

<i>SERFF Tracking Number:</i>	<i>FRCS-128002466</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Columbian Life Insurance Company</i>	<i>State Tracking Number:</i>	
<i>Company Tracking Number:</i>	<i>5671</i>		
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.202 Early Duration Reduced Benefit - Level Premium - Any Policy Design - Funeral Expense</i>
<i>Product Name:</i>	<i>Final Expense Application - A341</i>		
<i>Project Name/Number:</i>	<i>CML/83/83</i>		

Filing at a Glance

Company: Columbian Life Insurance Company

Product Name: Final Expense Application - A341 SERFF Tr Num: FRCS-128002466 State: Arkansas

TOI: L071 Individual Life - Whole

SERFF Status: Closed-Approved State Tr Num:

Sub-TOI: L071.202 Early Duration Reduced Benefit - Level Premium - Any Policy Design - Funeral Expense

Co Tr Num: 5671

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Donna Lambert

Authors: Exselsa Cartwright,
Michael Cochran

Disposition Date: 02/01/2012

Date Submitted: 01/30/2012

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date: 03/02/2012

State Filing Description:

General Information

Project Name: CML/83

Status of Filing in Domicile: Not Filed

Project Number: 83

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Not filing in domicile state.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 02/01/2012

State Status Changed: 02/01/2012

Deemer Date:

Created By: Michael Cochran

Submitted By: Exselsa Cartwright

Corresponding Filing Tracking Number:

Filing Description:

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

Our fee of \$100 has been sent by EFT on this same date.

The forms attached to the Form Schedule are submitted for approval. These are new forms and will replace the following forms:

SERFF Tracking Number: FRCS-128002466 State: Arkansas
Filing Company: Columbian Life Insurance Company State Tracking Number:
Company Tracking Number: 5671
TOI: L071 Individual Life - Whole Sub-TOI: L071.202 Early Duration Reduced Benefit - Level
Premium - Any Policy Design - Funeral Expense
Product Name: Final Expense Application - A341
Project Name/Number: CML/83/83

Form No. /Title/Description/Approved On
A336H-CL / Application for Life Insurance / 1-20-2006
A340H-CL/ Application for Reinstatement / 1-20-2006

The new forms differ from the previously approved forms. There have been changes made to the medical questions as well as the layout of the form and information collected for administrative purposes.

There are no unique or innovative features in these forms. All variable information is bracketed and there are Statements of Variability attached to explain the variable fields. The forms are written in readable language and used by licensed agents in the individual market.

Application Form No. A341Y-CL will be used to apply for Policy Form No. 1F143AB-L including optional benefits and riders that have been approved by the Department for use with these policy forms. Form No. 1F143AB-L is an individual Whole Life Insurance Policy. This form was approved by the Department on January 20, 2006 under File No. 31661; SERFF Tracking # SERT-6KVQFX572. Form No. A342Y-CL, Application for Reinstatement, will be used to apply for reinstatement of these policies. These applications will also be used with previously approved Form A338-CL, Supplemental Application for Children's Term Insurance Rider. This supplemental application form was approved by the Department on January 20, 2006 under File No. 31661; SERFF Tracking # SERT-6KVQFX572.

There is no HIV testing associated with this product.

The Company intends to make secured electronic versions of the applications available to our 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 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, we 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.

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

SERFF Tracking Number: FRCS-128002466 State: Arkansas
 Filing Company: Columbian Life Insurance Company State Tracking Number:
 Company Tracking Number: 5671
 TOI: L071 Individual Life - Whole Sub-TOI: L071.202 Early Duration Reduced Benefit - Level
 Premium - Any Policy Design - Funeral Expense
 Product Name: Final Expense Application - A341
 Project Name/Number: CML/83/83

If you have any questions or need additional information, please call toll-free 1-800-927-2730. Thank you for your assistance.

Company and Contact

Filing Contact Information

Exselsa Cartwright, Senior Compliance exselsa.cartwright@firstconsulting.com
 Specialist
 1020 Central 800-927-2730 [Phone] 2757 [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: \$100.00
 Retaliatory? No
 Fee Explanation: \$50.00 per form x 2 forms = \$100.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Columbian Life Insurance Company	\$100.00	01/30/2012	55923346

SERFF Tracking Number: FRCS-128002466 State: Arkansas
Filing Company: Columbian Life Insurance Company State Tracking Number:
Company Tracking Number: 5671
TOI: L071 Individual Life - Whole Sub-TOI: L071.202 Early Duration Reduced Benefit - Level
Premium - Any Policy Design - Funeral Expense
Product Name: Final Expense Application - A341
Project Name/Number: CML/83/83

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	02/01/2012	02/01/2012

SERFF Tracking Number: FRCS-128002466 *State:* Arkansas
Filing Company: Columbian Life Insurance Company *State Tracking Number:*
Company Tracking Number: 5671
TOI: L071 Individual Life - Whole *Sub-TOI:* L071.202 Early Duration Reduced Benefit - Level
Premium - Any Policy Design - Funeral Expense
Product Name: Final Expense Application - A341
Project Name/Number: CML/83/83

Disposition

Disposition Date: 02/01/2012

Implementation Date: 03/02/2012

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *FRCS-128002466* State: *Arkansas*
 Filing Company: *Columbian Life Insurance Company* State Tracking Number:
 Company Tracking Number: *5671*
 TOI: *L071 Individual Life - Whole* Sub-TOI: *L071.202 Early Duration Reduced Benefit - Level
 Premium - Any Policy Design - Funeral Expense*
 Product Name: *Final Expense Application - A341*
 Project Name/Number: *CML/83/83*

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Life & Annuity - Actuarial Memo	Approved	Yes
Supporting Document	Authorization	Approved	Yes
Form	Application for Whole Life Insurance	Approved	Yes
Form	Application for Reinstatement	Approved	Yes

SERFF Tracking Number: FRCS-128002466 State: Arkansas
 Filing Company: Columbian Life Insurance Company State Tracking Number:
 Company Tracking Number: 5671
 TOI: L071 Individual Life - Whole Sub-TOI: L071.202 Early Duration Reduced Benefit - Level
 Premium - Any Policy Design - Funeral Expense
 Product Name: Final Expense Application - A341
 Project Name/Number: CML/83/83

Form Schedule

Lead Form Number: FORM NO. A341Y-CL

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 02/01/2012	FORM NO. A341Y-CL	Application/ Enrollment Form	Application for Whole Life Insurance	Revised	Replaced Form #: A336H-CL Previous Filing #:	45.600	A341Y-CL (AR-WV).pdf
Approved 02/01/2012	FORM NO. A342Y-CL	Application/ Enrollment Form	Application for Reinstatement	Revised	Replaced Form #: A340H-CL Previous Filing #:	44.200	A342Y-CL (AR-WV).pdf

APPLICATION FOR WHOLE LIFE INSURANCE POLICY

COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: CHICAGO, IL

ADMINISTRATIVE SERVICE OFFICE: [PO Box 4850, Norcross, GA 30091-4850]

MAIL POLICY TO: Agent Owner

1. PROPOSED INSURED:					
Proposed Insured (First, Middle Initial, Last)	Social Security Number	Sex	Age Last Birthday	Date of Birth	State of Birth
Home Address/Apt. #, City, State, Zip Code				Phone Number ()	

2. OWNER: (Complete only if Owner is other than Proposed Insured)		
Name of Owner	Social Security Number	Relationship to Proposed Insured
Mailing Address/ (If different from Insured)		

3. BENEFICIARY:	
Primary Beneficiary Designation: (Full Name & Relationship to Insured)	Contingent Beneficiary Designation: (Full Name & Relationship to Insured)

4. POLICY INFORMATION:	
[Please select your preference for receiving correspondence from us: <input type="checkbox"/> US Mail <input type="checkbox"/> Email (If you choose Email please make sure you supply your email address.)]	Email Address
Base Plan of Insurance: <input type="checkbox"/> Full Benefit Plan <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Tobacco	Amount of Base Premium (Minus Riders): \$ _____
Amount of Insurance (Face Amount): \$ _____	Riders: <input type="checkbox"/> Accidental Death Benefit <input type="checkbox"/> Accelerated Death Benefit <input type="checkbox"/> Waiver of Premium – Nursing Home <input type="checkbox"/> Waiver of Premium – Disability <input type="checkbox"/> Children's Term Insurance Rider <input type="checkbox"/> Family Income Rider * *Circle benefit per month (250 / 350 / 500)
	Rider Premium: \$ _____ (No Charge) \$ _____ \$ _____ \$ _____ \$ _____
	Amount Paid with Application: \$ _____

Payment Mode: Annual Semi-Annual Quarterly Monthly EFT Draft 1st Premium?
 (Draft date must be within 30 days of application date.)

Requested Effective Date: _____ Automatic Premium Loan: Yes No

5. HEALTH HISTORY:		YES	NO
PART 1 (If any question in this section is answered "YES," DO NOT SUBMIT THE APPLICATION)			
1.	Is the Proposed Insured currently hospitalized, confined to a nursing home, hospice, bed, or confined to a wheelchair (due to a disease or chronic illness), institutionalized, receiving home health care, ever been recommended for an organ or bone marrow transplant, or ever had a heart, lung, liver or bone marrow transplant, or ever had an amputation due to disease or, within the last twelve (12) months, received kidney dialysis?.....	<input type="checkbox"/>	<input type="checkbox"/>
2.	Has the Proposed Insured ever been diagnosed or treated by a member of the medical profession for an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or has the Proposed Insured tested positive for Human Immunodeficiency Virus (HIV) or been diagnosed as having a terminal medical condition that is expected to result in death within the next twelve (12) months?.....	<input type="checkbox"/>	<input type="checkbox"/>
3.	Has the Proposed Insured ever been diagnosed with, or received treatment for: mental retardation, Down's Syndrome, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, sickle cell anemia or un-operated heart defects?.....	<input type="checkbox"/>	<input type="checkbox"/>
4.	Has the Proposed Insured ever been diagnosed or received treatment (including taking medication) with congestive heart failure, Alzheimer's disease, dementia or Lou Gehrig's disease (ALS)?.....	<input type="checkbox"/>	<input type="checkbox"/>
5.	During the last twenty-four (24) months, has the Proposed Insured had, been diagnosed or received treatment (including taking medication) for any form of cancer (other than basal cell skin cancer)?.....	<input type="checkbox"/>	<input type="checkbox"/>
6.	During the last twelve (12) months has the Proposed Insured been diagnosed as having a heart attack?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Are you male and over 350 pounds, or are you female and over 300 pounds?	<input type="checkbox"/>	<input type="checkbox"/>
8.	During the last thirteen to twenty-four (13 - 24) months has the Proposed Insured been diagnosed as having a heart attack?	<input type="checkbox"/>	<input type="checkbox"/>
9.	During the last twenty-four (24) months, has the Proposed Insured been diagnosed as having: A stroke (including TIA), aneurysm, enlarged heart, angina, pacemaker implant or any procedure to improve circulation to the heart or brain?.....	<input type="checkbox"/>	<input type="checkbox"/>
10.	During the last thirty-six (36) months, has the Proposed Insured had, been diagnosed or received treatment (including taking medication) for:		
	A. Emphysema, chronic obstructive pulmonary disease (COPD), black lung disease, any chronic respiratory disorder (excluding asthma or sleep apnea), or used oxygen equipment to assist in breathing?.....	<input type="checkbox"/>	<input type="checkbox"/>
	B. Kidney disease, kidney failure, liver disease, chronic hepatitis, drug or alcohol abuse, or Systemic Lupus?.....	<input type="checkbox"/>	<input type="checkbox"/>
	C. Multiple Sclerosis, Parkinson's Disease, schizophrenia, brain tumor or has the Proposed Insured been hospitalized or institutionalized for a mental or nervous disorder within the last twenty-four (24) months?.....	<input type="checkbox"/>	<input type="checkbox"/>
11.	During the last twenty-four (24) months, has the Proposed Insured experienced complications of diabetes, including insulin shock, diabetic coma, Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve, circulatory) disorder, or diabetes not under control with current treatment, or has the Proposed Insured used insulin for the treatment of diabetes prior to age 50?.....	<input type="checkbox"/>	<input type="checkbox"/>

PART 2 TOBACCO USE		YES	NO
1. Within the past twelve (12) months, has the Proposed Insured used any form of tobacco or nicotine products including cigarettes, cigars, pipes, chewing tobacco or snuff?.....		<input type="checkbox"/>	<input type="checkbox"/>
PART 3 ANSWER ONLY IF APPLYING FOR THE NURSING HOME WAIVER OF PREMIUM RIDER		YES	NO
(If any question in Part 2 is answered "YES," the Proposed Insured is not eligible for this rider):			
Does the Proposed Insured currently use mechanical devices such as a wheelchair, crutches, hospital bed or oxygen; or currently need or require assistance from another person in bathing, eating, dressing, toileting, transferring from bed to chair or maintaining continence; or has the Proposed Insured received medical advice or treatment or consulted with a member of the medical profession for osteoporosis or memory loss?		<input type="checkbox"/>	<input type="checkbox"/>
6. REPLACEMENT:		YES	NO
Do you have any existing life insurance or annuities?.....		<input type="checkbox"/>	<input type="checkbox"/>
Is this application for insurance intended to replace any life insurance or annuities now in force?..... <i>(If "YES," submit any special forms required by the state in which the application is signed.)</i>		<input type="checkbox"/>	<input type="checkbox"/>
7. SPECIAL REQUESTS / REMARKS:			
8. CONDITIONS RELATING TO THE APPLICATION:			
I have read the questions and answers in all parts of this application and agree that they are complete and true to the best of my knowledge and belief. I agree that this application shall form a part of any policy issued. I understand and agree that no agent has the authority to waive a complete answer to any question in the application, pass on insurability, make or alter any contract, or waive any of the Company's other rights or requirements; that any policy applied for shall not take effect (except as provided in the Conditional Receipt bearing the same number as this application) unless and until the policy has been issued and delivered and the full first premium, according to the mode of payment selected by the applicant (as permitted by the Company) and stipulated in the policy, has been paid and accepted by the Company during the lifetime and condition of health of the Proposed Insured as stated in the application.			
9. AUTHORIZATION & ACKNOWLEDGMENT:			
I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance company, 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: <input type="checkbox"/> Yes <input type="checkbox"/> No (I understand I would receive a link via email to a secure location for my policy packet.)]			
<hr style="border: none; border-top: 1px solid black;"/>	X	<hr style="border: none; border-top: 1px solid black;"/>	(Date)
Date of Application		Signature of Proposed Insured (Parent/Guardian if 15 or under)	
<hr style="border: none; border-top: 1px solid black;"/>	X	<hr style="border: none; border-top: 1px solid black;"/>	(Date)
Dated At (City, State)		Signature of Owner (If other than Insured)	
10. REPORT OF LICENSED AGENT:			
Does the applicant have any existing life insurance or annuities?.....		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is this insurance intended to replace, in whole or part, any life insurance or annuities?.....		<input type="checkbox"/> YES	<input type="checkbox"/> NO
<i>(If "YES," submit any special forms required by the state in which the application is signed.)</i>			
HAS THE TELEPHONE INTERVIEW BEEN COMPLETED?		<input type="checkbox"/> YES	<input type="checkbox"/> 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.			
<hr style="border: none; border-top: 1px solid black;"/>	X	<hr style="border: none; border-top: 1px solid black;"/>	(Date)
Name of Licensed Agent (Print)		Signature of Licensed Agent <i>(required)</i>	
<hr style="border: none; border-top: 1px solid black;"/>		<hr style="border: none; border-top: 1px solid black;"/>	
Agent Number %	Second Agent Number %	Agent's State License ID No. (in jurisdictions where required)	
	(If Splitting)		

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: \$ _____

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 \$ _____ from the account detailed below.

Financial Institution: _____ Name of Bank Account Holder: _____

Account Type : Checking or Savings

Routing Number: [] [] [] [] [] [] [] [] [] [] Must have 9 digits in routing #

Account Number: [] Can have up to 17 positions in account #

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

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

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 # [] [] [] [] [] [] [] [] [] [] Must have 9 digits in routing #

Account # [] Can have up to 17 positions in account #

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

_____ Name of Bank Account Holder _____ Date X _____ 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 4850, Norcross, GA 30091-4850].

[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 Payment Received

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

Received from (Name) _____ the sum of _____ dollars. Columbian Life Insurance Company ("we") accepts this payment in connection with an application for insurance having the same date and number, to provide coverage under the following conditions:

EFFECTIVE DATE - The "effective date" is the date of the application or a specific effective date as requested in the application, whichever is later.

CONDITIONS - Insurance coverage will begin on the effective date only if on that date (1) you had paid the full first premium on the policy applied for; and (2) you are insurable and an acceptable risk for the amount and plan requested, and for the premium paid. Otherwise, we shall have no liability except to return your payment.

TERMINATION OF COVERAGE - Any insurance that results from this receipt will terminate immediately: (1) if we offer to refund your payment; or (2) if you have not received the policy within ninety (90) days after the date of this receipt. In this event, we will refund your payment.

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: [PO Box 4850, Norcross, GA 30091-4850]

NAME OF INSURED	POLICY NUMBER	AMOUNT RECEIVED	FOR THE OUTSTANDING PREMIUMS :	
		\$	FROM	THROUGH
CURRENT ADDRESS: STREET/RD:			APT #	
CITY:	STATE:	ZIP CODE:	PHONE NUMBER:	
[Please select your preference for receiving correspondence from us: <input type="checkbox"/> US Mail <input type="checkbox"/> Email (If you choose Email please make sure you supply your email address.)			Email Address	
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:				
Part 1			YES	NO
1.	Is the Insured currently hospitalized, confined to a nursing home, hospice, bed, or confined to a wheelchair (due to a disease or chronic illness), institutionalized, receiving home health care, ever been recommended for an organ or bone marrow transplant, or ever had a heart, lung, liver or bone marrow transplant, or ever had an amputation due to disease or, within the last twelve (12) months, received kidney dialysis?.....		<input type="checkbox"/>	<input type="checkbox"/>
2.	Has the Insured ever been diagnosed or treated by a member of the medical profession for an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or has the Insured tested positive for Human Immunodeficiency Virus (HIV), or been diagnosed as having a terminal medical condition that is expected to result in death within the next twelve (12) months?.....		<input type="checkbox"/>	<input type="checkbox"/>
3.	Has the Insured ever been diagnosed with, or received treatment for: mental retardation, Down's Syndrome, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, sickle cell anemia or un-operated heart defects?.....		<input type="checkbox"/>	<input type="checkbox"/>
4.	Has the Insured ever been diagnosed or received treatment (including taking medication) with congestive heart failure, Alzheimer's disease, dementia or Lou Gehrig's disease (ALS)?.....		<input type="checkbox"/>	<input type="checkbox"/>
5.	During the last twenty-four (24) months, has the Insured had, been diagnosed or received treatment (including taking medication) for any form of cancer (other than basal cell skin cancer)?.....		<input type="checkbox"/>	<input type="checkbox"/>
6.	During the last twelve (12) months has the Insured been diagnosed as having a heart attack?.....		<input type="checkbox"/>	<input type="checkbox"/>
7.	Are you male and over 350 pounds, or are you female and over 300 pounds?.....		<input type="checkbox"/>	<input type="checkbox"/>
8.	During the last thirteen to twenty-four (13-24) months has the Insured been diagnosed as having a heart attack?.....		<input type="checkbox"/>	<input type="checkbox"/>
9.	During the last twenty-four (24) months, has the Insured been diagnosed as having: A stroke (including TIA), aneurysm, enlarged heart, angina, pacemaker implant or any procedure to improve the circulation to the heart or brain?.....		<input type="checkbox"/>	<input type="checkbox"/>
10.	During the last thirty-six (36) months, has the Insured had, been diagnosed or received treatment (including taking medication) for:			
	A. Emphysema, chronic obstructive pulmonary disease (COPD), black lung disease, any chronic respiratory disorder (excluding asthma or sleep apnea), or used oxygen equipment to assist in breathing?.....		<input type="checkbox"/>	<input type="checkbox"/>
	B. Kidney disease, kidney failure, liver disease, chronic hepatitis, drug or alcohol abuse, or Systemic Lupus?.....		<input type="checkbox"/>	<input type="checkbox"/>
	C. Multiple Sclerosis, Parkinson's Disease, schizophrenia, brain tumor or has the Insured been hospitalized or institutionalized for a mental or nervous disorder within the last twenty-four (24) months?.....		<input type="checkbox"/>	<input type="checkbox"/>
11.	During the last twenty-four (24) months, has the Insured experienced complications of diabetes, including insulin shock, diabetic coma, Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve, circulatory) disorder, or diabetes not under control with current treatment, or has the Insured used insulin for the treatment of diabetes prior to age 50?.....		<input type="checkbox"/>	<input type="checkbox"/>
12.	Within the past twelve (12) months, has the Insured used any form of tobacco or nicotine products including cigarettes, cigars, pipes, chewing tobacco or snuff?.....		<input type="checkbox"/>	<input type="checkbox"/>
ANSWER ONLY IF APPLYING FOR REINSTATEMENT OF A POLICY WITH THE NURSING HOME WAIVER OF PREMIUM RIDER:				
Does the Insured currently use mechanical devices such as a wheelchair, crutches, hospital bed or oxygen; or currently need or require assistance from another person in bathing, eating, dressing, toileting, transferring from bed to chair or maintaining continence; or has the Insured received medical advice or treatment or consulted with a member of the medical profession for osteoporosis or memory loss?.....			<input type="checkbox"/>	<input type="checkbox"/>
ANSWER ONLY IF APPLYING FOR REINSTATEMENT OF A POLICY WITH THE CHILDREN'S TERM INSURANCE RIDER:				
1.	Has any Insured Child ever been diagnosed or treated for cancer, diabetes, heart or circulatory disorder, mental or nervous disorder, mental retardation, Down's Syndrome, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, un-operated heart defects, epilepsy, asthma, disorder of the muscles or bones, anemia to include sickle cell or other blood disorder, or been diagnosed or received treatment for a kidney, liver or lung disorder?.....		<input type="checkbox"/>	<input type="checkbox"/>
2.	Has any Insured Child ever been diagnosed or treated by a member of the medical profession for an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or has any Insured Child tested positive for Human Immunodeficiency Virus (HIV)?.....		<input type="checkbox"/>	<input type="checkbox"/>
3.	Has any Insured Child ever used or received treatment, advice or counseling from a physician or other practitioner relating to the usage of alcohol, heroin, cocaine, narcotics, hallucinogens, tranquilizers, barbiturates, amphetamines, or other similar drugs except as prescribed by a physician?.....		<input type="checkbox"/>	<input type="checkbox"/>
4.	Is any Insured Child currently institutionalized, hospitalized, confined to a wheelchair or bed due to chronic illness or disease or has any Insured Child had or been recommended for an organ transplant?.....		<input type="checkbox"/>	<input type="checkbox"/>

NO INSURANCE COVERAGE IS CREATED BY THIS RECEIPT

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

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

It is understood and agreed that reinstatement shall 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 _____ Agent's Signature _____ Agent Number _____

INFORMATION PRACTICES RELATING TO UNDERWRITING YOUR APPLICATION FOR REINSTATEMENT

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

INVESTIGATIVE CONSUMER REPORT

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

IDENTIFICATION

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

ACCESS TO INFORMATION

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

WHERE TO WRITE US

You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please send your written request to Underwriting Department, Columbian Life Insurance Company, [PO Box 4850, Norcross, GA 30091].

[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.]

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 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."

SERFF Tracking Number: FRCS-128002466 State: Arkansas
 Filing Company: Columbian Life Insurance Company State Tracking Number:
 Company Tracking Number: 5671
 TOI: L071 Individual Life - Whole Sub-TOI: L071.202 Early Duration Reduced Benefit - Level
 Premium - Any Policy Design - Funeral Expense
 Product Name: Final Expense Application - A341
 Project Name/Number: CML/83/83

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachments: AR RDB.pdf AR COC.pdf	Approved	02/01/2012
Satisfied - Item: Application Comments: The two forms that are for review are both applications.	Approved	02/01/2012
Bypassed - Item: Life & Annuity - Acturial Memo Bypass Reason: Not applicable for this application filing. Comments:	Approved	02/01/2012
Satisfied - Item: Authorization Comments: Attachment: Authorization.pdf	Approved	02/01/2012

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. A341Y-CL	45.6
FORM NO. A342Y-CL	44.2



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

January 20, 2012

Date

**STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE**

Company Name: Columbian Life Insurance Company
Form Title(s): Application for Whole Life Insurance Policy, Application for Reinstatement
Form Number(s): FORM NO. A341Y-CL, FORM NO. A342Y-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
Assistant Vice President, Policy Filing and
Assistant Secretary

January 20, 2012
Date

January 19, 2012

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: _____  _____

Title: Assistant Vice President, Policy
Filing and Assistant Secretary