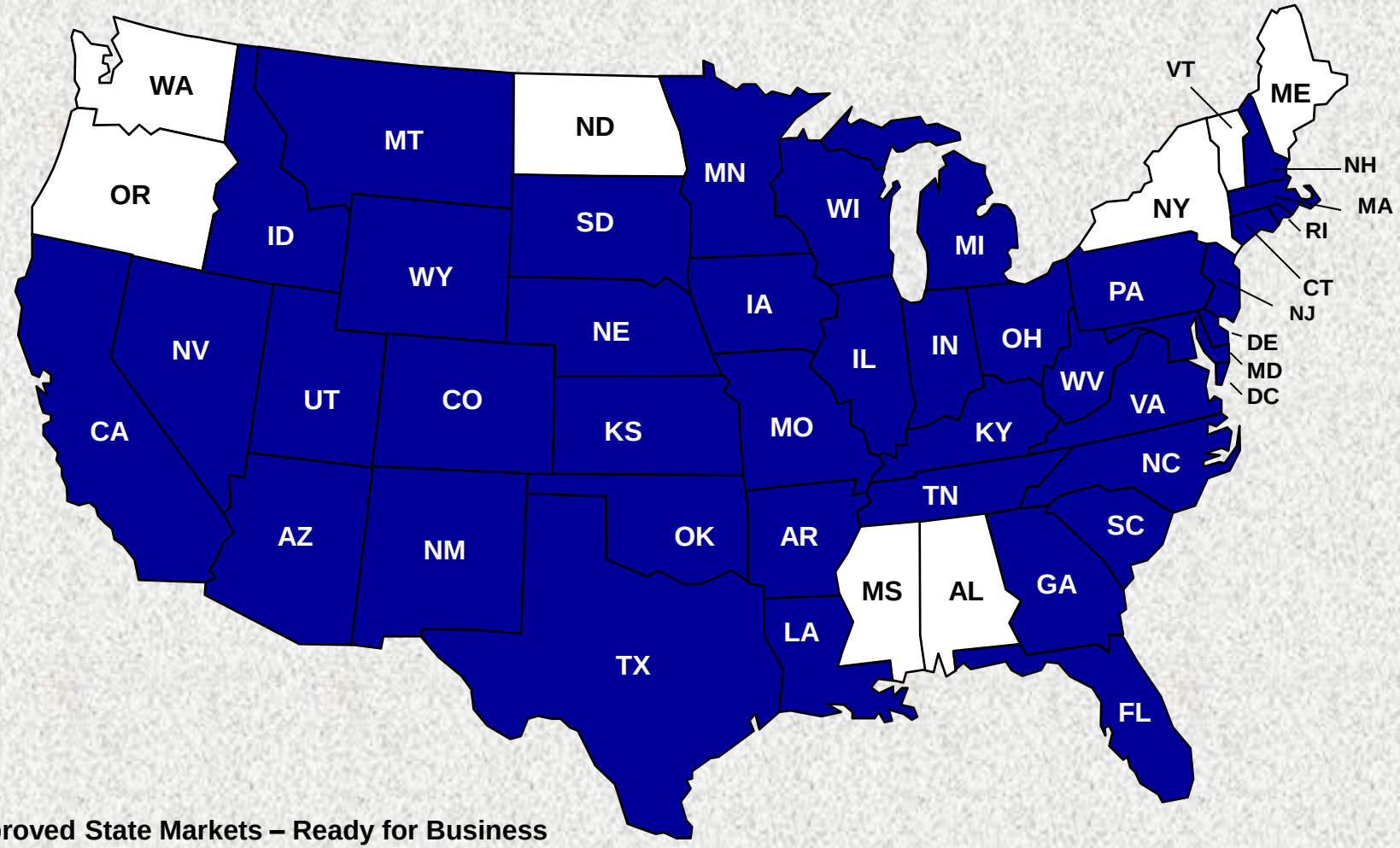
SafeShield®

Simplified Issue Term Life

State Markets



Approved State Markets – Ready for Business

Arkansas	Florida	Kansas	Missouri	New Mexico	South Carolina	West Virginia
Arizona	Georgia	Kentucky	Montana	Nevada	South Dakota	Wyoming
California	Hawaii	Louisiana	New Hampshire	North Carolina	Tennessee	
Colorado	Iowa	Massachusetts	New Jersey	Ohio	Texas	
Connecticut	Idaho	Maryland	Nebraska	Oklahoma	Utah	
District of Colombia	Illinois	Michigan	New Hampshire	Pennsylvania	Virginia	
Delaware	Indiana	Minnesota	New Jersey	Rhode Island	Wisconsin	

SafeShield® Product Overview

- Level benefit term insurance renewable to age 95
- SafeShield® available with initial level premiums for 15, 20 or 30 years
- SafeShield® *Plus* available with initial level premiums for 20 or 30 years. SafeShield® *Plus* returns 50% or 100% of base policy premiums at the end of the initial term period.
- Unemployment Premium Waiver included with the policy at no additional cost, where allowed by state.
- Accelerated Benefit Rider, Accidental Death Benefit Rider, Children's Insurance Rider, Disability Waiver of Premium Rider and Disability Income Rider available.

Policy/Rider availability and specifications may vary by state.

SafeShield® Policy Overview

Issue Amounts $25,000 - $250,000

Issue Ages
(Age Last Birthday)

SafeShield℠	SafeShield℠ *Plus*	
Non-ROP	**50% ROP**	**100% ROP**
15 YT: 18 – 65	20 YT: 18 – 60	20 YT: Non Tob: 18 – 50
20 YT: 18 – 60	30 YT: 18 – 50	20 YT: Tob: 18 – 45
30 YT: 18 – 55		30 YT: 18 – 50

Underwriting
- Simplified Issue
- Tobacco and Non-Tobacco Classes
- Standard issue only, through Table D

Conversions Convertible after the first policy anniversary:
- **15-Year Term:** Through year 10 or to age 65 if earlier
- **20-Year Term:** Through year 15 or to age 65 if earlier
- **30-Year Term:** Through year 25 or to age 65 if earlier

Policy availability and specifications may vary by state.

SafeShield® Policy Overview

Unemployment Premium Waiver

This benefit is automatically included with the policy at no additional cost, where allowed by state. If the insured becomes unemployed after the 2nd policy anniversary, all premiums for up to six months will be waived while the insured remains unemployed.

- The benefit has a two-year waiting period. The policy must be in effect for 24 months before unemployment begins.

- The benefit has a four-week elimination period. The insured must be collecting state or federal unemployment benefits for four weeks before premiums will be waived.

- The benefit has a six-month lifetime maximum. Premiums will not be waived for unemployment for more than a total of six months over the life of the policy.

SafeShield® Rider Overview

Accelerated Benefit Rider	50% advance on base policy benefit for terminal condition and life expectancy of 12 months or less (24 months in TX).
Accidental Death Benefit	Additional benefit equal to the face amount of the policy for accidental death. Rider remains in effect to the first policy anniversary on or after the insured's 70th birthday. $250,000 maximum ADB for all Columbian policies combined.
Children's Term Rider	Each Unit provides $1,000 level, convertible term coverage on all eligible children to each child's age 25. Children becoming eligible after rider issue are automatically covered. Available from 5 to 15 Units.
Disability Waiver	Waives premiums after six months of total and continuous disability. If disability begins before age 60, premiums will continue to be waived until disability ends. If disability begins on or after the 60th birthday, premiums will resume at age 65 or when disability ends, whichever occurs first.

Rider availability and specifications may vary by state.

SafeShield® Rider Overview

Disability Income Rider

Provides for a monthly benefit after 90 days of total disability due to accident or illness.

There are two versions of this rider:

- **The Off-the-job rider** is available to those who are covered by Worker's Compensation insurance at their job. This rider does not provide benefits for occupational disabilities.

- **The Occupational rider** is available for those who are not covered by Worker's Compensation insurance. Certain occupations are excluded (i.e. Mining, Off-Shore Workers). Contact the Home Office with questions. There are no restrictions on the cause of disability.

Rider availability and specifications may vary by state.

SafeShield® Rider Overview

Disability Income Rider

Benefit Period Year 1 - Own Occupation: Benefits will be paid during the first 12 months following the 90-day Waiting Period if the Insured is unable to perform *all of the duties of his or her occupation*.

Benefit Period Year 2 - Any Occupation: After 12 months following the 90-day Waiting Period, benefits will be paid if the Insured is unable to perform *the duties of any occupation for which the Insured may qualify by training, education or experience*.

Minimum Monthly Benefit: $250
Maximum Monthly Benefit is the lesser of:

- $2,000 per month; or
- 1.5% of base insurance face amount; or
- 50% of the insured's gross monthly income

The rider has a 24-month lifetime maximum benefit. Once a total of 24 months has been paid, the rider terminates.

Coordination of Benefits: Benefits will NOT be reduced by receipt of disability income from other sources.

Rider availability and specifications may vary by state.

SafeShield® Rider Overview

Disability Income Rider

Maximum Monthly Benefit Example

Maximum monthly benefit is the lesser of:
- $2,000 per month; or
- 1.5% of base insurance face amount; or
- 50% of the insured's gross monthly income

For this example, the base insurance face amount is $100,000 and the insured's gross monthly income is $5,000.

Maximum monthly benefit is the lesser of:
- **$2,000** per month; or
- **$1,500** (1.5% face amount); or
- **$2,500** (50% of gross monthly income)

In this example, the maximum monthly benefit amount is **$1,500**.

SafeShield® Calculator

Use the SafeShield® Calculator for quick calculations.

SafeShield℠ Simplified Issue Term Life

Input parameters in cells with yellow background.	Requested Benefits	Allowable Benefits*	Premium	Input Premium (if desired)
Plan Type	100% Return of Premium	100% Return of Premium		
Level Premium Period	15	20		
Issue Age (Age Last Birthday)	45	45		
Tobacco Class	Non-Tobacco	Non-Tobacco		
Premium Mode	Monthly EFT	Monthly EFT		0.00
Base Policy Face Amount	250,000.00	250,000.00	377.92	Otherwise leave at zero
Children's Insurance Rider Face Amount	7,000.00	7,000.00	3.50	
Accidental Death Benefit Rider (ADB)	Yes	Yes	22.50	
Waiver of Premium (WP)	Yes	Yes	58.96	
Disability Income Rider (Income/month)	700.00	700.00	17.26	Disability Income Rider premium guaranteed for first year only.
Monthly Gross Income (required for DI rider)	2,000.00			
Disability Rider Type	Occupational	Occupational		
		Total Modal Premium	**480.14**	

Return of Premium Benefit at end of year 20 at age 65 **$90,700.00**

*** Any benefits shown in red have been adjusted to conform with product issue limits.**

Input parameters in yellow cells.

If the parameters entered are not available, the calculator will suggest an alternative in red. The 100% ROP plan is not available with 15-year level term, so an allowed term is shown.

This message appears only when a return of premium plan is selected.

SafeShield℠ Simplified Issue Term Life

Input parameters in cells with yellow background.	Requested Benefits	Allowable Benefits*	Premium	Input Premium (if desired)
Plan Type	Non Return of Premium	Non Return of Premium		To adjust Base Face Amount to achieve a specified modal premium, input Total Modal Premium here:
Level Premium Period	30	30		
Issue Age (Age Last Birthday)	45	45		
Tobacco Class	Non-Tobacco	Non-Tobacco		
Premium Mode	Monthly EFT	Monthly EFT		200.00
Base Policy Face Amount	250,000.00	237,259.00	149.50	Otherwise leave at zero
Children's Insurance Rider Face Amount	7,000.00	7,000.00	3.65	Exact premium may vary due to rounding
Accidental Death Benefit Rider (ADB)	Yes		22.29	
Waiver of Premium (WP)	Yes		24.56	
Disability Income Rider (Income/month)	0.00		0.00	
Monthly Gross Income (required for DI rider)	0.00			
Disability Rider Type	Occupational			
		Total Mod	**200.00**	

*** Any benefits shown in red have been adjusted to conform with product issue limits.**

Face amount based on premium amount entered will be shown here.

To calculate face amount based on premium, enter the premium amount here.

Application Sample

5. HEALTH HISTORY

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

Disregard this question.

Include Driver's License number and state of issue.

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

Detail any "yes" answers.

Application questions may vary by state.

Application Sample

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

TABLE FOR "YES" ANSWERS IN SECTIONS B OR C

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

Detail any "yes" answers.

Application questions may vary by state.

Application Sample

6. ANSWER ONLY IF APPLYING FOR THE DISABILITY INCOME RIDER	YES	NO
Are you currently covered by Workers Compensation?	☐	☐
(If yes, you are only eligible to apply for an Off-the-Job Disability Income Rider. If so, skip to question #3.)		
Occupation Information:		
a. Description of duties _____		
b. Have you been working full-time (at least 30 hours per week) for the last 12 months?	☐	☐
c. If self-employed, % of time working at home? _____		
What is the monthly amount of any individual disability insurance you have in force? _____		
In the past ten (10) years, have you received care or treatment for, or been diagnosed by a member of the medical profession as having:		
a. Fibromyalgia, Chronic Fatigue Syndrome, Chronic Epstein-Barr, Rheumatoid Arthritis or other inflammatory arthritis?	☐	☐
b. Inflammatory Bowel Disease including Crohn's Disease or Ulcerative Colitis, Diabetes, Skin or Connective Tissue Disorder?	☐	☐
c. Disease or impairment of the spinal column, neck or back, including acute and Chronic neck or back strain; herniated disc syndrome, surgery of the spine or back, acute and chronic sciatica, or congenital disorders of the spinal column and back?	☐	☐
d. Recurring disease or impairment of other bones or joints, e.g. wrist, knee, or shoulder?	☐	☐
e. Any emotional or psychological disorder, including stress, anxiety, depression or nervous system disorder (including Grand mal Epilepsy)?	☐	☐
In the past five (5) years, have you filed for or received Disability, Worker's Compensation or State Disability benefits?	☐	☐
If yes, please provide details _____		

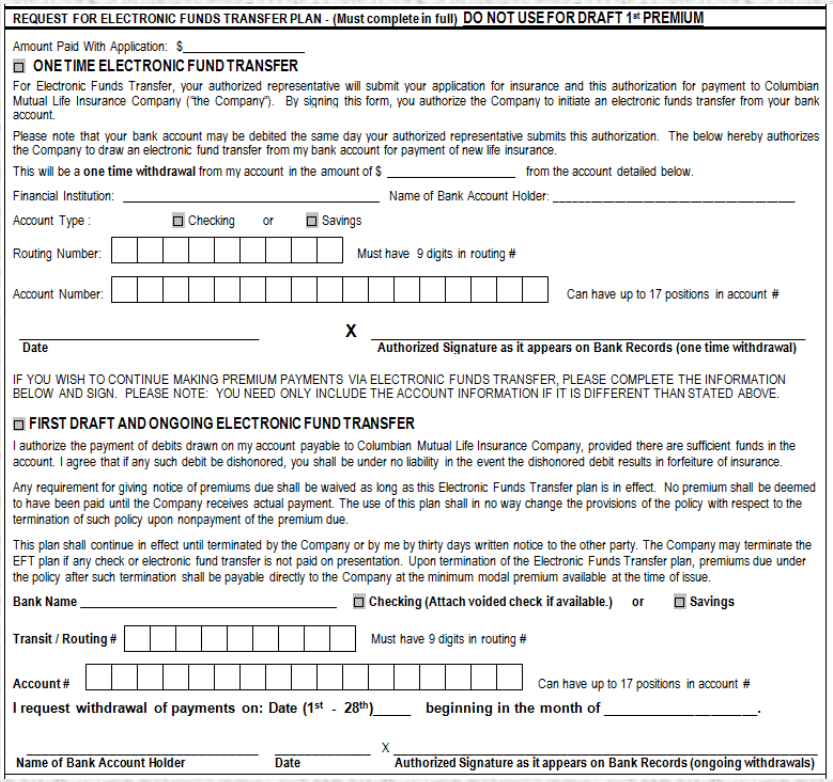
Application questions may vary by state.

Electronic Fund Transfers

When completing the Electronic Fund Transfer section of the application, please remember the following:

One Time Electronic Fund Transfer

- Complete this section for **immediate draft** of the initial premium, i.e., “cash with app.”
- You do not need to collect a check with the application, but if you do, enter the amount paid. Be sure to complete the One Time Electronic Fund Transfer section and obtain the authorized signature even if you are submitting a check.
- **The initial premium will be drafted immediately upon receipt of the application.**
- ***Do not complete this section if the initial premium is not intended to be drafted immediately.*** To specify a later date for the initial premium to be drawn, see the instructions below for the First Draft and Ongoing Electronic Fund Transfer section.
- The effective date of the policy will either be the application date or the underwriting approval date. If the underwriting approval date would result in a higher premium due to a change in age, the policy will be backdated to save age.



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 authorized representative will submit your application for insurance and this authorization for payment to Columbian Mutual 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 authorized representative 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 #

_____ X _____

Date 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 Mutual 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: Date (1st - 28th)____ beginning in the month of _____.

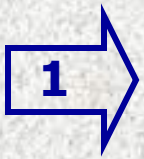
_____ _____ X _____

Name of Bank Account Holder Date Authorized Signature as it appears on Bank Records (ongoing withdrawals)

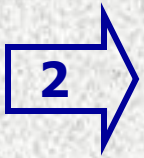
First Draft and Ongoing Electronic Fund Transfer

- Complete this section to specify a **later date** for the first premium to be drafted and/or for ongoing premiums to be drafted. The draft date can be any day between the 1st and the 28th of the month but must be within 30 days of the application date. **Please do not request “Draft on Approval.”**
- The policy effective date will be the date of the first draft. Commissions are not payable until the first premium has been drafted.

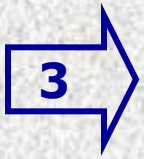
Underwriting Workflow



Complete the application, asking all questions in the Health History section.
- If the applicant has a driver's license, be sure to include the Driver's License Number and state of issue.
- If any questions in Section B or C are answered "yes," provide details in the spaces provided below the questions.



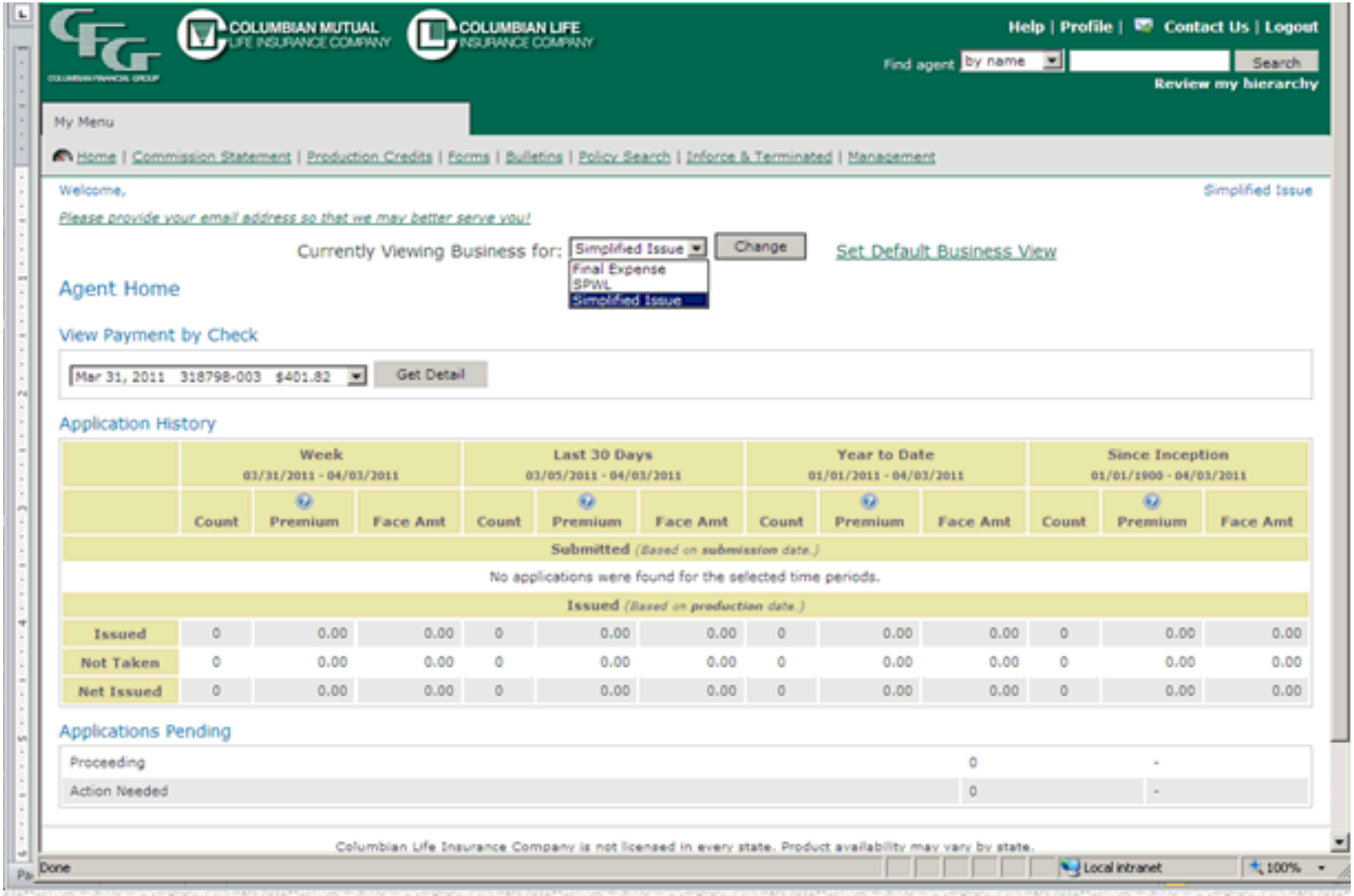
Submit the application and any required forms to your Agency Manager.



Upon receipt of the application, Columbian will perform an MIB check, prescription drug database check and Motor Vehicle Report check. A telephone interview may be conducted if necessary to follow up on any of the above items.

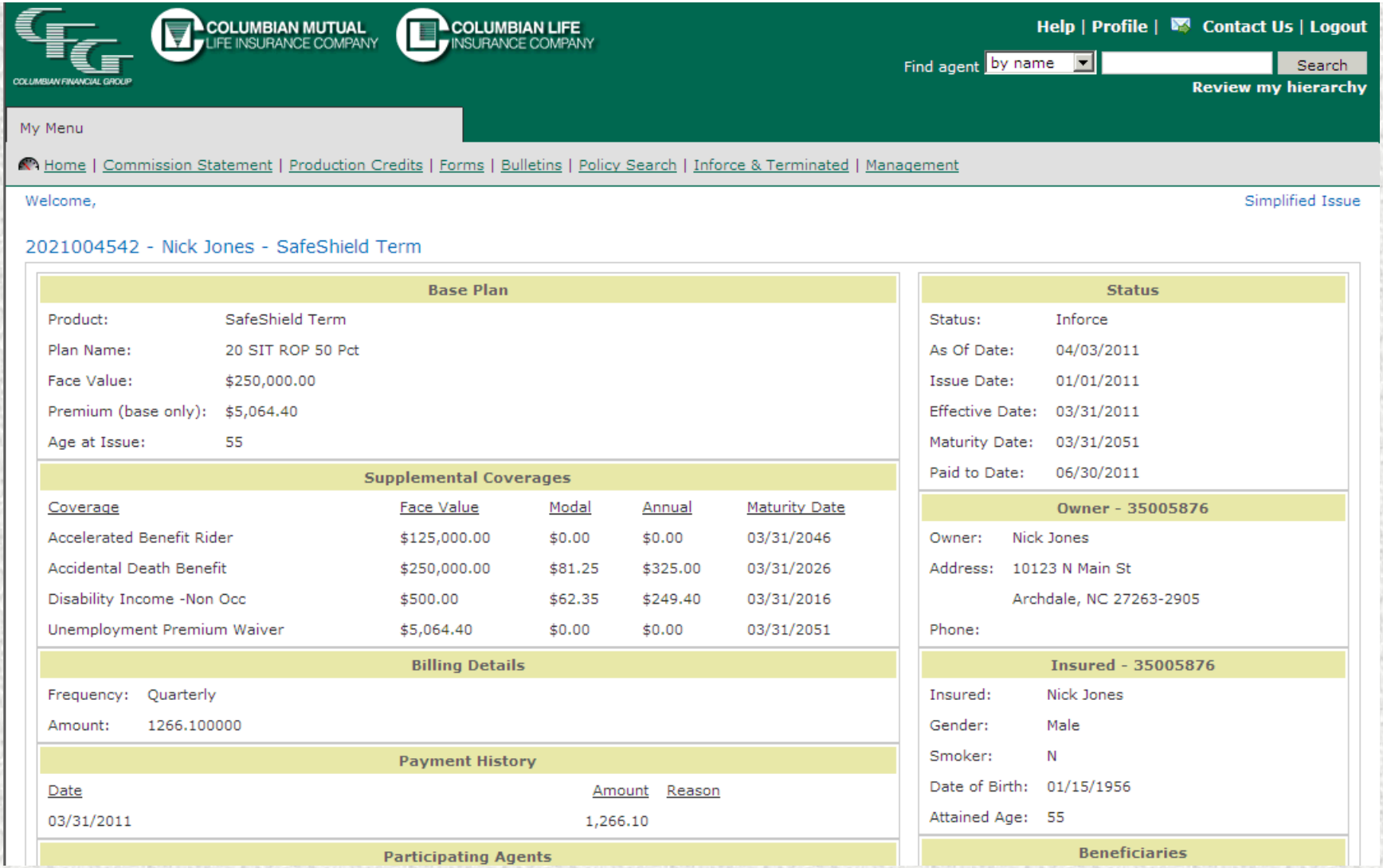
SafeShield® Web Support

Agent's Home Page (Dashboard)



SafeShield® Web Support

Policy Information



How To Contact Us

Product Support:	(800) 423-9765	Ext. 5959
Underwriting:	(800) 423-9765	Ext. 5904
New Business:	(800) 423-9765	Ext. 5944
Customer Service:	(800) 423-9765	Ext. 5920
Licensing:	(800) 423-9765	Ext. 6332
Commissions:	(800) 423-9765	Ext. 5908
	Online www.cfglife.com	
Forms:	(800) 423-9765	Ext. 7197
	Fax (607) 724-4345	
	Online www.cfglife.com	

New Business To: Agency Manager

www.cfglife.com

Product/rider specifications and availability may vary by state.
For full terms, refer to Policy/Rider Form Nos. 1F580-CL, 1F581-CL, 1F582-CL, 1F583-CL, 1F584-CL, 1F585-CL, 1F586-CL, 1F587-CL, 1F588-CL, 1F589-CL, 1F590-CL, 1H840-CL, 1H841-CL, 1H843-CL, 1H844-CL, 1H845-CL and 1H846-CL or state variation.