Final Expense

Dignified Choice® - Classic Series

Table of Contents

Columbian Life Insurance Company

- Columbian Mutual Life, our parent company, located in Binghamton, NY, has been in business for over 130 years (established 1882)

- $8.9 billion of life insurance in force across all product lines for Columbian Mutual and Columbian Life

- A.M. Best's rating of A- (Excellent)*

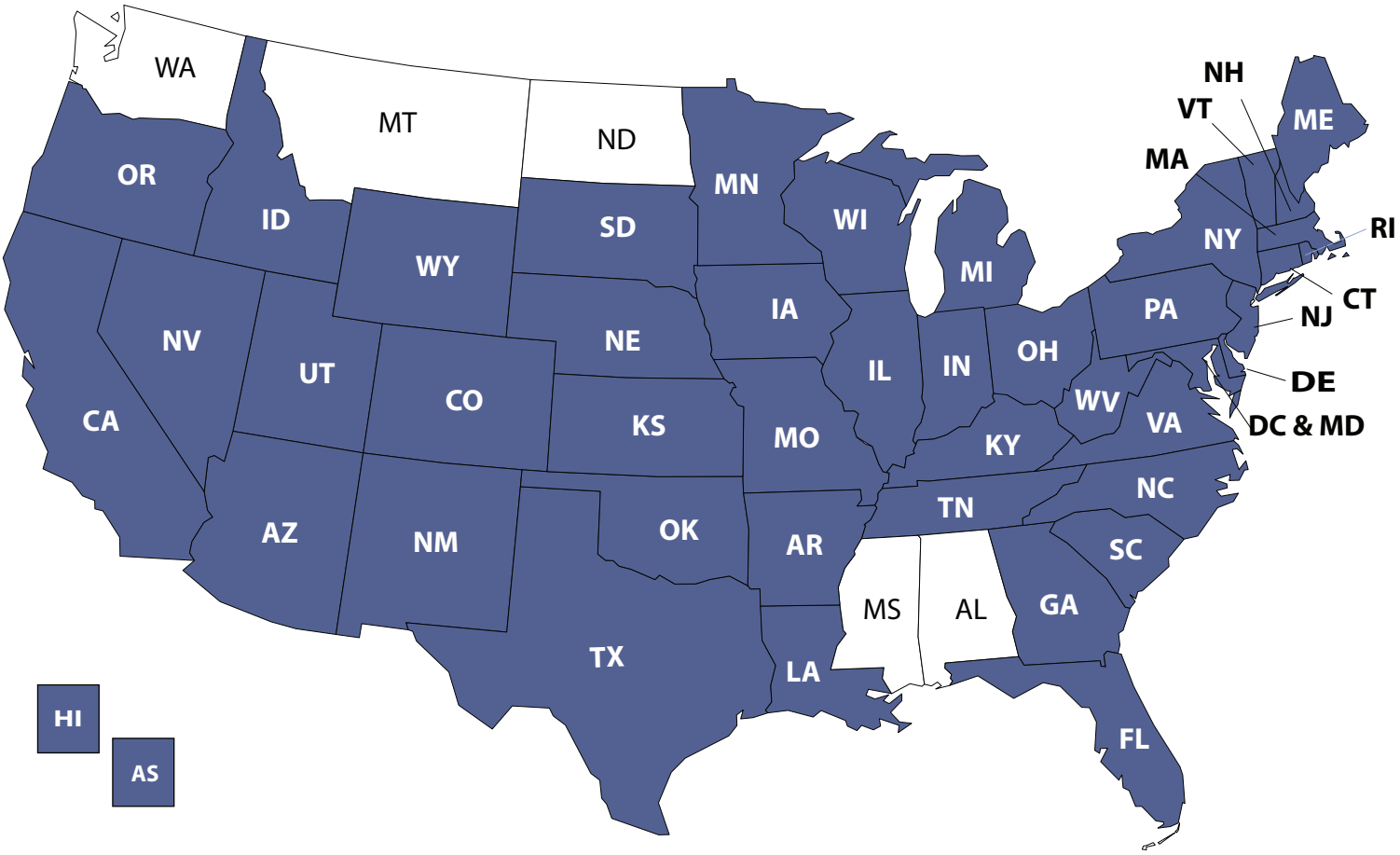
- Columbian Life is admitted in 45 States and 1 Territory

- Niche Market Focus

*Columbian's current rating is based on A.M. Best's opinion of the consolidated financial strength of the life/health members of the Columbian Financial Group, which operate under a group structure. This group member is assigned a Best's Rating of A- (Excellent), the fourth-highest of sixteen possible ratings on A.M. Best's scale. Rating as of 1/7/14.

Dignified Choice® - Classic Series

State Markets: Approved and Released



State Markets Approved & Released

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

***No soliciting, recruiting or contracting allowed in ME, NY or VT.**

Dignified Choice® - Classic Series

Product & Rider Availability 1/13/14

State	Base Plans		Riders/Benefits				
	Classic I Full Benefit	Classic II Graded	Accidental Death	Children's Term	Accelerated Benefit	Waive Prem Disiability	Waive Prem Nursing Home
AR	X	X	X	X	X	X	X
AZ	X	X	X	X	X	X	X
CA	X	X		X			X
CO	X	X	X	X	X	X	X
CT	X	X	X	X	X	X	X
DC	X	X	X	X	X	X	X
DE	X	X	X	X	X	X	X
FL	X	X	X	X	X	X	X
GA	X	X	X	X	X	X	X
HI	X	X	X	X	X	X	N/A
IA	X	X	X	X	X	X	X
ID	X	X	X	X	X	X	X
IL	X	X	X	X	X	X	X
IN	X	X	X	X	X	X	X
KS	X	X	X	X	X	X	X
KY	X	X	X	X	X	X	X
LA	X	X	X	X	X	X	X
MA	X	X	X	X	X	X	N/A
MD	X	X	X	X	X	X	X
ME	X	X	X	X	X	X	X
MI	X	X	X	X	X	X	X
MN	X	X	X	X	X	X	X
MO	X	X	X	X	X	X	X
NC	X	X	X	X	X	X	X
NE	X	X	X	X	X	X	X
NH	X	X	X	X	X	X	X
NJ	X	X	X	X	X	X	N/A
NM	X	X	X	X	X	X	X
NV	X	X	X	X	X	X	X
NY	X			X	N/A		X
OH	X	X	X	X	X	X	X
OK	X	X	X	X	X	X	X
OR	X	X	X	X	X	X	X
PA	X	X	X	X	X	X	X
PR	X	X	X		X	X	X
RI	X	X	X	X	X	X	X
SC	X	X	X	X	X	X	X
SD	X	X	X	X	X	X	X
TN	X	X	X	X	X	X	X
TX	X	X	X	X	X	X	X
UT	X	X	X	X	X	X	X
VA	X	X	X	X	X	X	N/A
VT	X	X	X	X	X	X	X
WI	X	X	X	X	X	X	X
WV	X	X	X	X	X	X	X
WY	X	X	X	X	X	X	X

No soliciting, recruiting or contracting allowed in ME, NY or VT.

Product Overview
Base Plans

Dignified Choice® - Classic I Full Benefit

Full benefit whole life insurance with simplified underwriting and level premiums.

Death Benefit:
- Immediate full coverage with level death benefit in all years

Underwriting:
- All health questions answered "no"
- Telephone interview (point of sale)
- Prescription Drug Database check
- MIB check

Classifications:
- Non-Tobacco
- Tobacco

Issue Limits:

Ages*	Face Amounts
25 - 44	$5,000 - $25,000
45 - 85	2,500 - 25,000

Available Riders:
- Accelerated Death Benefit Rider
- Accidental Death Benefit Rider
- Children's Term Insurance Rider
- Waiver of Premium Due to Disability Rider
- Nursing Home Waiver of Premium Rider

Dignified Choice® - Classic II Graded Benefit

Graded benefit whole life insurance with simplified underwriting and level premiums.

Death Benefit:
- Return of premiums plus 6% interest for non-accidental death occurring within the first two policy years.
- Full face amount for accidental death occurring within the first two policy years or for death by any cause in year three or thereafter.

Underwriting:
- Any Part 2 health question answered "yes"
- Prescription Drug Database check
- MIB check
- A telephone interview may be conducted by the Company if needed to clarify information

Issue limits:

Ages*	Face Amounts
45 - 85	$2,500 - 15,000

Available Riders:
- Children's Term Insurance Rider
- Accelerated Death Benefit Rider may be added after graded benefit period

Classification:
- Graded Benefit

Applications for Classic II Graded Benefit should not exceed 30% of the total number of Final Expense applications issued and paid.

*Age at the last birthday as of the ***effective date*** of the policy.

Policy/Rider specifications and availability may vary by state. Issue ages may vary by state.

Dignified Choice® - Classic Series

Application Health Questions

PART 1 -

Do not submit application for Classic I or Classic II if any Part 1 question is answered "yes."

PART 1 (If any question in this section is answered "YES," DO NOT SUBMIT THE APPLICATION)	YES	NO
1. Is the Proposed Insured currently hospitalized, confined to a nursing home, hospice, bed, or confined to a wheelchair (due to a disease or chronic illness), institutionalized, receiving home health care, ever been recommended for an organ or bone marrow transplant, or ever had a heart, lung, liver or bone marrow transplant, or ever had an amputation due to disease or, within the last twelve (12) months, received kidney dialysis?	☐	☐
2. Has the Proposed Insured ever been diagnosed or treated by a member of the medical profession for an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or has the Proposed Insured been diagnosed as having a terminal medical condition that is expected to result in death within the next twelve (12) months?	☐	☐
3. Has the Proposed Insured ever been diagnosed with, or received treatment for: mental retardation, Down's Syndrome, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, sickle cell anemia or un-operated heart defects?	☐	☐
4. Has the Proposed Insured ever been diagnosed or received treatment (including taking medication) with congestive heart failure, Alzheimer's disease, dementia or Lou Gehrig's disease (ALS)?	☐	☐
5. During the last twenty-four (24) months, has the Proposed Insured had, been diagnosed or received treatment (including taking medication) for any form of cancer (other than basal cell skin cancer)?	☐	☐
6. During the last twelve (12) months has the Proposed Insured been diagnosed as having a heart attack?	☐	☐
7. Are you male and over 350 pounds, or are you female and over 300 pounds?	☐	☐

PART 2 -

- Apply for Classic I Full Benefit if all questions are answered "no."
- Apply for Classic II Graded Benefit if any question is answered "yes."

PART 2 (If the answer to any question in Part 2 is "YES," the Proposed Insured is eligible for the GRADED BENEFIT PLAN only.)	YES	NO
1. During the last thirteen to twenty-four (13 - 24) months has the Proposed Insured been diagnosed as having a heart attack?	☐	☐
2. During the last twenty-four (24) months, has the Proposed Insured been diagnosed as having: A stroke (including TIA), aneurysm, enlarged heart, angina, pacemaker implant or any procedure to improve circulation to the heart or brain?	☐	☐
3. During the last thirty-six (36) months, has the Proposed Insured had, been diagnosed or received treatment (including taking medication) for:		
A. Emphysema, chronic obstructive pulmonary disease (COPD), black lung disease, any chronic respiratory disorder (excluding asthma or sleep apnea), or used oxygen equipment to assist in breathing?	☐	☐
B. Kidney disease, kidney failure, liver disease, chronic hepatitis, drug or alcohol abuse, or Systemic Lupus?	☐	☐
C. Multiple Sclerosis, Parkinson's Disease, schizophrenia, brain tumor or has the Proposed Insured been hospitalized or institutionalized for a mental or nervous disorder within the last twenty-four (24) months?	☐	☐
4. During the last twenty-four (24) months, has the Proposed Insured experienced complications of diabetes, including insulin shock, diabetic coma, Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve, circulatory) disorder, or diabetes not under control with current treatment , or has the Proposed Insured used insulin for the treatment of diabetes prior to age 50?	☐	☐

PART 3 -

Tobacco and Non-Tobacco classes available for Classic I Full Benefit.

PART 3 TOBACCO USE	YES	NO
Within the past twelve (12) months, has the Proposed Insured used any form of tobacco or nicotine products including cigarettes, cigars, pipes, chewing tobacco or snuff?	☐	☐

Application health questions may vary by state.

Product Overview
Rider Options

Accelerated Death Benefit Rider
Allows the Policyowner to request a benefit advance when the Insured is diagnosed by a physician as having a terminal condition and a life expectancy of 12 months or less. Rider coverage is provided at no additional premium charge and remains in force for the duration of the policy.*
Available with the Classic I Full Benefit Plan at the time of issue. The rider may be added to a Classic II Graded Benefit policy after the graded benefit period.
Issue Ages: Same as base policy (all ages)

Accidental Death Benefit Rider (Double Indemnity)
Doubles the death benefit for accidental death of the Insured. Rider coverage is maintained to age 70.
Available with the Classic I Full Benefit Plan only.
Issue Ages: 25 - 65

Children's Term Insurance Rider
Individual level term insurance on an eligible child, which includes a child, grandchild or great grandchild of the Insured. Coverage is maintained to the child's 25th birthday or until conversion.
Available with the Classic I Full Benefit Plan and Classic II Graded Benefit Plan.
Issue ages: Base Insured 25 - 85 / Children 15 days - less than 19 years
Minimum Issue: $2,500
Maximum Issue: $10,000, not to exceed the base policy face amount.
Maximum number of riders per policy is 20.

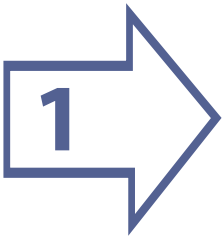
Waiver of Premium Due to Disability
Waives premium payments after 6 full months of total and continuous disability of the Insured.
Rider coverage is maintained until the policy anniversary on or next following the Insured's 65th birthday. If disability occurs prior to age 60, premiums continue to be waived as long as the Insured remains disabled. If the Insured becomes disabled between the ages of 60 and 65, the waiver benefit ceases at age 65.
Available with the Classic I Full Benefit Plan only.
Issue Ages: 25 - 55

Nursing Home Waiver of Premium Rider
Waives premium payments during the Insured's confinement in a qualified nursing home after 90 days of continuous confinement when care is recommended by a physician after the Rider is in effect.
Rider coverage remains in force for the duration of the policy.
Available with the Classic I Full Benefit Plan only.
Issue Ages: 56 - 85

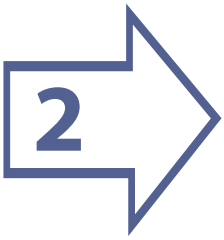
*If an accelerated benefit payment is made, a $250 administrative service fee is deducted from the payment and lien interest will be charged. Receipt of accelerated benefit may affect eligibility for public assistance programs and may be taxable.

Policy/Rider specifications and availability may vary by state.

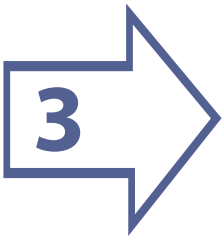
Underwriting Workflow



Complete and have the applicant sign the application.



For a Classic I Full Benefit Application, call Apptical, our third-party telephone inspection service, at **800-737-6972** for the telephone interview. ***Please note:*** *Any time a telephone interview is conducted, the signed application must be submitted to the Company, even if the application is withdrawn. Write "WITHDRAWN" across the front of the form.*



Mail the application and any required forms to your Agency Manager. The Agency Manager will forward to NAA, who will forward to Columbian. New Business Questions: **800-305-1335, Option 2**

Upon receipt of the application, Columbian will perform an MIB check. For Classic I Full Benefit applications completed outside of normal business hours (Monday through Friday 8:30 a.m. to midnight; Saturday and Sunday 10:00 a.m. to 8:00 p.m., Eastern Time), Columbian will order the telephone interview.

Call our Underwriting Team at **800-305-1335, Option 5,** with any underwriting questions.

Premium Calculations

Female, Age 65, Non-Tobacco, $10,000 Face Amount

Basic Policy Premium Calculation

Annual Mode

Annual Premium per $1,000	$49.97
Number of Thousands	x 10
	$499.70
Annual Policy Fee	+ 40.23
Total Annual Premium	$539.93

Monthly EFT Mode

Total Annual Premium	$539.93
Monthly EFT Modal Factor	x .087
Monthly EFT Premium	$46.97

Rider Calculations

Accidental Death Benefit

ADB Annual Premium	$1.78
Number of Thousands	x 10
	$17.80
Monthly EFT Modal Factor	x .087
ADB Modal Premium	$1.55

Children's Term Rider

Annual Premium per Child	$2.40
Number of Thousands	x 10
	$22.40
Monthly EFT Modal Factor	x .087
CTR Modal Premium	$2.09

Nursing Home Waiver of Premium

Policy Modal Premium	$46.97
ADB Modal Premium	+ 1.55
CTR Modal Premium	+ 2.09
Subtotal	$50.61
Nursing Home WP %	3.6%
Nursing Home WP Premium	$1.82

Total Premium Calculation

$50.61 (Subtotal) + $1.82 (Nursing Home WP) = $52.43 Total Premium

Round each calculation to the nearest cent.
For fast and easy calculations, download one of our
Final Expense calculators from naaleads.com.

Sample Base Application

APPLICATION FOR WHOLE LIFE INSURANCE POLICY

MAIL POLICY TO: ☑ **Agent** ☐ **Owner**

COLUMBIAN LIFE INSURANCE COMPANY
HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: PO Box 4850, Norcross, GA 30091-4850

1. PROPOSED INSURED:

Proposed Insured (First, Middle Initial, Last)	Social Security Number	Sex	Age Last Birthday	Date of Birth	State of Birth
Lucinda M. Jones	999-99-9999	F	65	3/11/49	FL

Home Address/Apt. #, City, State, Zip Code	Phone Number
1234 Happy Valley Road, Anywhere, FL 12345	(123) 456-7890

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

Name of Owner	Social Security Number	Relationship to Proposed Insured

Address/Apt. #, City, State, Zip Code (If different from Insured)

3. BENEFICIARY:

Primary Beneficiary Designation: (Full Name & Relationship to Insured)	Contingent Beneficiary Designation: (Full Name & Relationship to Insured)
John S. Jones - Spouse	Carrie A. Jones - Daughter

4. POLICY INFORMATION:

Base Plan of Insurance:	Amount of Base Premium (Minus Riders):	Amount of Insurance (Face Amount):	Riders:	Rider Premium:	Amount Paid with Application:
☑ Full Benefit Plan ☑ Non-Tobacco ☐ Tobacco ☐ Graded Benefit	$ 46.97	$ 10,000	☑ Accidental Death Benefit ☑ Accelerated Death Benefit ☐ Waiver of Premium – Nursing Home ☑ Waiver of Premium – Disability ☑ Children's Term Insurance Rider	$ 1.55 (No Charge) $ $ 1.82 $ 2.09	$ 52.43

ANSWER ONLY IF APPLYING FOR THE NURSING HOME WAIVER OF PREMIUM RIDER (If any question in Part 2 is answered "YES," the Proposed Insured is not eligible for this rider): **YES** **NO**

Does the Proposed Insured currently use mechanical devices such as a wheelchair, crutches, hospital bed or oxygen; or currently need or require assistance from another person in bathing, eating, dressing, toileting, transferring from bed to chair or maintaining continence; or has the Proposed Insured received medical advice or treatment or consulted with a member of the medical profession for osteoporosis or memory loss? ..... ☐ ☐

Payment Mode: ☐ **Annual** ☐ **Semi-Annual** ☐ **Quarterly** ☑ **Monthly (must be Electronic Funds Transfer)**

Requested Effective Date (if different from the application date): _____ Automatic Premium Loan: ☑ Yes ☐ No

5. HEALTH HISTORY:

PART 1 (**If any question in this section is answered "YES," DO NOT SUBMIT THE APPLICATION**)	**YES**	**NO**
1. Is the Proposed Insured currently hospitalized, confined to a nursing home, hospice, bed, or confined to a wheelchair due to a chronic illness or disease, institutionalized, receiving home health care, recommended for an organ transplant, ever had a heart, lung or liver transplant, ever had an amputation due to disease or, within the last twelve (12) months, received kidney dialysis?.....	☐	☑
2. Has the Proposed Insured ever been diagnosed or treated by a member of the medical profession for an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?.....	☐	☑
3. Has the Proposed Insured been diagnosed as having a terminal medical condition that is expected to result in death within the next twelve (12) months?.....	☐	☑
4. Prior to age 25, has the Proposed Insured had, or been diagnosed with or received treatment for mental retardation, Down's Syndrome, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, sickle cell anemia or un-operated heart defects?.....	☐	☑

PART 2 (If the answer to any of the questions in Part 2 is "YES," the Proposed Insured is eligible for the GRADED BENEFIT PLAN only.)	**YES**	**NO**
1. Has the Proposed Insured ever been diagnosed with congestive heart failure, Alzheimer's disease, dementia or Lou Gehrig's disease?.....	☐	☑
2. During the last twenty-four (24) months, has the Proposed Insured been diagnosed as having: A stroke, heart attack, aneurysm, enlarged heart, angina, pacemaker implant or any procedure to improve the circulation to the heart or brain?.....	☐	☑
3. During the last thirty-six (36) months, has the Proposed Insured had, been diagnosed or received treatment (including taking medication) for:		
A. Any form of cancer (other than basal cell skin cancer)?.....	☐	☑
B. Emphysema, chronic obstructive pulmonary disease (COPD), black lung disease or any other chronic respiratory disorder that required the use of oxygen, excluding asthma or sleep apnea?.....	☐	☑
C. Kidney disease, kidney failure, liver disease, drug or alcohol abuse?.....	☐	☑
D. Multiple Sclerosis, Parkinson's Disease, psychosis or schizophrenia?.....	☐	☑
4. During the last twenty-four (24) months, has the Proposed Insured experienced complications of diabetes, including: insulin shock, diabetic coma, eye or kidney disorder or diabetes not under control with current treatment or has the Proposed Insured used insulin for the treatment of diabetes prior to age 50?.....	☐	☑

PART 3 TOBACCO USE	**YES**	**NO**
1. Within the past twelve (12) months, has the Proposed Insured used any form of tobacco or nicotine products including cigarettes, cigars, pipes, chewing tobacco or snuff?.....	☐	☑

FORM NO. A332-CL PAGE 1 of 2

APPLICATION FORM NUMBER MAY VARY BY STATE

Sample Base Application

PART 3 TOBACCO USE — YES / NO

1. Within the past twelve (12) months, has the Proposed Insured used any form of tobacco or nicotine products including cigarettes, cigars, pipes, chewing tobacco or snuff? ☐ YES ☑ NO

PART 4 ANSWER ONLY IF APPLYING FOR THE NURSING HOME WAIVER OF PREMIUM RIDER — YES / NO

(If any question in Part 2 is answered "YES," the Proposed Insured is not eligible for this rider):

Does the Proposed Insured currently use mechanical devices such as a wheelchair, crutches, hospital bed or oxygen; or currently need or require assistance from another person in bathing, eating, dressing, toileting, transferring from bed to chair or maintaining continence; or has the Proposed Insured received medical advice or treatment or consulted with a member of the medical profession for osteoporosis or memory loss? ☐ YES ☐ NO

6. REPLACEMENT: — YES / NO

Do you have any existing life insurance or annuities? ☑ YES ☐ NO

Is this application for insurance intended to replace any life insurance or annuities now in force? ☐ YES ☑ NO

(If "YES," submit any special forms required by the state in which the application is signed.)

BOTH questions must be answered.

7. SPECIAL REQUESTS / REMARKS:

8. CONDITIONS RELATING TO THE APPLICATION:

I have read the questions and answers in all parts of this application and agree that they are complete and true to the best of my knowledge and belief. I agree that this application shall form a part of any policy issued. I understand and agree that no agent has the authority to waive a complete answer to any question in the application, pass on insurability, make or alter any contract, or waive any of the Company's other rights or requirements; that any policy applied for shall not take effect (except as provided in the Conditional Receipt bearing the same number as this application) unless and until the policy has been issued and delivered and the full first premium, according to the mode of payment selected by the applicant (as permitted by the Company) and stipulated in the policy, has been paid and accepted by the Company during the lifetime and condition of health of the Proposed Insured as stated in the application.

9. AUTHORIZATION & ACKNOWLEDGMENT:

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance company, the Medical Information Bureau, consumer reporting agency, or other organization, institution or person that has any records or knowledge of me, to give any such information to Columbian Life Insurance Company ("the Company") or its reinsurers for underwriting or claims purposes. This authorization also includes information about drugs, alcoholism, prescription drug records, or any other medical history information. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. **I understand** my information may be subject to redisclosure to a third party and may no longer be protected by federal privacy laws. **I understand** a telephone interview may be necessary to verify or supplement information given to the Company on this application. This interview may be made from the Administrative Service Office or from a consumer-reporting agency by a trained interviewer acting on the Company's behalf. A photocopy of this form will be as valid as the original; this authorization will be valid for two (2) years from the date shown below, and will survive my death if it occurs during such two (2) year period. You may revoke this authorization by contacting us at PO Box 1381 Binghamton, NY 13902-1381 however, we retain the right to use any information obtained under your authorization prior to your revocation. **I have read and understand** the Conditions Relating to the Application and the Authorization & Acknowledgment.
I acknowledge receipt and review of the Information Practices Relating to Underwriting Your Application.
I have read and acknowledge the applicable fraud notice required by state law.

1/13/14 — Date of Application

X Lucinda M. Jones — 1/13/14

ture of Proposed Insured (Parent/Guardian if 15 or under) (Date)

Anywhere, IL — Dated At (City, State)

ture of Owner (If other than Insured) (Date)

CIty and state where application is signed MUST be included.

10. REPORT OF LICENSED AGENT:

Does the applicant have any existing life insurance or annuities? ☑ YES ☐ NO

Is this insurance intended to replace, in whole or part, any life insu ☐ YES ☑ NO

(If "YES," submit any special forms required by the state in which

HAS THE TELEPHONE INTERVIEW BEEN COMPLETED ☑ YES ☐ NO

BOTH questions must be answered.

Completing the interview for Classic I will speed processing.

I hereby affirm that I personally solicited, witnessed, and com ll answers given above are true and correct to the best of my knowledge.

Alfred Q. Agent — Name of Licensed Agent (Print)

X Alfred Q. Agent — 1/13/14

Signature of Licensed Agent *(required)* (Date)

12345 — Agent Number %

Second Agent Number % (If Splitting)

678910 — Agent's State License ID No. (in jurisdictions where required)

FORM NO. A343-CL Page 2 of 4

APPLICATION FORM NUMBER MAY VARY BY STATE

Sample Base Application

MISCELLANEOUS — **Complete, If Applicable – Not Required In All States**

SECONDARY ADDRESSEE / THIRD PARTY DESIGNEE ☑ Not Electing A Secondary Addressee/Third Party At this Time.

(The Applicant/Owner may designate a Secondary Addressee/Third Party to receive a copy of Important Notices.)

Name & Address:

Secondary Addressee / Third Party Authorization

I hereby give permission to accept any Important Notices on behalf of the named Proposed Insured.

X _____

Signature of Secondary Addressee/Third Party (If Required)

REQUEST FOR ELECTRONIC FUNDS TRANSFER PLAN - (Must compl… DO NOT USE FOR DRAFT 1st PREMIUM

Complete this section for immediate payment of initial premium.

Amount Paid With Application: $ 52.43

☑ **ONE TIME ELECTRONIC FUND TRANSFER**

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

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

This will be a **one time withdrawal** from my account in the amount of $ 52.43 from the account detailed below.

Financial Institution: XYZ Bank Name of Bank Account Holder: Lucinda M. Jones

Account Type : ☑ Checking or ☐ Savings

Routing Number: 1 2 3 4 5 6 7 8 9 Must have 9 digits in routing #

Account Number: 0 0 0 1 1 1 2 2 2 3 3 3 4 4 4 Can have up to 17 pos… account #

1/13/14 X Lucinda M. Jones

Date **Authorized Signature as it appears on Bank Record…**

Signature required for initial withdrawal.

IF YOU WISH TO CONTINUE MAKING PREMIUM PAYMENTS VIA ELECTRONIC FUN… …NSFER, PLEASE COMPLETE THE… …ORMATION BELOW AND SIGN. PLEASE NOTE: YOU NEED ONLY INCLUDE THE ACCOUNT I… …ENT THAN STA… …D ABOVE.

Complete this section for Draft First Premium and/or Monthly EFT.

☐ **FIRST DRAFT AND ONGOING ELECTRONIC FUND TRANSFER**

I authorize the payment of debits drawn on my account payable to Columbian Life In… …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… …ired debit results in forfeiture of insurance.

Any requirement for giving notice of premiums due shall be waived as long as this Electronic F… …ds 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 XYZ Bank ☑ **Checking (Attach voided check if available.)** **or** ☐ **Savings**

Transit / Routing # 1 2 3 4 5 6 7 8 9 Must have 9 digits in routing #

Account # 0 0 0 1 1 1 2 2 2 3 3 3 4 4 4 Can have up to 17 positions in account #

I request withdrawal of payments on or about the ☐ 1st ☐ 3rd ☐ 5th ☐ 10th ☐ 15th ☑ 20th **or** ☐ 25th **of each month, b…ginning in the month of** August .

_____ 1/13/14 X Lucinda M. Jones

Name of Bank Account Holder **Date** **Authorized Signature as it appears on Bank Record…**

Signature required for Draft First Premium or Monthly EFT.

FORM NO. A343-CL Page 3 of 4

APPLICATION FORM NUMBER MAY VARY BY STATE

Telephone Interview - Classic I

A telephone interview is required on all **Classic I Full Benefit** applications. Calling for the interview at the point of sale allows you to close the sale while still in the applicant's home. Interviewers are available:

Monday through Friday 8:30 a.m. - 12:00 a.m. Eastern Time
Saturday and Sunday 10:00 a.m. - 8:00 p.m. Eastern Time

Simple procedures for the telephone interview:

1. Complete the application and ask all health questions. Have the applicant sign.

2. Call 1-800-737-6972 if the application is completed during the business hours listed above.* Provide your name and let the operator know that you are calling for a telephone interview for Columbian's Final Expense product. Be sure to advise the operator if the Proposed Insured does not speak English.

4. Have the Proposed Insured speak with the inspector in order to confirm the answers to the application questions. During the interview, the inspector will access a prescription drug database to determine whether any prescribed medication the Proposed Insured is using could indicate a medical condition that should have been disclosed on the application.

5. The inspector will speak to you at the end of the interview to let you know whether the prescription database shows any medications that are prescribed for conditions that could affect underwriting of the application. Because many drugs are prescribed for multiple conditions, the fact that a Proposed Insured uses a certain medication does not necessarily mean that they will not qualify for a Classic I Full Benefit policy; it simply means that you should have further discussion to clarify any possible health issues before you submit the application.

6. The completed and signed application must **always** be submitted to the Company, even if the application is withdrawn. Write "WITHDRAWN" across the form.

Completing the telephone interview at the time of sale helps to avoid miscommunications and gives you more complete information regarding your client's health history. Qualifying applicants at the point of sale for the proper plan speeds the underwriting process and results in fewer declined policies.

*If the application is completed outside of the business hours listed above, the telephone interview will be scheduled after the application is received by Columbian. Be sure to include the Proposed Insured's phone number on the application and indicate the best time to call in the Special Requests / Remarks section. If the Proposed Insured does not have a telephone, he or she will need to call the telephone inspection service during business hours.

Online Resources

The CFG website is an essential resource for our Final Expense producers. The website allows you to track the real-time status of your business and gives you access to production reports and commission statements at any hour. Our detailed online reporting is so efficient, we no longer mail commission statements or production reports.

Real-Time Reports

The real-time status of your new business is posted in your Application History. Clean business that is received before noon Eastern Time on Wednesday is issued by Friday. "Clean business" assumes that the application is properly completed, premium is accurate, and the MIB does not show undisclosed medical issues.

Commission statements and agent production reports are updated daily.

Additional Tools

The website allows you to access management reports, search for policies, see any policies that are past due, and provides instant access to printable forms.

Accessing the Website

You may access the CFG website through naaleads.com.

How to Contact Us

Licensing	Download forms from www.naaleads.com; Submit forms to Agency Manager. For licensing questions, call (800) 423-9765 Ext. 6315		
New Business/ Agent Support	Phone Fax	(800) 305-1335 (888) 233-6881	Extension 4902
Claims	Phone Fax	(800) 305-1335 (888) 233-6881	Extension 7557
Underwriting	Phone Fax	(800) 305-1335 (888) 233-6881	Extension 5904
Commissions	Phone Fax	(800) 305-1335 (888) 233-6881	Extension 5908
Supply Orders	Phone or through your Agency Manager	(800) 423-9765	Extension 7197
New Business to	Submit new business to Agency Manager; Agency Manager forwards to NAA; NAA forwards to Columbian		

Notes

Notes

Not For Consumer Use.

Product/rider specifications and availability may vary by state. For full and complete terms, please refer to Policy Form Nos. 1F154-CL, 1F155-CL, Rider Form Nos. 1H870-CL, 1H871-CL, 1H864-CL, 1H865-CL, 1H855-CL, 1HC12-CL or state variation.

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