

**State:** Arkansas **Filing Company:** Columbus Life Insurance Company  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** 2013 Citizenship Questionnaire CLIC  
**Project Name/Number:** 2013 Citizenship Questionnaire CLIC/2013 Citizenship Questionnaire CLIC

## Filing at a Glance

Company: Columbus Life Insurance Company  
Product Name: 2013 Citizenship Questionnaire CLIC  
State: Arkansas  
TOI: L08 Life - Other  
Sub-TOI: L08.000 Life - Other  
Filing Type: Form  
Date Submitted: 12/31/2012  
SERFF Tr Num: WSST-128829361  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: 2013 CITIZENSHIP QUESTIONNAIRE CLIC

Implementation  
Date Requested:  
Author(s): Ramona Piercefield, Kimberly Wright, Angelea Underwood, Kevin Ludwig, Stacey Gipson,  
Jaclyn Cox  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 01/08/2013  
Disposition Status: Approved-Closed  
Implementation Date:

State Filing Description:

State: Arkansas Filing Company: Columbus Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: 2013 Citizenship Questionnaire CLIC
Project Name/Number: 2013 Citizenship Questionnaire CLIC/2013 Citizenship Questionnaire CLIC

General Information

Project Name: 2013 Citizenship Questionnaire CLIC Status of Filing in Domicile: Pending
Project Number: 2013 Citizenship Questionnaire CLIC Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: filed in Ohio on 2/28/2012
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 01/08/2013
State Status Changed: 01/08/2013
Deemer Date: Created By: Jaclyn Cox
Submitted By: Jaclyn Cox Corresponding Filing Tracking Number:

Filing Description:
RE: CL 45.918-CT (2/13), Citizenship Questionnaire.

Columbus Life Insurance Company, NAIC # 99937

Dear Reviewer,

This filing is being submitted on behalf of the Columbus Life Insurance Company. The effective date of this questionnaire is February 2013.

CL 45.918 (2/13), a Citizen Questionnaire Form, is a Supplemental form that is intended to be used with the application to provide additional information on an applicant's citizenship. This form is not intended to replace any previous form.

The enclosed form is intended to be used with previously approved Application CL 45.300-A (6/09) which was approved on 12/03/2009 under SERFF tracking number WSST-126376987. The Questionnaire may also be used with Applications that may be approved in the future.

Columbus Life intends to allow applications for life insurance to be signed electronically. Please be aware that although the signing parties' signatures may be collected electronically, the application included in the policy at time of issue will be the same as if the form is signed by wet signature.

A Statement of Variability is attached explaining the bracketed items on the form.

This form is in final printed format.

Thank you for your consideration and we look forward to your approval.

Jaclyn Cox
Insurance Compliance Analyst
Columbus Life Insurance Company
1-800-446-0795 (6937)

Company and Contact

**State:** Arkansas **Filing Company:** Columbus Life Insurance Company  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** 2013 Citizenship Questionnaire CLIC  
**Project Name/Number:** 2013 Citizenship Questionnaire CLIC/2013 Citizenship Questionnaire CLIC

**Filing Contact Information**

Jaclyn Cox, Insurance Compliance analyst jaclyn.cox@wslife.com  
 400 Broadway 800-446-0798 [Phone] 6937 [Ext]  
 MS 03 513-357-4161 [FAX]  
 Cincinnati, OH 45202

**Filing Company Information**

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

**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? Yes  
 Fee Explanation: 50.00 per filing  
 Per Company: No

Company	Amount	Date Processed	Transaction #
Columbus Life Insurance Company	\$50.00	12/31/2012	66115289
Columbus Life Insurance Company	\$50.00	01/07/2013	66287323

**SERFF Tracking #:**

WSST-128829361

**State Tracking #:****Company Tracking #:**2013 CITIZENSHIP QUESTIONNAIRE  
CLIC**State:**

Arkansas

**Filing Company:**

Columbus Life Insurance Company

**TOI/Sub-TOI:**

L08 Life - Other/L08.000 Life - Other

**Product Name:**

2013 Citizenship Questionnaire CLIC

**Project Name/Number:**

2013 Citizenship Questionnaire CLIC/2013 Citizenship Questionnaire CLIC

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/08/2013	01/08/2013

### Objection Letters and Response Letters

#### Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Linda Bird	01/07/2013	01/07/2013

#### Response Letters

Responded By	Created On	Date Submitted
Jaclyn Cox	01/07/2013	01/07/2013

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Foreign Travel Questionnaire	Jaclyn Cox	01/03/2013	01/03/2013
Supporting Document	Flesch Certification	Jaclyn Cox	01/03/2013	01/03/2013

SERFF Tracking #:

WSST-128829361

State Tracking #:

Company Tracking #:

2013 CITIZENSHIP QUESTIONNAIRE  
CLIC

State:

Arkansas

Filing Company:

Columbus Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

2013 Citizenship Questionnaire CLIC

Project Name/Number:

2013 Citizenship Questionnaire CLIC/2013 Citizenship Questionnaire CLIC

## Disposition

Disposition Date: 01/08/2013

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document (revised)	Flesch Certification		Yes
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Statement of Variability		Yes
Form	Citizenship Questionnaire		Yes
Form	Foreign Travel Questionnaire		Yes

State: Arkansas Filing Company: Columbus Life Insurance Company  
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other  
Product Name: 2013 Citizenship Questionnaire CLIC  
Project Name/Number: 2013 Citizenship Questionnaire CLIC/2013 Citizenship Questionnaire CLIC

**Objection Letter**

Objection Letter Status Pending Industry Response  
Objection Letter Date 01/07/2013  
Submitted Date 01/07/2013  
Respond By Date 02/07/2013

Dear Jaclyn Cox,

**Introduction:**

*This will acknowledge receipt of the captioned filing.*

**Objection 1**

*Comments: We have not received the additional filing fee of \$50.00 for the Foreign Travel Questionnaire submitted on 1/3/13. We will hold your filing in a pending status until the additional \$50.00 filing fee is received.*

**Conclusion:**

*A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.*

*Please feel free to contact me if you have questions.*

*Sincerely,  
Linda Bird*

State: Arkansas Filing Company: Columbus Life Insurance Company  
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other  
Product Name: 2013 Citizenship Questionnaire CLIC  
Project Name/Number: 2013 Citizenship Questionnaire CLIC/2013 Citizenship Questionnaire CLIC

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 01/07/2013  
Submitted Date 01/07/2013

Dear Linda Bird,

**Introduction:**

Thank you for your letter on January 7, 2013.

**Response 1**

**Comments:**

The additional filing fees have been submitted.

**Related Objection 1**

Comments: We have not received the additional filing fee of \$50.00 for the Foreign Travel Questionnaire submitted on 1/3/13. We will hold your filing in a pending status until the additional \$50.00 filing fee is received.

**Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

**Conclusion:**

Thank you and I look forward to your approval.

Sincerely,

Jaclyn Cox

**SERFF Tracking #:**

WSST-128829361

**State Tracking #:****Company Tracking #:**2013 CITIZENSHIP QUESTIONNAIRE  
CLIC**State:**

Arkansas

**Filing Company:**

Columbus Life Insurance Company

**TOI/Sub-TOI:**

L08 Life - Other/L08.000 Life - Other

**Product Name:**

2013 Citizenship Questionnaire CLIC

**Project Name/Number:**

2013 Citizenship Questionnaire CLIC/2013 Citizenship Questionnaire CLIC

## Amendment Letter

Submitted Date: 01/03/2013

Comments:

Form CL 45.446 (2/13) Foreign Travel Questionnaire was not originally submitted with this filing. It has since been attached to this filing for review and approval. It is being used as supplemental form to the application to inquire details about an applicant's foreign travel.

This form has the same intent as 45.918 (2/13), as it will also be a supplemental form to the application as mentioned with CL 45.918 (2/13). It is not replacing any previously approved forms.

Additional filing fees will be submitted following this amendment.

I thank you and apologize for any inconvenience.

Changed Items:

### Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Foreign Travel Questionnaire	CL 45.446 (2/13)	AEF	Initial		68.000	CL_45-446-1302 bracketed.pdf	Date Submitted: 01/03/2013 By:

*No Rate Schedule Items Changed.*

SERFF Tracking #:

WSST-128829361

State Tracking #:

Company Tracking #:

2013 CITIZENSHIP QUESTIONNAIRE  
CLIC

State:

Arkansas

Filing Company:

Columbus Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

2013 Citizenship Questionnaire CLIC

Project Name/Number:

2013 Citizenship Questionnaire CLIC/2013 Citizenship Questionnaire CLIC

### Supporting Document Schedule Item Changes

Satisfied - Item:

Flesch Certification

Comments:

Attachment(s):

CLIC Flesch Certification STD (2).pdf

#### *Previous Version*

*Satisfied - Item:*

*Flesch Certification*

*Comments:*

*Attachment(s):*

*CLIC Flesch Certification STD.pdf*

SERFF Tracking #:

WSST-128829361

State Tracking #:

Company Tracking #:

2013 CITIZENSHIP QUESTIONNAIRE  
CLIC

State: Arkansas

Filing Company:

Columbus Life Insurance Company

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other

Product Name: 2013 Citizenship Questionnaire CLIC

Project Name/Number: 2013 Citizenship Questionnaire CLIC/2013 Citizenship Questionnaire CLIC

## Form Schedule

Lead Form Number: CL-45 918 (2/13)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Citizenship Questionnaire	CL 45.918 (2/13)	AEF	Initial		68.800	CL_45-918-1302 bracketed.pdf
2		Foreign Travel Questionnaire	CL 45.446 (2/13)	AEF	Initial		68.000	CL_45-446-1302 bracketed.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages



# Columbus Life Insurance Company

A member of Western & Southern Financial Group

400 EAST FOURTH STREET • CINCINNATI, OHIO 45202-3302 • 1-800-677-9696 • WWW.COLUMBUSLIFE.COM

## Citizenship Questionnaire

Name of Proposed Insured \_\_\_\_\_  
First Middle Last

1. Country of origin: \_\_\_\_\_ Current citizenship: \_\_\_\_\_

2. Date of entry into the United States: \_\_\_\_\_

3. Visa type: \_\_\_\_\_ Number: \_\_\_\_\_ Expiration date: \_\_\_\_\_

4. Do you also maintain a foreign residence?  No  Yes

If **YES**, what is the address? \_\_\_\_\_

5. What countries and cities will you visit within the next 24 months?

\_\_\_\_\_

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

\_\_\_\_\_

7. What will be the length of each stay? \_\_\_\_\_

8. What mode of transportation will be used while in foreign countries? \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

Signed At \_\_\_\_\_ Date \_\_\_\_\_  
City and State

\_\_\_\_\_  
Signature of Proposed Insured Signature of Owner, if other than Proposed Insured

Signature of Agent \_\_\_\_\_ Date \_\_\_\_\_



# Columbus Life Insurance Company

A member of Western & Southern Financial Group

400 EAST FOURTH STREET • CINCINNATI, OHIO 45202-3302 • 1-800-677-9696 • WWW.COLUMBUSLIFE.COM

## FOREIGN TRAVEL QUESTIONNAIRE

Name of Proposed Insured \_\_\_\_\_  
First Middle Last

1. What countries and cities will you visit within the next 24 months?  
\_\_\_\_\_
2. What is the purpose of each trip (business, personal, etc.)? \_\_\_\_\_  
If business, name & address of your employer and job duties while outside of U.S.: \_\_\_\_\_  
\_\_\_\_\_
3. Date of Departure from U.S.: \_\_\_\_\_
4. Date of return to U.S.: \_\_\_\_\_
5. What will be the length of each stay? \_\_\_\_\_
6. What mode of transportation will be used while in foreign countries? \_\_\_\_\_  
\_\_\_\_\_
7. What type of housing accommodations will be used (hotel, personal home, missionary family, etc.)?  
\_\_\_\_\_

Signed At \_\_\_\_\_ Date \_\_\_\_\_  
City and State

\_\_\_\_\_  
Signature of Proposed Insured Signature of Owner, if other than Proposed Insured

Signature of Agent \_\_\_\_\_ Date \_\_\_\_\_

**SERFF Tracking #:**

WSST-128829361

**State Tracking #:****Company Tracking #:**2013 CITIZENSHIP QUESTIONNAIRE  
CLIC**State:**

Arkansas

**Filing Company:**

Columbus Life Insurance Company

**TOI/Sub-TOI:**

L08 Life - Other/L08.000 Life - Other

**Product Name:**

2013 Citizenship Questionnaire CLIC

**Project Name/Number:**

2013 Citizenship Questionnaire CLIC/2013 Citizenship Questionnaire CLIC

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
CLIC Flesch Certification STD (2).pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
Satisfied - Item:	Application		
Comments:	Form CL 45.300-A (6/09), approved 12/03/2009, SERFF tracking number WSST-126376987		
Attachment(s):			
CL 45.300-A (6-09) John Doe-bracket.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):			
Statement of Variability Citizenship .pdf			

**Columbus Life Insurance Company**

NAIC CODE # 99937

**CERTIFICATION**

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

Form Numbers	Readability Score
CL 45.918 (2/13)	68.8
CL 45.446 (2/13)	68.0



---

Michael Moser  
Vice President and Chief Compliance Officer

Date: 12/28/2012



# Columbus Life Insurance Company

A member of Western & Southern Financial Group

400 EAST FOURTH STREET • CINCINNATI, OHIO 45202-3302 • 1-800-677-9696 • WWW.COLUMBUSLIFE.COM

New Business

Reinstatement of Policy # \_\_\_\_\_

## APPLICATION FOR LIFE INSURANCE – PART 1

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

### A. Proposed Insured 1

1. Name of Proposed Insured Male  Female   
John E. Doe

2. Date of Birth 06/01/1974 Age 35  
(mm/dd/yyyy)

3. Place of Birth (state/country) ST, USA

4. Social Security No. or Tax I.D. 123-45-6789

5. Drivers License No. and State ST 123456

6. Marital Status M

7. Employer ABC Company  
 Length Of Employment At This Business 5 years  
 Occupation Analyst  
 Duties \_\_\_\_\_

Earned Income \$45,000 Net Worth \$100,000

8. U.S. Citizen  Yes  No

**If No, complete the Citizenship Supplement CL 45.461.**

9. Home Address: Years at Address 5 E-mail john.doe@dmail.com  
123 Main Street  
Street/Apt No.  
City, ST 45678  
City State Zip Code

10. Home Phone (513) 555-6789 Alternate Phone \_\_\_\_\_

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

1. Name of Proposed Insured Male  Female   
 \_\_\_\_\_

2. Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
(mm/dd/yyyy)

3. Place of Birth (state/country) \_\_\_\_\_

4. Social Security No. or Tax I.D. \_\_\_\_\_

5. Drivers License No. and State \_\_\_\_\_

6. Marital Status \_\_\_\_\_

7. Employer \_\_\_\_\_  
 Length Of Employment At This Business \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Duties \_\_\_\_\_

Earned Income \_\_\_\_\_ Net Worth \_\_\_\_\_

8. U.S. Citizen  Yes  No

**If No, complete the Citizenship Supplement CL 45.461.**

9. Home Address and Phone Information: E-mail \_\_\_\_\_  
 Same as Proposed Insured 1  
 Different; Provide information below:  
 \_\_\_\_\_  
 \_\_\_\_\_

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

Plan of Insurance <u>Term</u>	Term Plans Only,	\$ <u>100,000</u>
If UL or VUL, select Death Benefit Option:	Select Term Period:	Base Amount
<input type="checkbox"/> 1 – Level Death Benefit	<input type="checkbox"/> Ten Year	\$ _____
<input type="checkbox"/> 2 – Specified Amount plus Cash Value	<input checked="" type="checkbox"/> Twenty Year	Supplemental Coverage Rider (SCR) Amount
If UL, select Life Insurance Qualification Test	<input type="checkbox"/> Thirty Year	(if applicable)
<input type="checkbox"/> Guideline Premium (default, if none selected)	<input type="checkbox"/> _____ Year	\$ _____
<input type="checkbox"/> Cash Value Accumulation (not available with all plans)		Total Base Plus SCR Amount

### D. Optional Benefits and Riders.

Universal Life Only: <input type="checkbox"/> No-Lapse Guarantee: <input type="checkbox"/> Intermediate <input type="checkbox"/> Lifetime <input type="checkbox"/> Capital Transfer <input type="checkbox"/> Disability Credit: indicate Monthly Credit Amount \$ _____ <input type="checkbox"/> Term Rider: Check one: <input type="checkbox"/> 20 Years <input type="checkbox"/> 30 Years \$ _____ <input type="checkbox"/> Extended Maturity Plus: <input type="checkbox"/> Pay at Issue, or <input type="checkbox"/> Pay at Age 80 <input type="checkbox"/> Change of Insured <input type="checkbox"/> Enhanced Cash Value <input type="checkbox"/> Estate Protection Rider	Term Plans Only: <input checked="" type="checkbox"/> Return of Premium <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Accidental Death/Specific Loss Universal Life and Term: <input type="checkbox"/> Accidental Death \$ _____ <input type="checkbox"/> Insured Insurability \$ _____ <input type="checkbox"/> Other Insured \$ _____ <input type="checkbox"/> Children's Term <b>(complete supplement form CL 45.458)</b> For Voyager only, you may select a shorter No-Lapse Guarantee than the Lifetime No-Lapse: <input type="checkbox"/> To age 90 <input type="checkbox"/> To age 95 <input type="checkbox"/> To age 100
--	--

### E. Child as Primary Proposed Insured

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

1. Is Applicant a Parent or Legal Guardian (attach proof of guardianship) of proposed Insured?  Yes  No

2. Is Applicant employed and providing Proposed Insured's main support?  Yes  No

3. Is all life insurance in force on Applicant at least equal to 2 times that on Proposed Insured?  Yes  No

4. Are all other children in family insured or to be insured for an amount at least equal to that on Proposed Insured?  Yes  No

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

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

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

**G. Beneficiaries**

	Name	Relationship	%
Primary:	Jane Doe	Wife	100
Primary <input type="checkbox"/> Secondary <input type="checkbox"/>	_____	_____	_____
Primary <input type="checkbox"/> Secondary <input type="checkbox"/>	_____	_____	_____

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

Modal Premium Amount \$ 1000 Mode A (Note: 2 months premium required for monthly PAT mode)  
 Total Amount Paid at time of Application. If none, indicate zero or leave blank \$ \_\_\_\_\_  
**Payer Name and Address if other than Owner** (if not the same as home address in section A) – please print.  
 \_\_\_\_\_  
First Name M.I. Last Name Street Address or P.O. Box Number  
 \_\_\_\_\_  
City State Zip Code  
 Relationship to Proposed Insured \_\_\_\_\_

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

	Proposed Owner	Proposed Insured 1 If other than Owner	Proposed Insured 2 If other than Owner
1. Have you been involved in any discussion about the possible sale or assignment of this policy to a life, settlement, viatical or other secondary market provider?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever sold a policy to a life, settlement, viatical or other secondary market provider?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Will any portion of the premiums for this policy be financed? .....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
4. Will any insured or policy owner receive any payment in connection with insurance issued on the basis of this application? .....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

For **Yes** answers to questions 1, 2, 3 or 4, please give details:

**J. Life Insurance In Force, Pending or Replacement.**

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

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

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

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

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

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

For **Yes** answers, complete Details section below.

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

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

Question No. and Proposed Insured	Details

**L. Personal Physician Information**

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

**M. Additional Remarks**

--

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

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

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

<b>Medical Information Details</b>			
Details of <b>Yes</b> answers to the above questions 1-5.			
Question No. and name of proposed insured.	Physicians, hospitals, illness, treatment, medical information, reason for checkup.	Dates and duration of illness.	Name, address, phone number of medical professionals, hospitals.

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

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

The purpose for this disclosure is for Columbus Life Insurance Company to 1) underwrite applications for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine full responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I/we have or have applied for with Columbus Life Insurance Company.

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

### AGREEMENT AND ACKNOWLEDGEMENT

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

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

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

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

I have read and understand the Accelerated Death Benefit Disclosure Statement. I have received 1) a Privacy Policy Disclosure which details the method I must use to exercise my right to access, correct and amend any information gathered about me or my children which relates to this application; and 2) Disclosures Regarding Insurance Information Practices, including the MIB, Inc Pre-Notice.

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

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

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

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

Signature of Applicant/Owner if other than Proposed Insured

Signature of Proposed Insured 2

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

Ima Agent \_\_\_\_\_ 98765 \_\_\_\_\_  
Agent's Name (Please Print) License No.  
Signature of Agent Ima Agent /s/ \_\_\_\_\_ Date 1/4/2010 \_\_\_\_\_

## **Statement of Variability**

December 28, 2012

The variable information is identified by brackets and may change as indicated below. Any changes will be submitted for prior approval in a revised Memorandum of Variable Material.

**Company Logo:** The flexibility to change our logo does include the Company name. We understand if our Company name changes for any reason, we must notify the department accordingly.

**Company Address, website and customer service:** The flexibility to change our company address, website and contact telephone number, should such items change in the future.

**Page Numbers:** Page numbers will vary based on formatting.