

State: Arkansas **Filing Company:** Columbus Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: CL 45.300 (01/13)/MIB/rp
Project Name/Number: CL 45.300 (01/13)/MIB/rp/CL 45.300 (01/13)/MIB/rp

Filing at a Glance

Company: Columbus Life Insurance Company
Product Name: CL 45.300 (01/13)/MIB/rp
State: Arkansas
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form
Date Submitted: 01/09/2013
SERFF Tr Num: WSST-128841725
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: CL 45.300 (01/13)

Implementation: On Approval
Date Requested:
Author(s): Ramona Piercefield, Kim Wright, Angelea Underwood, Jaclyn Cox
Reviewer(s): Linda Bird (primary)
Disposition Date: 01/14/2013
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: CL 45.300 (01/13)/MIB/rp
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General Information

Project Name: CL 45.300 (01/13)/MIB/rp Status of Filing in Domicile: Authorized
 Project Number: CL 45.300 (01/13)/MIB/rp Date Approved in Domicile: 12/11/2012
 Requested Filing Mode: Review & Approval Domicile Status Comments: Ohio is our state of domicile.
 Application ICC09 CL 45.300 (6/09) (Revised 1/13) was approved through the IIPRC
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Individual Market Type:
 Overall Rate Impact: Filing Status Changed: 01/14/2013
 State Status Changed: 01/14/2013
 Deemer Date: Created By: Ramona Piercefield
 Submitted By: Ramona Piercefield Corresponding Filing Tracking Number:

Filing Description:
 RE: Columbus Life Insurance Company – NAIC Code # 99937
 CL 45.300-A (01/13), Application for Life Insurance

Dear Reviewer:

The above referenced form is being submitted in “John Doe” fashion for review and approval. The application is intended to replace previously state approved form CL 45.300-A (6/09), approved on December 3, 2009, under SERFF Tracking #WSST-126376987.

The following changes have been made to the application:

The edition date was changed to (01/13)

On page 1, #8, the form number was removed from the instructions.

On page 1, Item C, Coverage Applied For, the instructions were updated and “Fifteen Year” after “Ten Year” was added.

On page 1, Item D. Optional Benefits and Riders, the instructions for Children Term Rider were updated.

On page 3, K. Lifestyle Information on Proposed Insured 1 and Proposed Insured 2, instructions were added to #8.

On page 5, AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION, the MIB language was updated per regulation effective 1/1/2013.

This application is intended to be marketed on an individual basis by licensed insurance producers.

Statement of Variability

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

Format

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

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change in language will occur.

Thank you for your assistance with this filing.

We look forward to your review and approval. Please do not hesitate to contact me with any questions or concerns.

Ramona Piercefield
 Insurance Compliance Analyst
 Insurance Compliance
 1-800-446-0795 (1873)

Company and Contact

Filing Contact Information

Ramona Piercefield, Product & State Filing Analyst
 Ramona.Piercefield@wslife.com
 400 Broadway
 Cincinnati, OH 45202
 800-446-0795 [Phone] 1873 [Ext]
 513-357-4123 [FAX]

Filing Company Information

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

Filing Fees

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

Company	Amount	Date Processed	Transaction #
Columbus Life Insurance Company	\$50.00	01/09/2013	66387765

State: Arkansas Filing Company: Columbus Life Insurance Company
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/14/2013	01/14/2013

SERFF Tracking #:

WSST-128841725

State Tracking #:

Company Tracking #:

CL 45.300 (01/13)

State:

Arkansas

Filing Company:

Columbus Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

CL 45.300 (01/13)/MIB/rp

Project Name/Number:

CL 45.300 (01/13)/MIB/rp/CL 45.300 (01/13)/MIB/rp

Disposition

Disposition Date: 01/14/2013

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Form	CL 45.300-A (01/13)		Yes

SERFF Tracking #:

WSST-128841725

State Tracking #:

Company Tracking #:

CL 45.300 (01/13)

State: Arkansas
 TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
 Product Name: CL 45.300 (01/13)/MIB/rp
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Filing Company: Columbus Life Insurance Company

Form Schedule

Lead Form Number: CL 45.300-A (01/13)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		CL 45.300-A (01/13)	Application for Life Insurance	AEF	Initial		50.000	CL 45.300-A (01-13) John Doe-bracket.pdf

Form Type Legend:

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

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.

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.

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

C. Coverage Applied For. (If VUL, complete VUL Supplement; If Indexed UL, complete Premium Allocation Election.)

Plan of Insurance Term

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

If UL, select Life Insurance Qualification Test
 Cash Value Accumulation (default, if none selected; not available for all plans)
 Guideline Premium (automatic if Cash Value Accumulation is not available)

Term Plans Only, Select Term Period:
 Ten Year
 Fifteen Year
 Twenty Year
 Thirty Year

\$ 100,000
Base Amount

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

\$ _____
Total Base Plus SCR Amount

D. Optional Benefits and Riders.

Universal Life Only:
 No-Lapse Guarantee: Intermediate Lifetime
 Income Rider (Enhanced Value Rider)
 Disability Credit: indicate Monthly Credit Amount \$ _____
 Extended Maturity Plus: Pay at Issue, or Pay at Age 80
 Change of Insured
 Enhanced Cash Value
 Estate Protection Rider
 Capital Transfer (Enhanced No-Lapse Guarantee) must select one below:
 Death Benefit Return of Premium Accumulation

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

Universal Life and Term:
 Accidental Death \$ _____
 Insured Insurability \$ _____
 Other Insured \$ _____
 Children's Term (**complete Child Term Rider supplement**)

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

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 F) 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 No , select the answer that best describes tobacco/nicotine product history. Proposed Insured 1: Quit: Over <input type="checkbox"/> 5, <input type="checkbox"/> 2, <input type="checkbox"/> 1 year(s) ago <input checked="" type="checkbox"/> Never Used Proposed Insured 2: 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 Yes , list where, when, purpose and duration in the Details section. If Yes, complete a Supplemental Questionnaire.	<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 Yes, complete a Supplemental Questionnaire.	<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 Yes, complete a Supplemental Questionnaire.	<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 Yes , 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 Yes , 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

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Complete this section unless a full paramedic exam or medical exam is required on the Proposed Insured(s). 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	_____

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

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

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

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

I also authorize the Columbus Life Insurance Company or its reinsurers to release any information collected about me or my minor child(ren) to MIB, Inc. and to other insurance companies with whom I may apply for insurance.

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

SERFF Tracking #:

WSST-128841725

State Tracking #:

Company Tracking #:

CL 45.300 (01/13)

State:

Arkansas

Filing Company:

Columbus Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

CL 45.300 (01/13)/MIB/rp

Project Name/Number:

CL 45.300 (01/13)/MIB/rp/CL 45.300 (01/13)/MIB/rp

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
CL 45.300-A (01-13) Flesch Certification.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):			
CL 45.300-A (01-13) Statement of Variability.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 45.300-A (01/13), Application for Life Insurance*	50

*Flesched with CL 89 0707, Flexible Premium Survivorship Universal Life Insurance Policy



Michael Moser
VP & Chief Compliance Officer

Date: 1/9/2013

Statement of Variability

CL 45.300-A (01/13) Application for Life Insurance

Columbus Life Insurance Company – NAIC 99937

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

1. Company Logo

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

2. Administrative Address

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

3. Marketing Names and Administrative Forms

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

4. Part A. Proposed Insured 1

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

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

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

6. Part C. Coverage Applied For

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

7. Part D. Optional Benefits and Riders

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

8. Page Numbers

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

9. Part E. Child as Primary Proposed Insured

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

10. Part F. Owner of Policy

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

11. Part G. Beneficiaries

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

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

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

13. Part I. Premium Financing

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

14. Authorization to Obtain Information

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

15. Agent/Producer's Certification

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

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