugs or any other illegal substance? <input type="checkbox"/> ▪ Been convicted of three or more moving violations, been convicted of driving under the influence of alcohol or drugs, or had a driver's license suspended or revoked? <input type="checkbox"/> If "YES" to above, please provide details: _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have you used tobacco or any nicotine products in the past twelve (12) months (to include cigarettes, cigars, snuff/chew/dip, pipes, nicotine patch and nicotine gum)? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

SECTION B.

- | | YES | NO |
|---|--------------------------|-------------------------------------|
| 1. Have you been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infections (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or health care provider? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Have you ever received or been recommended for an organ or bone marrow transplant? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Are you currently:
a. Bedridden or confined to any hospital, nursing home, or other medical facility? <input type="checkbox"/>
b. Using any of the following: walker, wheelchair, electric scooter, oxygen or catheter? <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Current Height: <u>61</u> Current Weight: <u>190</u>
Any unexplained history of weight loss or more than 10 lbs. in the last year?
If "YES," please provide details: _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. In the past three (3) years have you:
a. Engaged in: hang-gliding, cliff diving, scuba diving over 130 feet, parachuting, skydiving, rock or mountain climbing, speeds (in any vehicle) in excess of 100 mph (land or water) or plan such activity in the next 2 years? <input type="checkbox"/>
b. Flown as a student pilot, or private pilot with over 250 flight hours per year, used an ultra-light aircraft or plan such activity in the next 12 months? <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

SECTION C.

If "YES" to questions 1-6 in this section, please provide details in chart below.

- | | YES | NO |
|--|--------------------------|-------------------------------------|
| 1. In the past three (3) years, have you ever been declined, postponed, rated or denied reinstatement or asked to pay extra premium by any insurance company? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. In the past five (5) years, have you:
a. Used cocaine, narcotics, hallucinogens, barbiturates, amphetamines, marijuana or other drugs except as prescribed by a physician? <input type="checkbox"/>
b. Been advised by a healthcare professional to reduce or stop alcohol or drug use or received treatment for alcohol or drug abuse? <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Do you have or had a diagnosis of diabetes prior to the age of 35 and/or experienced complications of diabetes, including insulin shock, diabetic coma, Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve, circulatory) disorder, leg ulcers, amputation or diabetes not under control with current treatments? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. In the past ten (10) years, have you received a diagnosis of or required follow-up for:
a. Cancer (other than basal cell or squamous cell carcinoma of the skin), leukemia, or lymphoma? <input type="checkbox"/>
b. Stroke (CVA), transient ischemic attack (TIA), paralysis? <input type="checkbox"/>
c. Systemic lupus, sarcoidosis, rheumatoid arthritis, Crohn's Disease or ulcerative colitis, degenerative muscle or nerve disease/disorder, immune system or connective tissue disease/disorder? <input type="checkbox"/>
d. Schizophrenia, bipolar disorder, major depression, mental retardation, Down's Syndrome, Alzheimer's disease, dementia, Parkinson's disease or Multiple Sclerosis? <input type="checkbox"/>
e. Coronary artery disease, heart attack, coronary bypass surgery (CABG), coronary angioplasty (PTCA), heart valve replacement, angina, heart arrhythmia, congenital heart disease, cardiomyopathy, congestive heart failure (CHF), pacemaker, defibrillator, aneurysm, disease or disorder of the brain, peripheral arteries, blood, liver, pancreas, or kidney (other than kidney stones)? <input type="checkbox"/>
f. Emphysema, COPD or asthma that has required one or more acute emergency care visits or an inpatient hospitalization? <input type="checkbox"/>
g. Epilepsy and recurring seizures with the last seizure occurring within the past year? <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Are you awaiting a diagnosis or been advised to have a surgical operation, a diagnostic test or a medical or mental evaluation that has not been completed? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. In the past five (5) years, have you been prescribed medication or taken any medication prescribed by a physician or been hospitalized or consulted a physician or medical facility for any reason? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

CONDITIONS RELATING TO THE APPLICATION FOR REINSTATEMENT:

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

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

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

AUTHORIZATION AND ACKNOWLEDGMENT:

I **authorize** any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance company, the Medical Information Bureau, consumer reporting agency, or other organization, institution or person that has any records or knowledge of me, 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 **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, and will survive my death if it occurs during such two (2) year period. 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 understand that a telephone interview may be necessary to verify or supplement information given to the Company on this application for reinstatement. 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.

Please contact me between the hours of 9 and 5.

RECEIPT OF NOTICES

I have read and understand the Conditions Relating to the Application for Reinstatement and the Authorization & Acknowledgment.

I acknowledge receipt of the Information Practices Relating to Underwriting Your Application for Reinstatement.

I have read and acknowledge the applicable fraud notice required by state law.

<u>11/16/10</u> Date of Application	x <u>John Doe</u> Signature of Insured (Parent/Guardian if 15 or under)	<u>11/16/10</u> (Date)
<u>City, MO</u> Dated At (City & State)	x _____ Signature of Owner (If other than Insured)	_____ (Date)
<u>1212</u> Agent's State License Identification Number (In jurisdictions where required)	x <u>John Smith</u> Signature of Licensed Agent	<u>156</u> Agent Number

REQUEST FOR ELECTRONIC FUNDS TRANSFER PLAN - (Must complete in full)

Bank Name UMB Checking (Attach voided check if available.) or Savings

Transit / Routing #

1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---

 Must have 9 digits in routing #

Account #

1	5	6	8	1	2	7	4	3	1	2	2	5	1	1	2	3
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

 Can have up to 17 positions in account #

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

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

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

[I request withdrawal of payments on: (CHOOSE ONE) Date (1st - 28th) 15 (OR) Week (1st - 4th) _____ /Day (Mon - Fri) _____ beginning in the month of _____.] 11/16/10 x John Doe
Date Authorized Signature as it appears on Bank Records

NO INSURANCE COVERAGE IS CREATED BY THIS RECEIPT

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

Received from John Doe the sum of \$ 200.00 to be retained by the Company while the Reinstatement Application bearing the above number is processed. This is not a conditional receipt and shall have no binding effect on the Company. The Company will refund any money remitted herewith for a policy that is not approved for reinstatement. The Reinstatement Application applies to the policy number: 121.

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

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

Date 11/16/10 Agent's Signature John Smith Agent Number 156

INFORMATION PRACTICES RELATING TO UNDERWRITING YOUR APPLICATION FOR REINSTATEMENT

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

INVESTIGATIVE CONSUMER REPORT

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

IDENTIFICATION

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

ACCESS TO INFORMATION

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

WHERE TO WRITE US

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FRAUD WARNING STATEMENTS

If the application already includes a fraud warning, the state specific warnings listed below prevail over the standard warning in the application.

The law in ARKANSAS, LOUISIANA, RHODE ISLAND and WEST VIRGINIA states: "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."

The law in COLORADO states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

The law in DISTRICT OF COLUMBIA states: "WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

The law in FLORIDA states: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree."

The law in KENTUCKY states: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime."

The law in MARYLAND states: "ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

The law in NEW JERSEY states: "Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

The law in NEW MEXICO states: "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 CIVIL FINES AND CRIMINAL PENALTIES."

The law in OHIO states: "Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

The law in OKLAHOMA states: "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."

The law in PENNSYLVANIA states: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concealing any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

The law in TENNESSEE, VIRGINIA and WASHINGTON states: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

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 fatal 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 additional minimum premium required to keep the policy in force for the next twelve (12) month period, and an Administrative Service Fee of \$250.00. The policy loan and unpaid loan interest will be repaid. No additional premiums will be payable for the next twelve (12) month period. If the insured is still living at the end of this period, 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.

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
Form No. 6141-CL

License No.
COMPANY COPY

Date

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 fatal 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 additional minimum premium required to keep the policy in force for the next twelve (12) month period, and an Administrative Service Fee of \$250.00. The policy loan and unpaid loan interest will be repaid. No additional premiums will be payable for the next twelve (12) month period. If the insured is still living at the end of this period, 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.

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
Form No. 6141-CL

License No.

Date

APPLICANT COPY

SERFF Tracking Number: FRCS-126924641 State: Arkansas
 Filing Company: Columbian Life Insurance Company State Tracking Number: 47481
 Company Tracking Number: 5431
 TOI: L041 Individual Life - Term Sub-TOI: L041.500 Other
 Product Name: Mortgage Term Life
 Project Name/Number: CML-2/61/61

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments: The Company offers their assurances that the Guaranty Association notice required by Regulation 49 will be provided.		
Attachments: AR COC.pdf AR RDB.pdf AUTH Distilled.pdf AR consumer notice.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments: The applications to be used with this filing are located under the form schedule.		

	Item Status:	Status Date:
Satisfied - Item: Accelerated benefit letters, for your information		
Comments:		
Attachment: 6142-CL DISTILLED.pdf		

**STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE**

Company Name: Columbian Life Insurance Company

Form Titles: Individual Term Life Insurance Policy (15 year period), Children's Term Insurance Rider, Accelerated Benefit Rider, Disability Income Rider (Accident and Sickness), Disability Income Rider (Off-the-job Accident and Sickness), Disclosure: Accelerated Death Benefit Terminal Condition Rider, Application for Individual Term Life Insurance, Application for Reinstatement

Form Numbers: FORM NO. 1F580-CL, FORM NO.1H843-CL, FORM NO. 1H844-CL, FORM NO. 1H845-CL, FORM NO. 1H846-CL, 6141-CL, FORM NO. A430-CL, FORM NO. A431-CL

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.



Dorothy M. Klie, FLMI, AIRC
Assistant Vice President, Policy Filing and Assistant Secretary

December 3, 2010

Date

**STATE OF ARKANSAS
READABILITY CERTIFICATION**

COMPANY NAME: Columbian Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
FORM NO. 1F580-CL	54.0
FORM NO. 1H843-CL	58.6
FORM NO. 1H844-CL	50
FORM NO. 1H845-CL	50.1
FORM NO. 1H846-CL	55.8
6141-CL	55.8
FORM NO. A430-CL	*
FORM NO. A431-CL	*

* The score is 50+ when combined with the policy.



Dorothy M. Klie, FLMI, AIRC
Assistant Vice President, Policy Filing and Assistant Secretary

December 3, 2010

Date



November 15, 2010

To: The Insurance Commissioner

Authorization

This letter, or a copy thereof, will authorize the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

Columbian Life Insurance Company

By: Donna M. Klie

Title: Assistant Vice President, Policy
Filing and Assistant Secretary

COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: Chicago, IL

Administrative Service Office: Vestal Parkway East

PO Box 1381, Binghamton, NY 13902-1381

Telephone: (607) 724-2472 Fax (607) 724-4435

IMPORTANT NOTICE

You can contact the Arkansas Insurance Department at:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
(501) 371-2600
1-800-282-9134



COLUMBIAN LIFE INSURANCE COMPANY

Home Office: Chicago, IL

Administrative Service Office:

PO Box 1381 Vestal Parkway East, Binghamton, NY 13902-1381

Dear _____ :

We have received your request for Accelerated Benefit payment. Please review the following information carefully before electing to receive this benefit.

As specified in your Rider, the Accelerated Benefit amount is equal to 50% of your policy's death benefit. Processing of the Accelerated Benefit payment is subject to an administrative service fee of \$250, which will be deducted from the payment. The minimum amount of premium required to keep the policy in force for the next 12-month period, as well as any unpaid loan and loan interest, will also be deducted from the benefit payment.

Payment of the benefit will result in a lien against the death benefit of the policy equal to the amount of the Accelerated Benefit plus accrued interest as specified in your rider. You are under no OBLIGATION to repay this lien. However, if you choose to do so, you can repay all or any portion of the lien or lien interest at any time.

Your election to receive this benefit will have the following effects on your policy:

- ◆ The policy death benefit will be reduced by 50%.
- ◆ The cash value of the policy will be reduced by the amount of the Accelerated Benefit.
- ◆ Any outstanding loan amount will be reduced to \$0.
- ◆ There will be no change in premiums. Because premiums will be deducted from the benefit payment as indicated above, no additional premiums will be payable for the next twelve-month period. If the insured is still living at the end of this period, regular premium payments as specified in the policy will be required in order to keep the policy in force.
- ◆ There will be no future charges for this benefit.
- ◆ There will be no reduction in any Accidental Death Benefit amount of insurance or premium.
- ◆ No other claim for Accelerated Benefit can be made; this benefit is available only once during the lifetime of the Insured.

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 Accelerated Benefit payment 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.

If, after reviewing this information and consulting with the appropriate parties, you still wish to apply for the accelerated benefit payment, please complete and sign the enclosed Accelerated Benefit Statement and return it to us. If an irrevocable beneficiary has been designated or your policy has been assigned, you must obtain the written consent of the beneficiary and/or assignee in Section C of the form.

If you have any questions, please call me at _____ .

Sincerely,